Llywodraeth Cymru
Welsh Government

# Reflecting on our Health

## CHIEF MEDICAL OFFICER FOR WALES ANNUAL REPORT 2024–2025


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# Contents




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# Foreword

**Thank you for your interest in this Annual Report of the Chief Medical Officer (CMO) for Wales.**

This year's publication differs from previous editions as it comes at a time of change of CMO. Sir Frank Atherton stepped down from the role in February 2025 and Professor Oliver commenced in post in May. The original draft of this report was written by Sir Frank Atherton and, where "I" is used, represents his views and experiences at the time. Professor Oliver, the current CMO, has reviewed this report and supports the recommendations. She offers her views and experiences for her first six months as an addendum.

As is usual with our independent CMO reports in Wales we have used the first chapter to summarise at a high level the health status of the people of Wales. We have previously signalled a concern that the gains in life expectancy and healthy life expectancy seen in Wales over previous decades are stagnating; the reasons for this are still not entirely clear but lifestyle issues, living conditions including economic well-being, and our ageing population are all likely factors.

A major concern of this report is the issue of prevention. It is often cited that "prevention is better than cure" but refocussing the health service towards a preventive approach at a time of constrained resources and increased pressure is never an easy task. However, we make the case that without such a shift the health of the population will continue to stagnate or worsen. This is a major challenge to our health service leaders. It also demands changes in society, and at an individual level, so that health is a responsibility – as well as a right – for everyone in Wales.

Finally, health services make an important contribution in the delivery of better population health, so we have used this report to look in detail at the workforce we have and the workforce we need if we are to deliver better health through our health services.

We hope that you will enjoy reading this annual report. We don't expect everyone to agree entirely with our analysis and recommendations, and we encourage your comments, suggestions, and further conversations as to how we can collectively build a healthier nation.

**Sir Frank Atherton**
Former Chief Medical Officer

**Professor Isabel Oliver**
Chief Medical Officer

Chapter 1:

# Health of the nation

## Our changing population

**The population of Wales continues to grow: the latest mid-year Welsh population estimate is 3.16 million for 2023, with 1.55 million males and 1.61 million females (1).**

Wales is set to continue along a trend towards an ageing population, with the associated economic challenges (2). The number of those aged 65 and over is expected to increase from 669,000 people (21% of the population) in 2020 to just under 837,000 (25%) by 2045. The proportion of the working-age (16–65) population is expected to decrease over the same period, despite anticipated population growth and positive net migration. The proportion of young people (those aged 0–15) in Wales is set to decrease by the year 2045 and account for just under 15% of the population; down from just under 18% in 2020 (approximately 563,000 in 2020 down to 487,000 in 2045). Current age distributions are already uneven amidst continuing rural to urban migration, with relatively higher numbers of older persons and lower numbers of younger persons in more rural areas, such as Ceredigion and Powys, and the inverse in urban locations, such as Cardiff and Newport.

Wales continues to become more ethnically diverse (3). In the 2021 census, 93.8% identified as “White British/Welsh/Irish/Scottish/English” (compared to 95.6% in 2011) followed by 2.9% identifying as “Asian, Asian Welsh/British”, 0.9 % identifying as “Black, Black Welsh/British, Caribbean or African” and 0.9% identifying with an “Other ethnic group”.

Economically, there is a mixed picture (4). Average (median) gross hourly earnings have risen and are currently estimated at £16.42 in Wales (compared to £17.48 for the UK as a whole), economic inactivity (excluding students) for 2023-4 was 20.6% (compared to 17.8% for the UK as whole), whilst the unemployment rate has fallen to 3.1% (compared to 3.7% for the UK). Relative pensioner poverty remained around 16% (after housing costs) in 2024 whilst relative child poverty (after housing costs) rose to 31% (5).

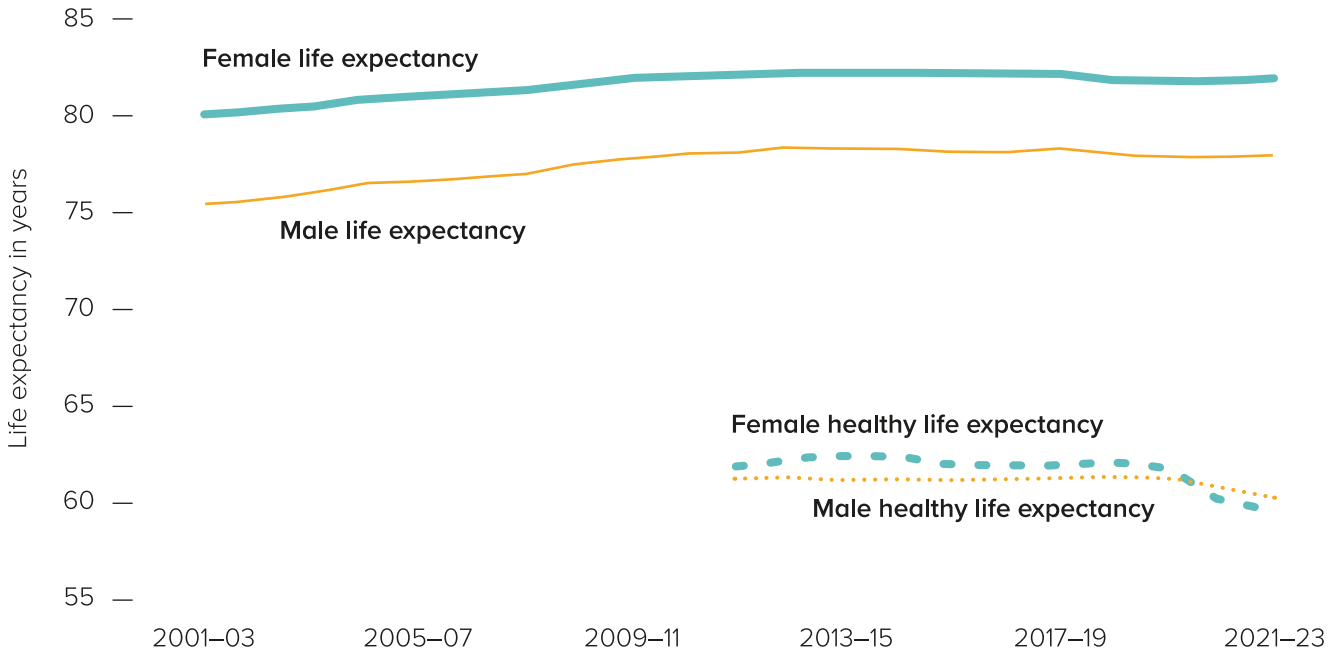
## Life expectancy

Overall life expectancy for the UK (at birth) for 2021–2023 has fallen to 82.8 for females and 78.8 for males (6). In Wales, for 2021–2023, the average life expectancy at birth is 82.0 for females and to 78.1 for males (6). This represents small decreases for women and men compared to 2019-21. Healthy life expectancy refers to the number of years spent in good health. The latest estimate for Wales, for 2021–2023, shows a healthy life expectancy at birth of 60.3 years for males and 59.6 years for females (7). Both are small decreases from previous years and are the lowest in the UK. The healthy life expectancy gap between the most deprived and least deprived areas in Wales has widened at 16.4 years for males and 20.2 years for females.

In 2023, there were 36,054 deaths registered in Wales, which now has an age-standardised mortality rate of 1,053.7 per 100,000 population (8). This continues a small decline in mortality rate since 2020 (the peak of the COVID-19 pandemic) but is still higher than the rates seen between 2015 and 2019 (1,020.6 in 2019). This recent plateauing of mortality rates in Wales is similar to trends in other UK nations, where previously mortality rates had generally been falling since the end of the Second World War.

The leading cause of death in Wales is now dementia and Alzheimer's disease (10.6%) followed by ischaemic heart diseases (10.4%), chronic lower respiratory diseases (5.9%), malignant neoplasm of the trachea, bronchus and lung (5.1%), cerebrovascular diseases (5.0%) and influenza and pneumonia (4.3%) (8). COVID-19 has notably dropped out of the top 6 leading causes of death for the first time since the pandemic.

**Figure 1: Life expectancy and healthy life expectancy at birth, by sex, 2001–03 to 2021–23. The chart shows that increases in life expectancy for males and females have stalled in recent years. Healthy life expectancy has decreased, especially for females compared with 2011–13 when the time series began.** (7) (9)




Source: Healthy life expectancy in England and Wales, ONS

For self-reported health, there is a mixed picture. The 2021 census showed that the age-standardised proportion of the Welsh population reporting very good health was 46.6% and for good health was 32.5% (10). This was a marginal increase of 0.9 and 1.1 percentage points respectively since 2011. In 2021, 5.1% of respondents reported bad health, a decrease of 0.9 percentage points from 6.0% in 2011. 1.6% of respondents reported very bad health, 0.3 percentage points decrease from 1.9% in 2011. However, the latest National Survey for Wales suggests there has been a recent marginal decline (11). For the period April 2022 to March 2023, 69% of adults in Wales reported good or very good health, with 36% reporting having at least one limiting long-standing illness). These compared to 72% reporting good or very good health and 33% reporting a limiting long-standing illness in the year prior. Women, older people and adults in the most deprived area were less likely to report good health and more likely to report limiting illness.

## Premature mortality

In 2023, 8,193 people died prematurely before the age of 75 in Wales, which equates to 22.7% of all deaths (12). Avoidable deaths are defined as either preventable or treatable for those aged under 75 years. The leading cause of avoidable deaths remains neoplasms (cancer), but this continues to decline. Across the UK, we are seeing a relative worsening of mortality rates, particularly in people aged 25-49. In 2023, UK female mortality rates for this age group were 46% higher than the median of peer countries, while male rates were 31% higher (13).

Concerningly, avoidable mortality for drug and alcohol-related deaths continues to steadily rise in Wales, from 24.2 per 100,000 population in 2019 to 30.2 in 2022 (standardised for age), associated with socio-economic and geographic inequalities (14). This continues an overall increasing trend in drug-related deaths in the UK since 2010, with the drug-related mortality rate more than three times higher in 2019 than the median of peer countries (13). In Wales, there were 377 deaths related to drug poisoning registered in 2023, the equivalent of 12.9 deaths per 100,000 population, higher than in 2022 (15). In Wales, there were 486 alcohol-specific deaths in 2022, a rate of 15.4 deaths per 100,000 people and the highest level for over two decades (12). There were 14.0 deaths by suicide per 100,000 people in 2023 (386 deaths), also an increase compared with 2022 (16).

Previous work by Public Health Wales has demonstrated that, in the most deprived areas in Wales, both premature mortality and years of life lost are around double those of the most affluent areas (17). With each increase in level of deprivation, both the premature deaths and the years of life lost also increased. The latest data from ONS shows an avoidable age-standardised mortality rate (ASMR) nearly three times higher for males in the most deprived areas of Wales compared to the least deprived areas (557.5 vs 207.3 deaths per 100,000 males) (12). The ASMR was also nearly three times higher for females in the most deprived areas compared to the least deprived areas (348.0 vs 126.7 deaths per 100,000 females). With a significant number of premature deaths being attributable to socioeconomic inequality, this remains an important public health challenge.

One of the ways these inequalities manifest is through behavioural risk factors, like tobacco smoking. We know from the Lancet's Global Burden of disease Report that modifiable risk factors make the largest contribution to premature mortality and health inequalities (18). The top risk factor for high income countries like Wales continues to be tobacco smoking, followed by high body mass-index, high blood sugar, high blood pressure, and dietary risk factors, such as low fibre and regularly consuming foods high in sugar, salt and fat (18). Health behaviours are explored in greater detail on the following page.

The circumstances where we are born, live, learn, work and play (also known as upstream conditions, the social or wider determinants of health, or the building blocks of health) have the most powerful influence on individual and collective health, well-being and equity. Public Health Wales hosts a World Health Organisation (WHO) Collaborative Centre assisting research that has found, that, in European countries (including Wales), five essential conditions contribute to two thirds of the inequities seen in health and well-being (19). The biggest contributor is income insecurity (35%) followed by living conditions (29%, including poor-quality housing cold homes, and insecure housing tenure), poor social and human capital (19%, mainly due to differences in educational achievement), and unemployment and poor working conditions (7%). 'Social capital', as used here, means the way that people relate to each other and how much they share values and norms – so it can be considered similar to the concept of community cohesion. 'Human capital' relates to qualities held by an individual (such as knowledge, skills, education and health) that might be associated with that person being socially or economically successful.

The quality, availability, and affordability of health services are responsible for about 10% of the inequities in health and well-being. If significant progress on reducing the healthy life expectancy gap in Wales is to be achieved, then effective action on the building blocks of health is required. A focus on prevention is most likely to have impact on health inequalities at the population level.

Several national well-being indicators in Wales can be related to these building blocks of health. Notably, educational attainment (as defined by qualification levels) has improved slightly between 2015 and 2023, as has the proportion of 16–24 years olds in education/employment/training. The employment rate gap between Wales and the rest of the UK has improved since 2015, and volunteering rates have improved slightly since 2017. There has been a significant reduction in hazardous housing since 2017 (20), but progress will need to continue in areas such as relative poverty, as outlined earlier. Interventions that address the upstream determinants of health and health behaviours should continue to be prioritised if we are to meet our health in all policies ambition, greater detail for which is given in the next chapter.

**Figure 2: box showing the five essential conditions and policies for healthy and prosperous lives from the Welsh Health Equity Status Report initiative (WHESRi) (21) as per the WHO Health Equity Status Report Initiative (HESRi) framework (22).**

## The early years

In historical terms, Wales's rate of infant mortality remains low, but progress has stagnated since 2014. In 2023, there were 98 infant deaths in Wales with an infant mortality rate of 3.6 deaths per 1,000 live births (23). Low birthweight (<2.5kg at birth), can be associated with health risks in an infant's first year of life. This indicator was 7% of all live births in 2023 with a marginal upward trend since 2013 (24). Maternal mortality in the UK between 2020 and 2022 has risen to 13.56 women per 100,000, the highest rate since 2003 with non-white ethnicity, deprivation, older age, obesity and smoking as leading risk factors (25). Maternal obesity (BMI>30 at initial assessment) rose to a record 32% in Wales in 2023 (5.8% higher since 2016) whilst maternal smoking has dropped to a record low of 14% (24).

## Health behaviours in children and young people

The School Health Research Network (SHRN) regularly reports on the health, well-being and behaviours of children and young people in Wales in both the primary and secondary sectors. This enables us to provide a broad overview of the health and well-being of those aged seven through to 16.

Some 32,500 learners from 354 primary schools in years 3 to 6 (7- to 11-year-olds) participated in the initial data collection in primary schools in 2022-23, following earlier feasibility work. Mental health and well-being are integral to SHRN, with highlights from the findings (26) at a national level including, for example, five in six children (84%) reporting being satisfied with their life (measured by a score of at least 6 out of 10 on the Cantril ladder visual analogue scale), while around one in four (27%) reported 'elevated' emotional difficulties, with one in eight reporting potentially clinically significant emotional difficulties (measured by the Me and My Feelings Questionnaire). Similarly, one in seven (14%) reported elevated behavioural difficulties, with one in 12 reporting potentially clinically significant behavioural difficulties. In terms of physical activity and nutrition, fewer than half of this age group reported eating fruit (48%) or vegetables (37%) daily, with less than half (46%) of reporting to exercise in their free time (so much that they get out of breath and sweat) four times or more a week. Girls and learners from more affluent families were more likely to report daily fruit and vegetable consumption, while boys and learners from more affluent families reported more exercise. Socioeconomic gradients can be observed in numerous indicators, including mental health, bullying, healthy eating, physical activity, and sleep, with those from less affluent families less likely to report positive outcomes. Findings from the 2024 SHRN survey in primary schools, in which 510 schools participated, will be published in autumn 2025.

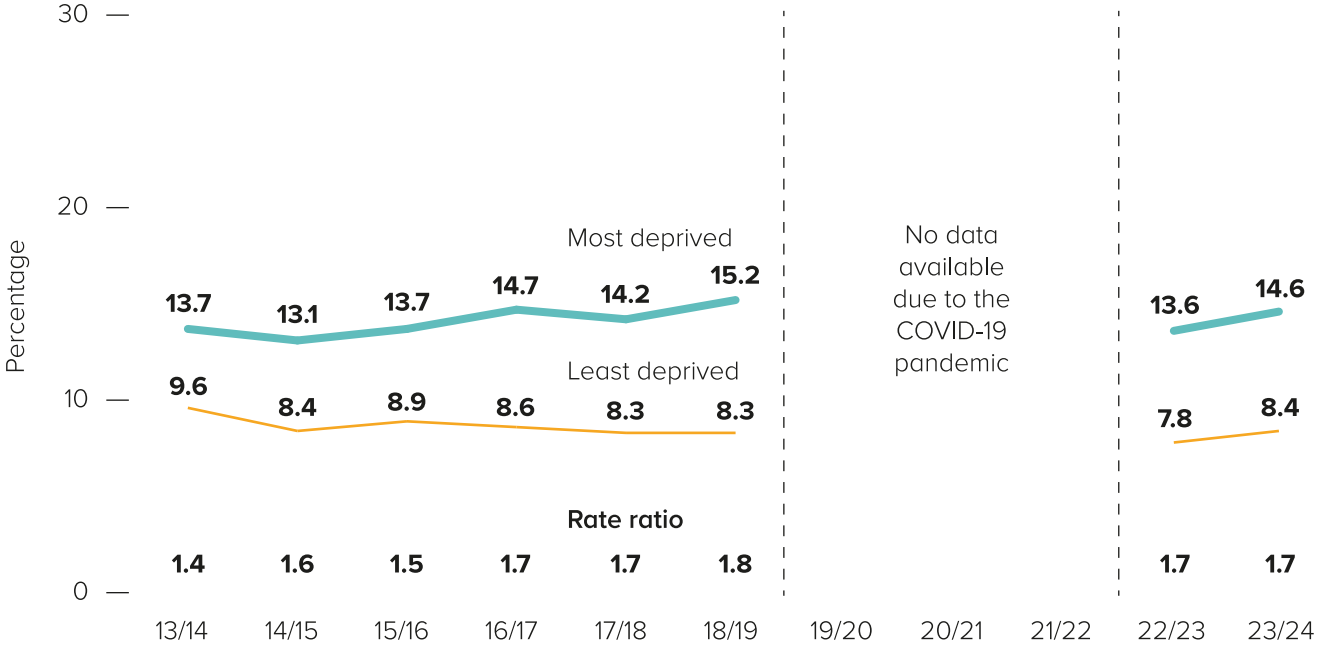
The most recent SHRN Secondary School data collection took place in 2023. The sample included all maintained secondary schools across Wales and a small number of independent schools (27). In total 129,761 students aged 11 to 16 from 201 schools participated in the survey, an overall 75% response rate), with data available via an interactive dashboard. In terms of general health, highlights from the findings include between one in three and two in five reporting sleeping difficulties (40%), feeling nervous (35%), irritability (40%), and feeling low (32%) at least once a week in the last six months. For physical activity, just one in five (18%) report meeting the recommended physical activity guidelines of at least 60 minutes per day, while one in three (33%) report daily active travel to school. Around half (47%) report daily consumption of fruits and vegetables, with 18% reporting consumption of sugary soft drinks and 26% sweets at least daily.

The percentage of young people aged 11 to 16 reporting two or more healthy behaviours forms one of Wales' national well-being indicators, and rose slightly to a high of 89.8% in 2021–22, compared to 87.7% in 2017-18, against a target of 94% by 2035 (20).

A range of mental health and well-being indicators are covered by SHRN, the most recent data showing a slight decline among 11- to 16-year-olds in average reported score from 23.9 in 2017 to 23.5 in 2023 (measured using the short form Warwick-Edinburgh Mental Wellbeing Scale). Furthermore, four in five young people (80%) report being satisfied with their life (measured by a score of at least 6 out of 10 on the Cantril ladder visual analogue scale).

The SHRN dataset also includes a range of substance use indicators, with a particular interest currently on vaping. For example, one in four young people (26%) in school years 7 to 11 report having ever tried vaping, with a smaller proportion (7%) reporting to do so at least once a week. Vaping prevalence was highest among year 11 girls, with 19% reporting to vape at least weekly in 2023, 14% reporting to vape on a daily basis and 50% reporting to have vaped on at least one occasion. With regards to smoking cigarettes, 6% of year 11 boys report smoking at least once a week, compared to 4% of year 11 girls. Overall, 3% of all 11- to 16-year-olds report smoking at least once a week.

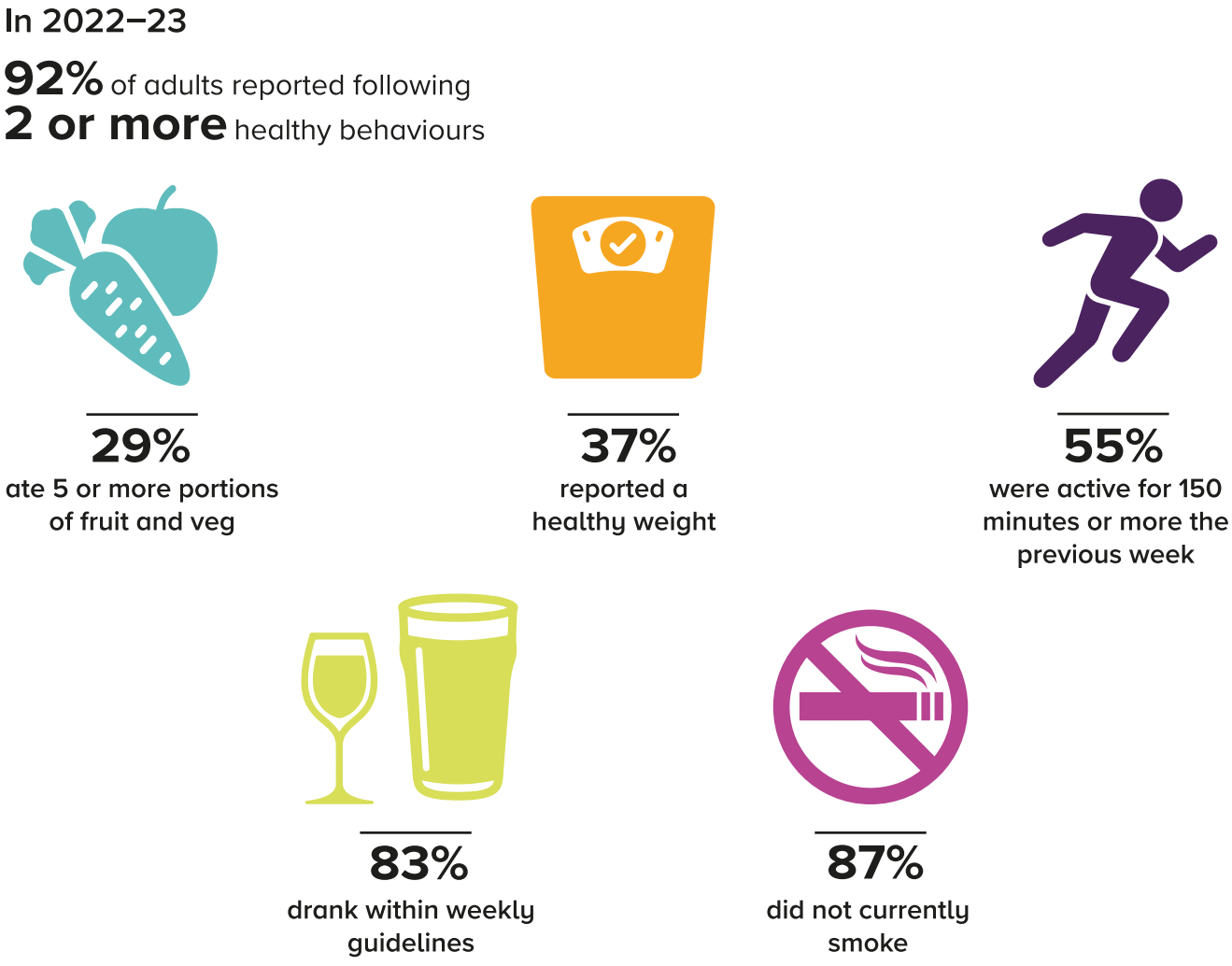
**Figure 3: A line chart showing the percentage of children aged 4 to 5 years who are living with obesity in Wales, by most and least deprivation fifth 2013–14 to 2023–24, as per the Welsh Child Measurement Programme (28). The chart shows a persistent gap with higher proportions of children with obesity living in the most deprived fifth of areas across Wales. Note: caution should be applied when reviewing the trend due to the three years when data were not available.**



## Health behaviours in adults

For healthy lifestyle behaviours in adults, there was a marked deterioration in the number of adults with two or more healthy behaviours between 2016 and 2019 according to the National Survey for Wales (29). It has since recovered and is currently stable at 92.3%, with a 2050 target of greater than 97%. Lower rates were seen in males, people aged 45 to 64, and those living in deprived areas. Adults in the most deprived areas were generally less likely to report healthy behaviours, for example smoking prevalence was 22% in the most deprived quintile but 8% in the least, and obesity prevalence was 32% in the most deprived quintile but 22% in the least. A notable exception is alcohol where it is the least deprived areas that have the highest average consumption.

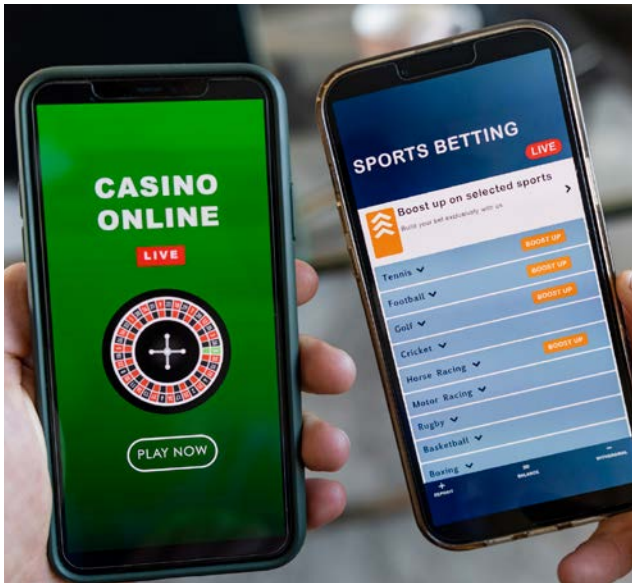
Figure 4: Infographic of the percentage of adults reporting following individual healthy lifestyle behaviours




Source: Wellbeing of Wales 2023 (20). (Note: drank within weekly guidelines includes those who do not drink).

The percentage of adults over the age of 16 who smoke has remained stagnant at 13% whilst the percentage of e-cigarette users has risen to 8%, from 5% in 2020–21 (30). For adults who drink alcohol, the average annual consumption of alcohol was 508 units with 17% of all adults over 16 drinking over the weekly maximum guideline of 14 units. People in the least deprived quintile consumed on average 29% more units of alcohol per year than those in the least quintile (615 vs 476 units). 29% of adults reported meeting the recommend minimum of 5 portions of fruit and vegetables the previous day and 55% of adults met the recommended minimum of 150 minutes of physical activity the previous week.

Gambling has been a specific area of interest in Wales in recent years as appreciation of the harms it causes has grown. A Chapter in my 2016-2017 CMO Annual Report "Gambling with our health" was devoted to the topic and highlighted gambling as an emerging public health risk (31). I also covered the industry's approach and reliance on problem gamblers as part of my report in 2022-2023, which highlighted how commercial interests have a detrimental impact on public health and subvert policy and regulatory controls. In the latest data, 63% of adults over 16 reported gambling in 2022–23, the most common form being lotteries and scratchcards (58% had bought these in the last 12 months). 1 in 10 of those gambling were found to be at risk of gambling harm with 2% of gamblers demonstrating 'Moderate' and 1% 'High' risk gambling behaviours (National Survey for Wales, 2022–23, Problem Severity Gambling Index categories of gambling risk) (29). Following the introduction of the statutory gambling levy, Welsh Government are working with NHS Wales Performance and Improvement (NHSWP&I) and PHW to develop gambling prevention and treatment services.




Finally, the survey also reports on mental well-being and loneliness (29). Thirteen percent of people were found to be lonely, with 34% of materially deprived people saying they are lonely and 24% of Black, Asian or Minority Ethnic people reporting loneliness (29). Mental well-being as assessed by the Warwick Edinburgh Mental Wellbeing Scale (WEMWEBS) found that 32% of people report low mental well-being, with younger people the most affected. The overall average WEMWEBS score in 2022-23 was 48.2 out of 70 – by comparison slightly lower than the mean score in the UK population of 51.0. This is similar to 2021–22 but the gap between the most and least deprived quintiles has widened, against our target to improve the average and eliminate the deprivation gap by 2050.

**Figure 5: A line chart showing the percentage of adults with two or more healthy behaviours from the National Survey for Wales, 2016–17 to 2022–23 (20), 29). Note that data since 2020–21 is not comparable with previous years due to a change in the method of reporting.**

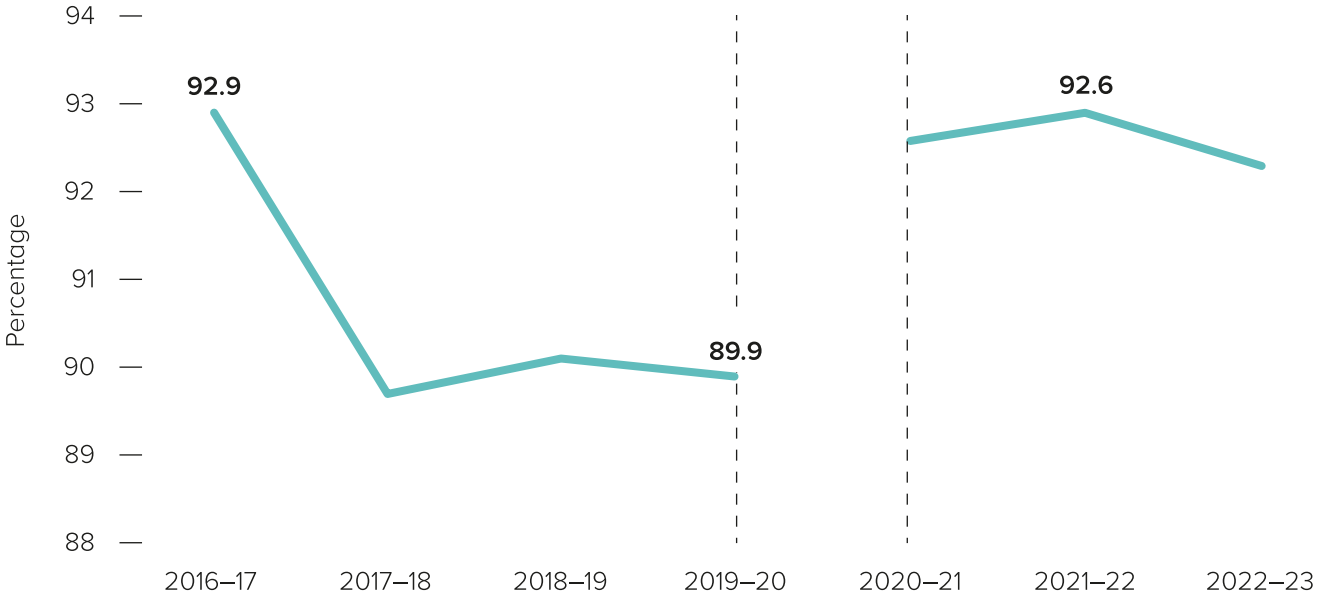
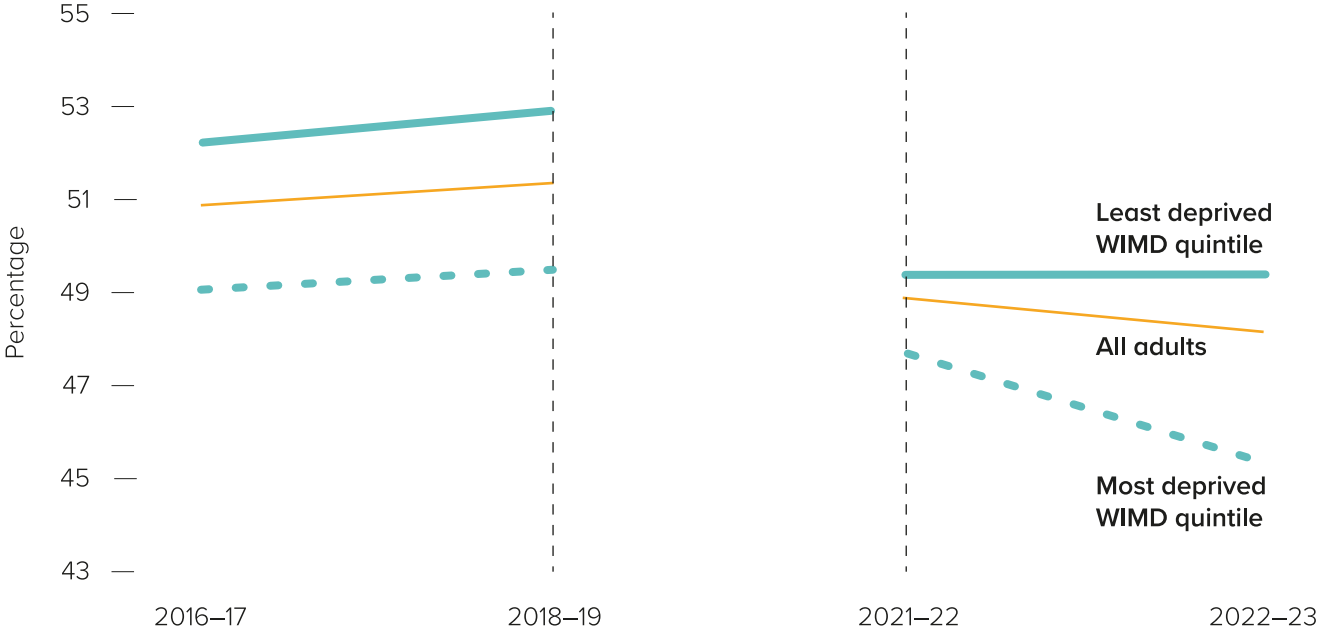



**Figure 6: A line chart from the National Survey for Wales showing the average Warwick-Edinburgh Mental Wellbeing Scale (WEMWEBS) score for adults, 2016–17 to 2022–23 (20), (29). Note that the results from 2020–21 are not comparable with previous years due to changes in the survey.**



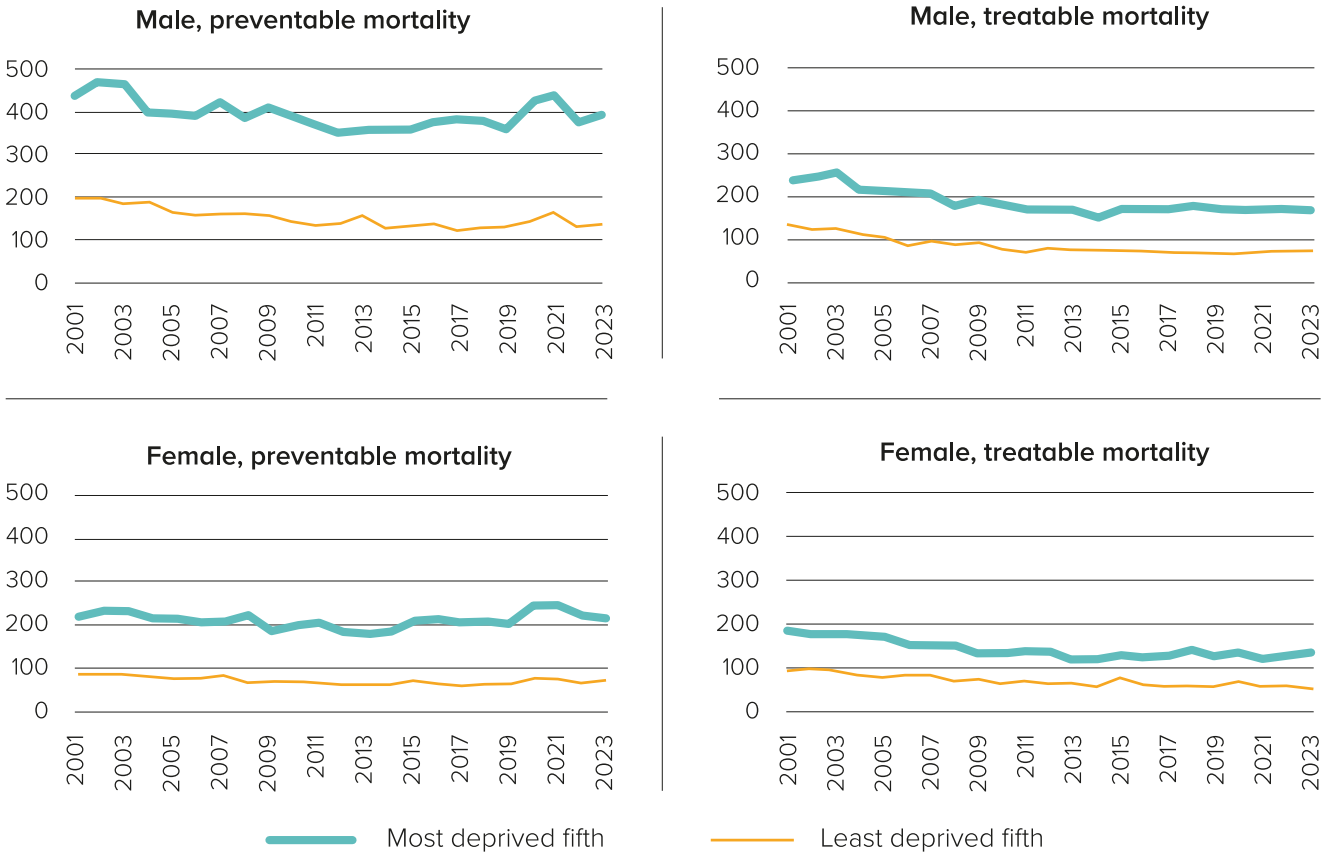
Chapter 2:

# Prevention

## Introduction

People in Wales are dying too early from preventable ill-health. As set out in Chapter 1, healthy life expectancy has recently declined. In 2021-2023 it was 60.3 years for males and 59.6 years for females, a decline on previous years and the lowest in the UK (7). Even before the pandemic, after a century of growth, it had stalled over the last decade. It is also not equal: healthy life expectancy is 16 years and 20 years lower in the most deprived areas than the least deprived areas for males and females respectively. The likelihood of dying early from a cause that is preventable for those in the most deprived areas of Wales is around double that seen in the least deprived areas (see graphs below).

**Figure 7: Line charts showing preventable and treatable deaths in Wales, male and female, age-standardised rates per 100,000**




Source: Socioeconomic inequalities in avoidable mortality in England and Wales: 2001 to 2023, ONS (12).

As well as dying early, many people in Wales are living more years of their life in ill-health. Much of this ill-health is also preventable. In the most deprived areas grandparents (assuming the average age of parenthood in England and Wales) may, on average, expect to have no years of living in good health with their grandchildren, and grandfathers may, on average, not expect to see their grandchildren leave primary school at all (32). In the least deprived areas grandmothers can expect to see their grandchildren reach 23 years and to be in good health until after they reach primary school (being in good health until their grandchildren are on average 6 years old).

**Figure 8: Bar charts showing male and female life and healthy life expectancy, comparing most and least deprived groups for the years 2020–2022**


Sources: Public Health Outcomes Framework, PHW; Birth Characteristics in England and Wales, 2022, ONS (32).

Welsh government has set a national milestone to increase the time lived in good health, as measured by healthy life expectancy, and to narrow the gap between the least and most deprived by 15% by 2050 (20). However, as seen in the most recent Well-being of Wales report, progress on this goal is still awaited. The stalling of improvements in healthy life expectancy in particular, and in overall life expectancy, is a worrying trend, and the gap related to deprivation remains as large as ever. UK females aged 25–49 have a particularly higher mortality rate than the median of peer countries as noted in Chapter 1. While 'A Healthier Wales' sets out a strategic ambition for Welsh Government in actively creating the conditions for health across all of society, there is a need to consider how effective current approaches are. More should be done, and relative priorities given to different activities that are intended to improve health and well-being across Wales (9).

We also know that NHS Wales cannot manage the increasing levels of preventable disease and that to meaningfully reduce NHS Wales pressures and waiting times we must prioritise preventing avoidable ill-health, or these pressures will worsen year-on-year as need and demand continues to outstrip capacity within the healthcare system.

It is acknowledged that even prior to the COVID-19 pandemic, the capacity to deliver timely services was not in balance with increasing demand. Analysis of the data tells us that, pre-pandemic, the demand for planned care was increasing by around 5% per annum, increasing the imbalance between demand and the capacity to deliver. Since the pandemic, services are faced not only with growing demand, but with the backlog resulting in suspension of planned care delivery to respond to the COVID-19 challenge. The pandemic has laid bare the limitations of our approach to addressing inequalities in health status through healthcare provision. Current demand represents the accumulation of ill-health over many years and a cumulative failure of our collective efforts to create the conditions for people to live healthy lives (33).

> ***'Much of what we project in this paper is avoidable if we switch our focus to prevention'***
>
> Science Evidence Advice, NHS in 10+ years 2023 report (34)

The *NHS in 10+ years Report* forecasts people living with four or more long term health conditions almost doubling by 2035, alongside rising NHS Wales staffing needs required to meet health and care demand, as covered in the next chapter (34). Without taking accelerated action, obesity and diabetes are set to rise dramatically and much of the future healthcare burden will fall on already struggling social and primary care services in the community. A recent Audit Wales report into cancer care in Wales identified that our Welsh Government Quality Statement does not set out any specific expectations in respect of cancer prevention, despite 38% of cancers being preventable (35). The report illustrated the clear benefits that prevention has for managing future demand on cancer services, as shown on the following page.

**Figure 9: Box showing potential capacity gains associated with preventing cancer occurring in the first place, showing estimated capacity gains for 10%, 20% and 38% reduction in cancer cases based on 2022–23 activity, from Audit Wales analysis of data from the Patient Episode Database for Wales (35).**

Note: *Regular attenders are patients who are admitted to hospital on a regular basis to receive treatment.

| |  |  |  |  |
|---|---|---|---|---|
| **2022-23** | **90,532** finished consultant episodes | **84,583** admission episodes | **164,971** bed days | **10,864** regular attenders* |
| **-10%**  | **81,479** finished consultant episodes (9,053 reduction) | **76,125** admission episodes (8,458 reduction) | **148,474** bed days (16,497 reduction) | **9,778** regular attenders (1,086 reduction) |
| **-20%**  | **72,426** finished consultant episodes (18,106 reduction) | **67,666** admission episodes (16,917 reduction) | **131,977** bed days (32,994 reduction) | **8,691** regular attenders (2,173 reduction) |
| **-38%**  | **56,130** finished consultant episodes (34,402 reduction) | **52,441** admission episodes (32,142 reduction) | **102,282** bed days (62,689 reduction) | **6,736** regular attenders (4,128 reduction) |

As I have consistently argued in my reports, prevention is incredible value for money. Studies have repeatedly demonstrated the highly cost-saving nature of well-designed and sustained interventions to prevent ill-health. A systematic review identified public health interventions had a typical return on investment of 14 to 1 (36). Reviews have also established that population-level, low agency interventions are one of the most powerful ways of both improving population health whilst also reducing health inequalities (37).

In addition to being inherently valuable, a healthier population contributes wider benefits for families, communities, and the economy. For example, preventable physical and mental ill-health is contributing to rising economic inactivity as well as to increasing economic costs, and pressure on NHS Wales. Not investing in, or disinvesting from, ill-health prevention builds up future costs for wider society and NHS Wales and reduces future tax revenue.

## Types of prevention

In 2018 a definition of levels of prevention was agreed between the Future Generations Commissioner and Welsh Government especially for the purpose of budget strategy and decision making. This is illustrated below.

**Figure 10: The definition of prevention agreed by Welsh Government and the Office of the Future Generations Commissioner** (33)

| | |
|---|---|
| **Primary prevention:** | Building resilience – creating the conditions in which problems do not arise in the future. A universal approach. |
| **Secondary prevention:** | Targeting action towards areas where there is a high risk of a problem occurring. A targeted approach, which cements the principles of progressive universalism. |
| **Tertiary prevention:** | Intervening once there is a problem, to stop it getting worse and prevent it reoccurring in the future. An intervention approach. |
| **Acute spending:** | Spending, which acts to manage the impact of a strongly negative situation but does little or nothing to prevent problems occurring in the future. A remedial approach. |

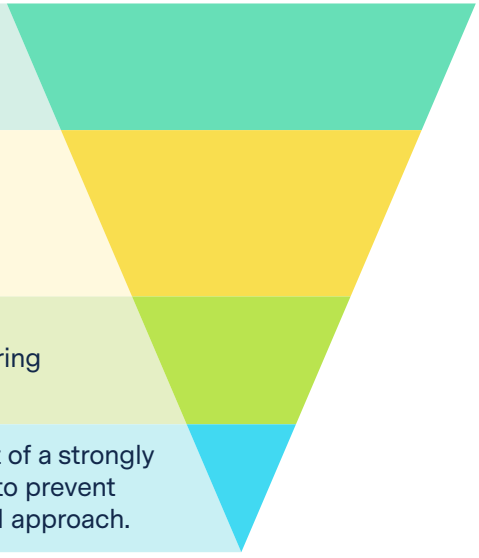


**Table 1: Showing examples for the levels of prevention.**

| | Definition | Examples |
|---|---|---|
| Primary prevention | Building resilience – creating the conditions in which problems do not arise in the future. A universal approach. | E.g. safe, warm secure housing, fair work, healthy food environment, environments for active transport, healthy schools. |
| Secondary prevention | Targeting action towards areas where there is a high risk of a problem occurring. A targeted approach, which cements the principles of progressive universalism*. | Vaccinations, smoking cessation programmes, flying start programmes, trauma informed approaches. |
| Tertiary prevention | Intervening once there is a problem, to stop it getting worse and prevent it reoccurring in the future. An intervention approach. | Early identification e.g. Most population screening (e.g. breast, bowel cancer), cardiovascular risk prevention (blood pressure control, obesity management). |
| Acute spending | Spending, which acts to manage the impact of a strongly negative situation but does little or nothing to prevent problems occurring in the future. A remedial approach. | Many secondary care services. |

* Progressive universalism is a determination to provide support for all, giving everyone and everything a voice and vested interest, but recognises more support will be required by those people or areas with greater needs.

The concept of 'progressive universalism' is aligned with other concepts such as 'proportionate universalism' promoted by Professor Sir Michael Marmot and the Institute of Health Equity (38). All levels of prevention are necessary and mutually reinforcing. Most complex issues that impact on health will require multiple interventions incorporating a range of approaches.

## Prevention

Primary and Secondary prevention, as defined above, aims to tackle the underlying causes of ill-health, preventing or substantially delaying onset, reducing the burden of disease in populations, and helping individuals to live longer, healthier lives. These interventions are some of our most effective public health tools and typically save costs and reduce inequalities. They may be aimed at behaviours that have a major impact on levels of poor health in our population such as tobacco control, tackling obesity, or minimum unit pricing for alcohol. It also includes approaches such as vaccination. These approaches have high value because they prevent, or reduce, the negative consequences of illness such as physical and emotional suffering and social and economic deprivation.

Whilst NHS Wales has an important role in supporting people to stay in good health, action is also needed at other levels for primary prevention. Legislation can be effective in driving significant changes to behaviour for the benefit of both individuals and the population's health. For instance, the 2007 ban on smoking in indoor public places and workplaces had a significant effect – not only in encouraging people to quit and therefore reducing smoking prevalence but in reducing the harm caused by second hand smoke, particularly to children. During my tenure, the Public Health (Wales) Act 2017 has been a powerful example of primary prevention and included measures which aimed to avert health harms as well as create the social conditions conducive to good health (39). The Act put in place important protections for the public, including extending the smoke-free requirements to certain open spaces – in hospital grounds, public playgrounds and school grounds, creating a mandatory licensing scheme for special procedures like tattooing and body piercing, supporting the provision of toilets for use by the public as well as prohibiting the intimate piercing of anybody under the age of 18. The Act also introduced a requirement for Health Impact Assessments and the publication of a national strategy on preventing and reducing obesity levels in Wales – a pressing public health issue in Wales, the UK and globally. The sections below relay some of the action in Wales on these topics within the scope of the Act.

## Tobacco and vapes

As well as the direction from legislation, a clear policy objective is critical to ensuring the public health system directs its energy and resources towards important causes of poor health and inequalities. In July 2022, Welsh Government published 'A smoke-free Wales', setting out its ambition for Wales to become smoke-free by 2030 (40). Reducing tobacco smoking prevalence to below 5% will be a key milestone in eradicating the harm caused by tobacco.

Public health risks can emerge rapidly, particularly when there is clear and significant commercial incentive. The industry's focus on creating and marketing vapes with widespread appeal through the use of flavours and colours has not only led to increases in non-smokers using these products but most worryingly a huge rise in youth vaping. As well as addressing the advertising and marketing of vapes, the Tobacco

and Vapes Bill aims to create a smoke free future through a change in the age of sale for tobacco products in the UK so that no young person born after 1 January 2009 will ever be able to legally sold them (40). This Bill is an excellent example of all the four governments of the UK coming together to create and support legislation for the protection of current, as well as future generations. At the time of writing, the Bill is currently progressing through the UK Parliament and if passed will be one of the most significant pieces of legislation for a generation.

The provisions in the Tobacco and Vapes Bill have been further supplemented by a ban on single use vapes in Wales and the rest of the UK that came into effect on the 1 June 2025 (41).

## Obesity

The Public Health (Wales) Act 2017 required Welsh Ministers to publish a national strategy on preventing obesity and reducing obesity levels in Wales (39). Around a quarter of adults in Wales are living with obesity. This is a major health concern because obesity significantly increases the risk of many chronic diseases. People with obesity are seven times more likely to develop type 2 diabetes than people of a healthy weight. Levels of childhood obesity are also high: over one in ten children are already living with obesity by the time they start primary school (42). This is hugely worrying for future health outcomes as childhood obesity is a significant risk factor for obesity in adulthood, with more than half of obese children being obese in later life. A range of approaches is required to support people to maintain a life-long healthy weight.

There are treatments and approaches that lead to weight loss, but this weight loss is notoriously difficult to maintain in the long term. The approach to supporting people with overweight or obesity involves the provision of stepped clinical support, as envisaged in the All-Wales Weight Management Pathway, with escalating support as weight and with it, the risk of adverse health outcomes increase (43). Individual treatment for overweight and obesity does not address the environmental conditions or factors that lead to the development of overweight.

Nonetheless, there is currently a focus of attention on pharmaceutical interventions as a support to weight loss in those with obesity. The drug treatments, which must be offered in concert with comprehensive dietary and physical activity support, have demonstrated effectiveness in reducing weight over a relatively short period. Ongoing clinical support for individual diet and physical activity changes is part of all the drug trials that have demonstrated successful weight loss. However, not all people with obesity will be able to benefit from drug treatment. For example, up to 10% of those prescribed tirzepatide will discontinue it because of side-effects (44).

Individual treatment for management of overweight is not about returning an individual to a ‘normal’ weight but about reducing their risk of future ill-health. However, sustained clinically significant weight loss might also be expected to be associated with a positive change in the ability of an individual to undertake some activities and carry some social benefits (e.g., through a reduction in stigma).

The Healthy Weight, Healthy Wales strategy was launched in 2019 to prevent and reduce obesity in Wales (45). The long-term strategy has a core focus of enabling change through a whole system approach in recognition of the complexity of the issue and the multitude of contributory factors. The approach aims to

co-ordinate action across different sectors and levels of government. This includes establishing six regional teams that are able to develop a comprehensive understanding of local challenges and opportunities and cultivate strong regional partnerships to co-create sustainable solutions. Public Health Wales and senior leadership within the health boards monitor progress and help identify effective local approaches that could be scaled up to national level.

In 2021, Welsh Government published an updated **weight management pathway** which aims to improve outcomes by providing a patient centred framework with a more flexible and agile approach to delivery (43). Funding was provided to health boards to strengthen and diversify their weight management provision across the life course. Public Health Wales developed new digital resources that provide expert, tailored advice to people on a weight management journey. The **Healthy Weight Healthy You** website, launched in 2023, has received almost 100,000 visitors to date.

In February 2025, Welsh Government also laid The Food (Promotion and Presentation) (Wales) Regulations 2025, as part of the Healthy Weight: Healthy Wales Strategy (46). These regulations, which will come into effect in March 2026, restrict the promotion of high fat, salt and sugar foods and its presentation at key locations such as at the end of supermarket aisles. They will also restrict free refills on sugary soft drinks. Promotional and marketing strategies used by the food and drink sector have a significant impact on the dietary choices we make as consumers. These regulations aim to make it easier for consumers to make healthier choices and avoid diet-related ill health.

**CASE STUDY:**
**The Regional Whole System Approach to Healthy Weight Addressing the rise in fast food takeaways**

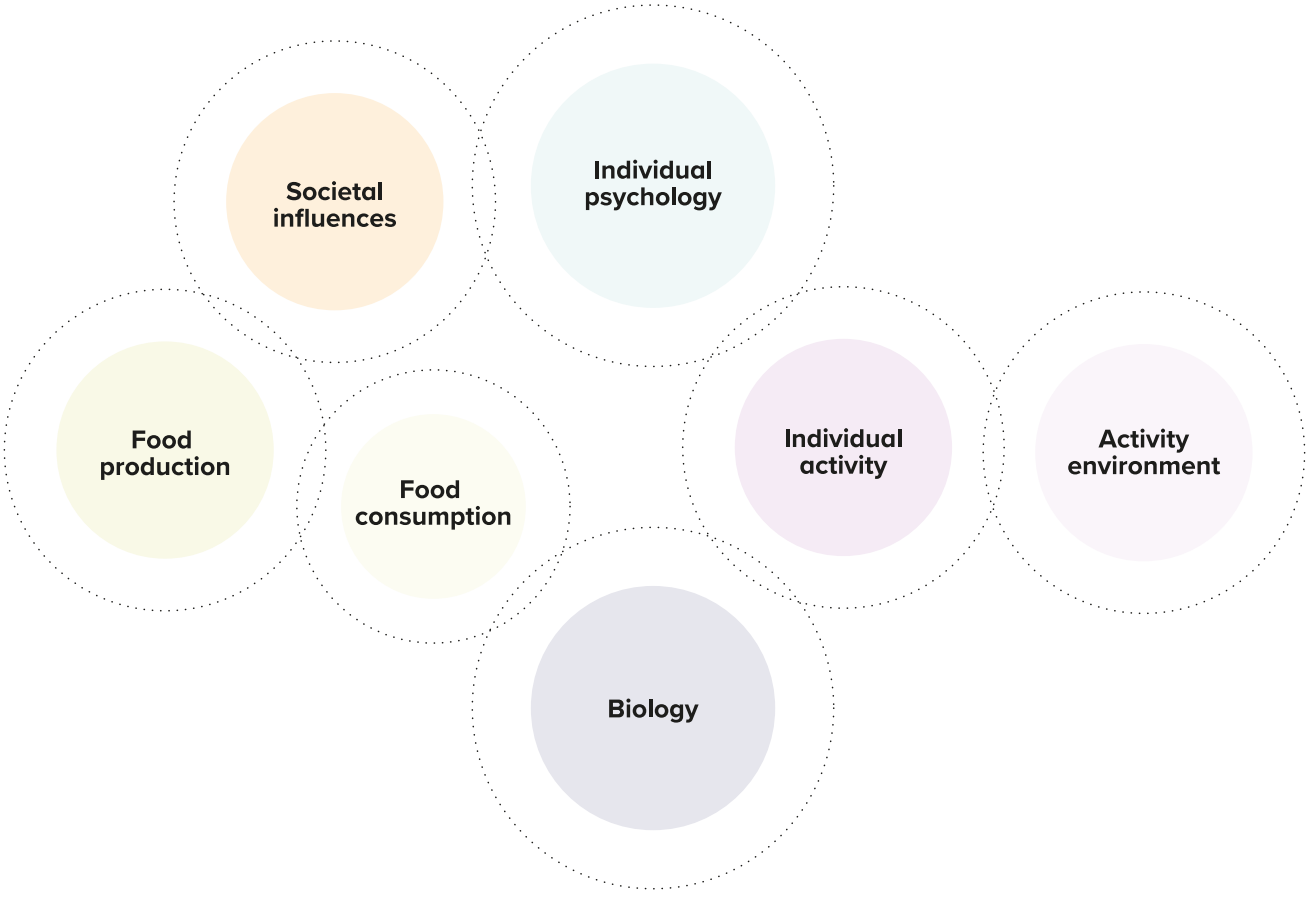
Welsh Government is funding local health boards to support regional approaches to a healthy weight.

The Public Health team at Betsi Cadwaladr University Health Board have established a new process to respond to planning applications, including new food and drink establishments. They have developed a response template to quickly pull together compelling evidence on their likely health impact. This includes relevant policy information and research as well as local data on takeaway densities, proximity to schools and rates of obesity.

Currently, cafes or restaurants can be converted into takeaways without needing planning permission as they fall within the same use category. Responses by the health board have successfully resulted in conditions being added to approvals to reduce potential negative health impacts. These include restricting opening hours and preventing hot food being sold for take away or delivery.

Their actions have strengthened the evidence and options available to planning officers, empowering them to make health-informed recommendations.

**Figure 11: Tackling obesities: future choices – project report (2nd edition)** (47)




This is a simplified version of The full obesity system map with thematic clusters that can be found in **Tackling obesities: future choices - project report (2nd edition)**

As evidence gathered by Public Health Wales and others demonstrates, tackling obesity is a highly complex endeavour that requires multiple interventions across multiple levels and sectors as part of improving people's food environment (48). In my last report, I also wrote extensively and made recommendations regarding the commercial and industry influences on food and obesity (31). The Future Generations Commissioner recently made food one of his priorities and, working with the Food, Farming and Countryside Commission held a series of food conversations with citizens across Wales. Recommendations included a national food strategy, exploring the role of food in the national curriculum, building a local and sustainable food supply chains that promote health, and ensuring the sustainable farming scheme supports farmers and promotes health (49).

Officials in Welsh Government are currently exploring a range of options for delivery for the next Healthy Weight Healthy Wales delivery plan 2025–27, with a key focus on children and early years as well as education settings, our food environment, and movement and physical activity to name a few themes. The delivery plan will support the conditions required to impact on our nation's health in the long-term. We would welcome a food strategy that helps secure healthy nutritious food

## Minimum Unit Pricing for Alcohol

In 2020, Welsh Government introduced a minimum unit price (MUP) of 50p for alcohol, with the aim of reducing alcohol related harm by targeting low cost, high strength products and reducing alcohol consumption and related health inequalities at a population level (50).

Welsh Government commissioned an independent evaluation of the legislation. The four "lots" of the evaluations have now been completed and were published on 15 January 2025 (51). The report confirms that minimum unit pricing for alcohol has been successfully implemented and has led to lower average alcohol consumption than would have been the case otherwise. Certain high-strength, low-cost alcohol products are now longer available following the introduction of MUP. This is also a positive step, which will help reduce the harm associated with hazardous drinking.

This complements the more in-depth evaluations by Public Health Scotland on the impact of MUP in Scotland, which has been in place for longer (52). These evaluations demonstrate that MUP has reduced alcohol consumption, alcohol related hospital admissions and alcohol related deaths. The impact of this has been greater for households purchasing the most alcohol and those living in more deprived areas.

Evaluations have found some important, potentially negative consequences of MUP on people with alcohol dependence, in both Wales and Scotland. It is important to consider these in future policy development and to continue to deliver alcohol and substance misuse services for these groups.

The final reports from the evaluations will help inform the report on the operation and effect of the legislation. There is a "sunset clause" included in the legislation, which gives Senedd Members the opportunity to consider repealing or continuing the provisions set out in the bill. The findings of the final evaluation reports recommend renewing minimum unit pricing and recommends that the level of the minimum unit price should be increased from 50p to at least 65p to sustain its value.

## Vaccination programme for Respiratory Syncytial Virus (RSV) and seasonal influenza

Vaccination is a safe and highly effective approach to the prevention of serious illness and its complications and in reducing the impact of infections on vulnerable individuals. In Autumn 2024, Welsh Government accepted the latest recommendations from the Joint Committee on Vaccinations and Immunisations and implemented a new vaccination programme for Respiratory Syncytial Virus (RSV) (53). RSV infections cause the greatest burden in young children and the elderly leading to thousands of additional GP appointments, hospitalisations and deaths each year. The new routine vaccination programme provides protection in newborn and infants and for older people who are vulnerable to more serious illness because of infection. The targeted programme will make a significant difference to population health through primary prevention, as has been evidenced in other UK Nations, though the rate of uptake so far in Wales has been below our targets (54).

In the context of upcoming Winter flu seasons, it is vital that we improve seasonal vaccination uptake across all relevant groups to reduce pressures facing our hospitals. Influenza vaccination reduces the impact of influenza in vulnerable groups by preventing infection and reducing transmission. Central procurement of influenza vaccine is intended to provide for a more responsive vaccination campaign and will create opportunities to reach higher levels of coverage than seen in recent years.

These developments build on recent successes, such as the mass roll-out of COVID-19 vaccinations which was crucial in combating the pandemic and the vaccine for Human Papillomavirus Virus which has reduced cervical cancer incidence in those vaccinated by over 80% (55). The implementation of the National Immunisation Framework with the associated benefits such as dedicated immunisation workforce and improved digital infrastructure put Wales in a strong position to continue to deliver safe and effective vaccines as a keystone of prevention approaches.


## The building blocks of health and health in all policies

In Chapter 1 we described how people living in some of our communities on average die much earlier than others and live for more time in ill-health. This reflects the way that building blocks for health are unequally distributed across our communities.

These building blocks need to be in place to prevent ill-health and to give our communities a fair chance for health. This means everyone having good education and skills, a warm and safe home, fair work that gives a sense of purpose as well as the money we need to keep us and our families healthy, and supportive relationships free from discrimination. It also relates to the quality of the environments in which we live, learn, work and play and in how connected we are to important places and

services in our lives. These building blocks or wider determinants of health, when present, help prevent disease and allow us to grow up with a strong sense of our own value and well-being, enjoy healthy opportunities across the life course and live longer, more fulfilled lives in good health.

The negative experiences of children in poverty in Wales are a major threat to our future health as a nation. The seminal Black Report identified the importance of acting on child poverty as central to preventing the unequal ill-health experience in our communities (56). I commend the cross-government efforts that lie behind the Child Poverty Strategy for Wales 2024 (57). It is imperative that in all our public policies we seek to ensure that children have the best start in life, with secure building blocks in place.

Acting on the wider determinants of health is the most effective and equitable way of improving population health. This an approach we are committed to in Wales with our ground-breaking Well-being of Future Generations (Wales) Act 2015, which requires us to work in an integrated way to improve social, economic, cultural and environmental well-being for the people of Wales (58). In this legislation, prevention is specifically identified as one of the five 'ways of working'.


Good prevention requires acting at multiple policy levels, including with specific programmes and initiatives that are designed to make tangible differences. I note that it is over a year ago that Welsh Government introduced the 20mph speed limit on restricted roads in Wales, with the primary objective of this policy being to save lives and reduce casualties in urban residential areas. This policy was based on sound evidence from elsewhere but has been controversial with a significant motoring lobby seeking its reversal, regardless of its intention. Transport for Wales' monitoring framework recommended three-years' worth of collision data pre and post implementation to measure the impact of 20mph. However, early indications are positive with 2024 having the lowest number of police-recorded road collisions and road collision-associated deaths (apart from 2020) on record (provisional figures show 81 casualties) (59).

As I outlined in my last report, challenging the commercial determinants of health – the way in which industries operate and market their products and the subsequent impact on health – is a vital part of any approach to put in place the building blocks of health (31). In a Well-being Economy, the rules, norms, and incentives are set up to deliver quality of life and flourishing for all people, in harmony with our environment, by default. So, while a strong economy is seen as a pre-requisite for strong public services this must not be at the expense of the well-being of our citizens and planet. The Wellbeing Economy Governments partnership (WEGo) is a collaboration of national and regional governments interested in sharing expertise and transferable policy practices to advance their shared ambition of building Well-being Economies (60). Welsh Government has been an active participant in the collaboration since May 2020 and I commend the role Wales is playing in developing a Well-being economy approach.

## Importance of the Early Years and the first 1000 days

Ensuring all children in Wales have the best possible start in life is a priority for Welsh Government. This means tackling the barriers which can prevent this, such as Adverse Childhood Experiences (ACEs) and other forms of childhood adversity and trauma, including those which are associated with structural and social inequalities like poverty and discrimination. Our early years, parenting, and family support programmes, including Flying Start and Families First are central to ensuring all children have the best start in life, by helping to reduce adversity and build resilience in children, parents and families, across the early years and beyond. The main focus of our support is on early intervention and prevention. This support offered by the programmes is underpinned by our **Parenting in Wales: Guidance on Engagement and Support**.

Welsh Government recognises the particular importance of the first 1000 days of life, from conception to age two, significantly influence the outcomes for children, parents, and families throughout the life course, and from generation to generation. Evidence highlights that this is a critical period of development when the foundations of babies' future health and mental and social well-being are formed (61). Welsh Government have several Early Years Programmes that support the first 1000 days because we know the first 1000 days of life significantly influence the outcomes for children, parents, and families, throughout the life course, and from generation to generation. In addition, our **Parenting. Give it time** campaign and bilingual website provides universal positive parenting information, advice and support to parents and carers on all aspects of parenting including advice on potty training, tantrums, bedtime and bathtime routines and children's behaviour in the early years (62).

All Local Authorities in Wales have a statutory duty to provide information, advice and assistance to families. The mechanism in which this service is provided is through the Family Information Service. The Family Information Service can act as the front door of the authority for parents and families looking for advice, information and signposting on a range of services available within their local area. This includes but not limited to offering up to date information on childcare, access to advice and support for funding childcare and signposting to early intervention and prevention programmes, including those which provide support during the early years.

Flying Start (see following page) continues to make a real difference to the lives of children in some of our most disadvantaged communities. We know from independent evaluation evidence that Flying Start is having a positive impact on families' lives and has been life-changing for some "high need families" (63). That is why Welsh Government is expanding the childcare element of the programme.

**Flying Start** (64)

Flying Start is Welsh Government's targeted Early Years programme for families with children under 4 years of age who live in some of the most disadvantaged areas of Wales. Flying Start aims to make a decisive difference to the life chances of children by mitigating the impact of poverty, which is linked to poor life outcomes in early childhood, including health outcomes.

The Programme comprises four entitlements which provide:

» free, quality, part-time childcare for 2–3 year olds;
» an intensive health visiting service;
» access to parenting support; and
» support for speech, language and communication development.

Through a multidisciplinary team approach, which identifies all of the needs of the child and their family and provides prudent and proportionate interventions, Flying Start aims to ensure that:

» children are healthy and thriving;
» families are capable and coping; and
» Flying Start children are reaching potential.

The focus of Flying Start is upon the early identification of any needs and the timely application of interventions. While Flying Start offers a distinct programme of health interventions the programme builds upon the universal programme of health visitor interventions set down in Healthy Child Wales Programme (HCWP) (65).

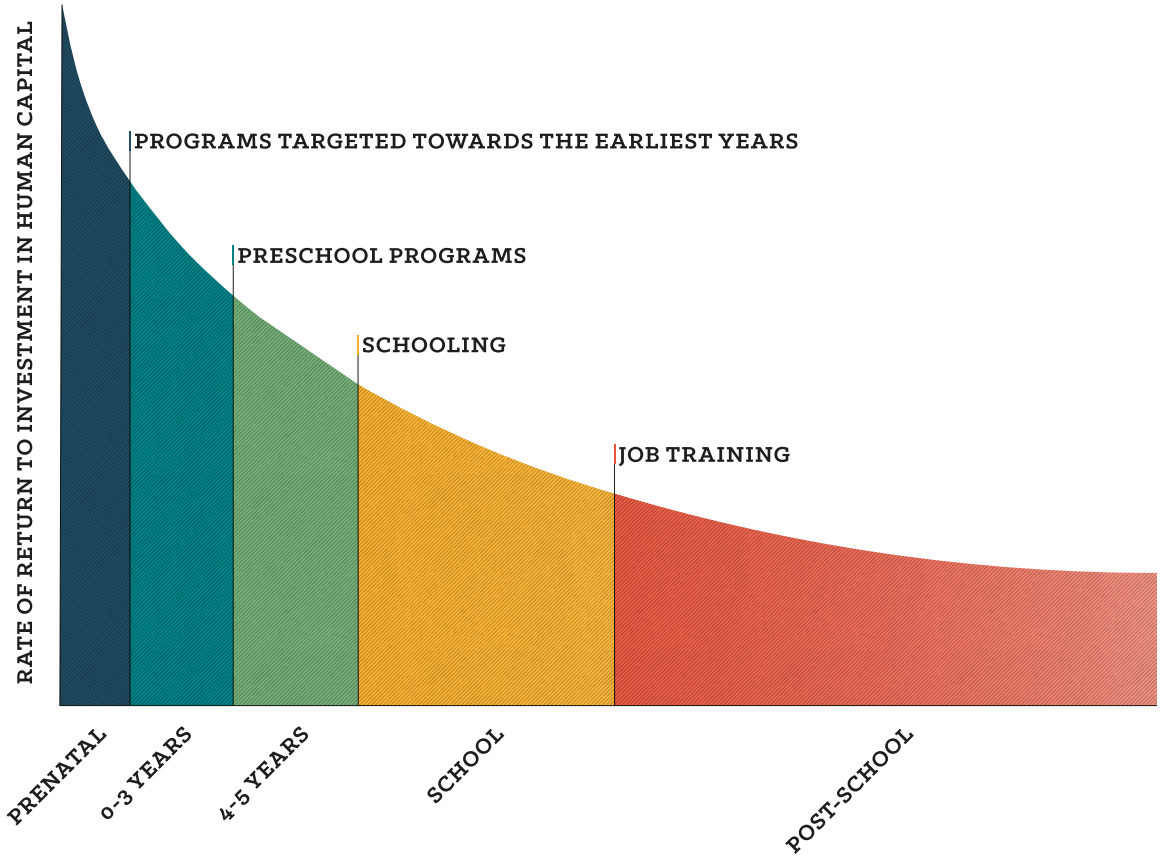
Through our Families First programme we provide tailored, multi-agency, support to address the individual needs of families. Support is available to families across the first 1000 days, early years and beyond. The programme takes a holistic approach to health, recognising that physical health is deeply interconnected with social, emotional, and economic well-being. Through its comprehensive and integrated approach, Families First helps create healthier families and stronger communities, thereby reducing health disparities and promoting overall well-being. By fostering environments where healthy habits are encouraged and normalised, the programme is helping to lay the foundation for lifelong healthy behaviours.

Families First also provides essential support for mental health and delivers evidence-based interventions for people experiencing anxiety and other mental health challenges.

These initiatives help provide parents with the help they need to foster a positive and healthy environment for their children, which can help to ensure they are able to enjoy the best start in life. By nurturing the physical, mental, and emotional well-being of families and empowering them with the tools and knowledge to thrive, Families First not only addresses immediate challenges but helping to cultivate the foundations for healthier generations to come.

The Heckman Curve shows that the highest rate of economic returns comes from the earliest investments in children, providing an eye-opening understanding that society invests too much money in later development when it is often too late to provide great value (66). It shows the economic benefits of investing early and building skill upon skill to provide greater success to more children and greater productivity and reduce social spending for society.

**Figure 12: The Heckman Curve, which demonstrates how the highest economic and social benefits come from investing in early skill development**



The first 1000 days: a golden opportunity to build a fairer future' is a visual narrative report published by PHW that makes a compelling case for action, explaining why this is the best and most cost-effective way to create a happier, healthier, fairer future for Wales (67). The report says that creating the conditions for all families to flourish – like safe homes, fair work and income, accessible transport and built and natural environments which are family friendly – acts as the foundations of a society that enables all children to have the best start in life. Identifying six priority areas for action, where making small changes to the way that things are done can deliver a huge difference to families across Wales. The report also explains why the early years are so important, what babies need for the best start in life and how we are doing currently in Wales.

Delivery data for 2023–24 shows that 41,328 children received services from Flying Start services in the latest full reporting year for which monitoring data is available, representing around 28% of children under four years old in Wales. A 2024 process evaluation noted successes in the expansion of Flying Start which is delivered by local authorities by way of a grant (Children and Communities Grant), and recently moved from an annual cycle to a three cycle, which is far more conducive to planning for longer term preventative work (68).

## Speech, language and communication

It is estimated that 10% of all children in the UK have long-term, persistent speech, language and communication (SLC) needs (69). Research shows that children living in poverty suffer disproportionately from transient early language delay. Language skills are a critical factor in the intergenerational cycles that can perpetuate poverty as poor communication skills are passed down from parent to child (70).

SLC development is an important indicator of children's overall well-being. Children's SLC skills have an impact on a wide range of outcomes including behaviour and mental health, employability, and their likelihood of entering the criminal justice system. SLC skills follow a social gradient, with children living in poverty being at higher risk of having SLC needs. By identifying and supporting these children at the earliest opportunity, we can help to narrow the disadvantage gap. The Talk With Me: Speech, Language and Communication (SLC) Delivery Plan was developed by Welsh Government in partnership with professionals including the Royal College of Speech and Language Therapists (RCSLT) (71). The plan seeks to drive improvement in the way in which children in Wales are supported to develop their SLC skills. It aims to increase awareness that SLC is 'everybody's business', with families, childcare settings and communities playing an important role in supporting children's development.

## Health Impact Assessments

A further provision of the Public Health (Wales) Act 2017 requires Welsh Ministers to make regulations about the circumstances in which public bodies in Wales must carry out Health Impact Assessments (39). Health Impact Assessments offer a systematic means of taking health into account as part of decision making and planning processes. By supporting organisations to positively influence the wider determinants of health, Health Impact Assessments improve population health and reduce health inequalities.

Many public services, people, and communities in Wales have already benefited from the use of Health Impact Assessments and the Welsh Health Impact Assessment Support Unit hosted in Public Health Wales has been an excellent source of expertise and related resources for over 20 years (72).

**Putting the Spotlight on Health, Well-being and Equity Using Health Impact Assessment: Case Studies from Public Bodies in Wales** was published in November 2024 and includes several case studies of HIA from public bodies in Wales (73).

Welsh Government has developed and consulted on regulations that will mandate the use of Health Impact Assessments by specified public bodies in certain circumstances. These regulations when laid in the Senedd will aim to bring consistency and ensure that health impacts are considered as part of decision-making processes. The effective and systematic implementation of this approach will move Wales closer to a genuine 'Health in All Policies' approach, as advocated for by the World Health Organisation and Wales's Future Generations Commissioner. This will be an important contribution in meeting our National Milestone of improving healthy life expectancy and reducing related inequalities, whilst over time also helping to relieve pressure on NHS Wales services by preventing people developing illness.

A consultation on the draft regulations closed on March 29, 2024, with the intention of laying the draft regulations before the Senedd during 2025 (74). Once the regulations are enacted, it will be crucial that there is support and guidance in place so that those responsible for completing the assessments can maximise their potential for improving policies and decisions that prevent ill health.

If we want to make the most for the health of the people of Wales, Health Impact Assessment cannot be a tick-box exercise. Those making policy and decisions across government, and the many other bodies for whom the requirements apply, must meaningfully consider opportunities for improving health outcomes and reducing health inequalities from the earliest stages.

Our aim is that everyone will have the opportunity to reach their full potential and maximise their chances of leading a healthy, prosperous and fulfilling adulthood, enabling them to participate fully in communities, the workplace, and contribute to our future economic success. Investing in early years interventions such as the first 1000 days, from conception to 2 years of age, is recognised in global research, policy and practice, as a crucial period for physical growth and brain development in children (75).

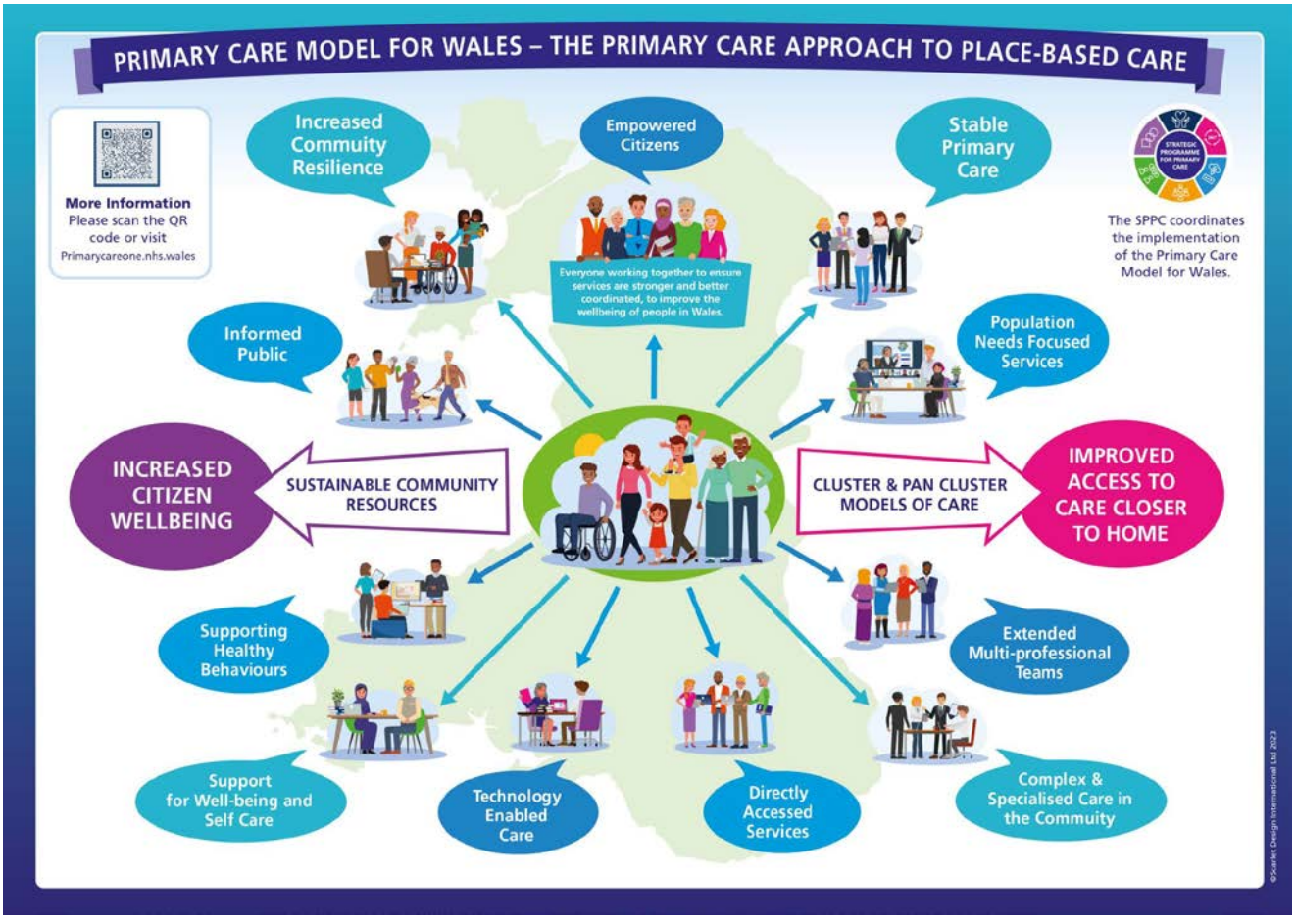
## Tertiary prevention

Clinically-led prevention interventions focus on the early identification and management of risk factors or diseases thereby minimising adverse health outcomes. As such, this type of prevention has some of the strongest evidence in medicine. The beneficial effects of this type of prevention of cardiovascular disease including risk-based advice and prescription of appropriate antihypertensive agents and statins, for example, are profound and rapid (76). Other clinician led interventions such as the initiation of smoking cessation or obesity reduction programmes also have important effects on risk of disease progression for multiple conditions, including many cancers (77).

In February 2023, with my fellow CMOs from England, Scotland and Northern Ireland, the Chair of the Academy of Medical Royal Colleges and the National Medical Director of NHS England, we published an editorial article in the BMJ on the pressing need to extend our approach to clinically-led prevention (78). The article called for a whole system response with action from a range of medical and allied professions, not just those in general practice or public health, to ensure that people already under the care of the NHS get the preventative interventions that they need.

The impact of existing ill-health was amplified by the impact of the COVID-19 pandemic leading to both an increased burden of poor health and widening inequalities. The excess mortality that was observed during the pandemic has continued, even now that COVID-19 infection is endemic. As our article makes clear, some of this represents a disease burden created by missed opportunities to deliver preventive care during the pandemic. But this is added to by a gap in delivery between what we should do in relation to clinically-led prevention and what is being delivered.

More fundamental reform in service redesign is needed to address the long-term increase in demand for primary care. The **Primary Care Model for Wales** was adopted in 2018 as a whole system approach to sustainable and accessible local health and well-being care. It focuses on place-based care, care closer to home and multi-professional working. It aims, by creating local, multi-disciplinary clinically led decision making based on an understanding of needs and assets at the community level, to support innovation in responses to meeting care needs.



Our article also called for a focus on population groups with historically low uptake of prevention approaches. Disease prevalence is higher than average in many of these groups, so the benefits of clinically-led prevention are likely to be even greater (79). Engagement with these groups will require creativity in the development and testing of various delivery models (80). We should make it much easier and more attractive for people to come forward for assessment and provide a range of approaches, tailored to specific segments of the population to support this. This requires flexibility in delivery and better insight into the behaviours and motivations of our target populations.

A recent BMJ article highlighted the tension within General Practice between using specialist clinicians to manage risk and maintaining capacity to diagnose and treat patients with acute and chronic medical needs (81). To be effective and sustainable, the system challenge is to link access to an informed assessment of risk factors, conducted in a consistent and quality assured way, to a customised programme of support and, if necessary, individual clinical management. It includes issues such as the clinical governance of such approaches, transfer of clinical responsibility between parties, and, of course, how data is captured and shared. Given imagination, none of these issues is insuperable. On the other hand, they reflect a mode of working that is novel to NHS Wales at a system level, although individual examples of this approach do exist. Such an approach, with a focus on keeping people healthy, is vital to secure our aspirations for the people of Wales.

Public Health Wales, in collaboration with health boards, delivers several population-based national screening programmes that form an important part of prevention, identifying conditions early so they can be managed more effectively. Recently, bowel cancer screening eligibility was extended so that screening now starts for adults aged 50 (82). Public Health Wales also continues to work on improving screening equity and developing a national lung cancer screening programme, building on the success of an operational pilot delivered in Cwm Taf Morgannwg University Health Board (83). The pilot showed high uptake (58.3%) for those invited compared with pilots in England. Lung cancers were typically detected at an earlier stage, 2/3 being stage 1 or 2 compared to the current average of 1/3 being stage 1 or 2 across Wales. Accordingly, most lung cancers detected in the pilot could be managed with radical treatment with an intent to cure in stark contrast to the current situation where most lung cancer cases are detected as a coincidental finding or as late presentations, too late for curative treatment.

A further example of this type of prevention is seen through the work being taken forward by Public Health Wales – working with health boards to roll out an All-Wales Diabetes Prevention Programme that offers brief interventions by trained professionals to patients identified with pre-diabetes, helping to reduce their future risk of type 2 diabetes mellitus (84).

**Tertiary prevention** also concerns the management of an existing, usually chronic disease to prevent complications or further damage. It encompasses the management of common chronic conditions such as diabetes, cardiovascular disease and kidney disease to delay disease progression. It also includes managing respiratory conditions to reduce exacerbations of breathlessness and chest-infections, treatment of stroke or cardiac events with medication to prevent recurrence and rehabilitation to restore function and minimise disability.

Recently, the issuing of Quality Statements to NHS Wales has been used to promote and direct activity in relation to tertiary prevention. At the individual level, Public Health Wales offers self-management courses supporting people to learn and to maintain and improve their quality of life, when living with chronic conditions (85).

Tertiary prevention approaches are often rooted in clinical practice and so there is a strong evidence base expressed in clinical guidelines. This supports both the setting of national expectations as part of the planning process, and audit of performance.

In community and public health, an example of tertiary prevention is the growing movement around inclusion health. Inclusion health uses specific, evidence-based interventions to support socially excluded populations (86).

These groups include people experiencing homelessness, people with drug and/or alcohol dependence, vulnerable migrants, sex workers, people in contact with the justice system, modern slavery victims, and Gypsy, Roma and Traveller communities. What these groups share is that they typically experience extremely poor health outcomes and often present with advanced disease. These outcomes and this health-seeking behaviour may be associated with multiple risk factors including poverty, adverse childhood experiences, and trauma which is compounded by stigma and discrimination. Such groups face frequent barriers when accessing health and care and are more likely to suffer from digital exclusion.

This example of tertiary prevention is slightly different to that above because it is focused on groups whose needs are poorly met by mainstream service design and operation and so key elements of inclusion health include a greater emphasis on delivery through a patient-centred and holistic approach, nimble and agile service provision, multi-disciplinary and multi-sectoral collaboration.

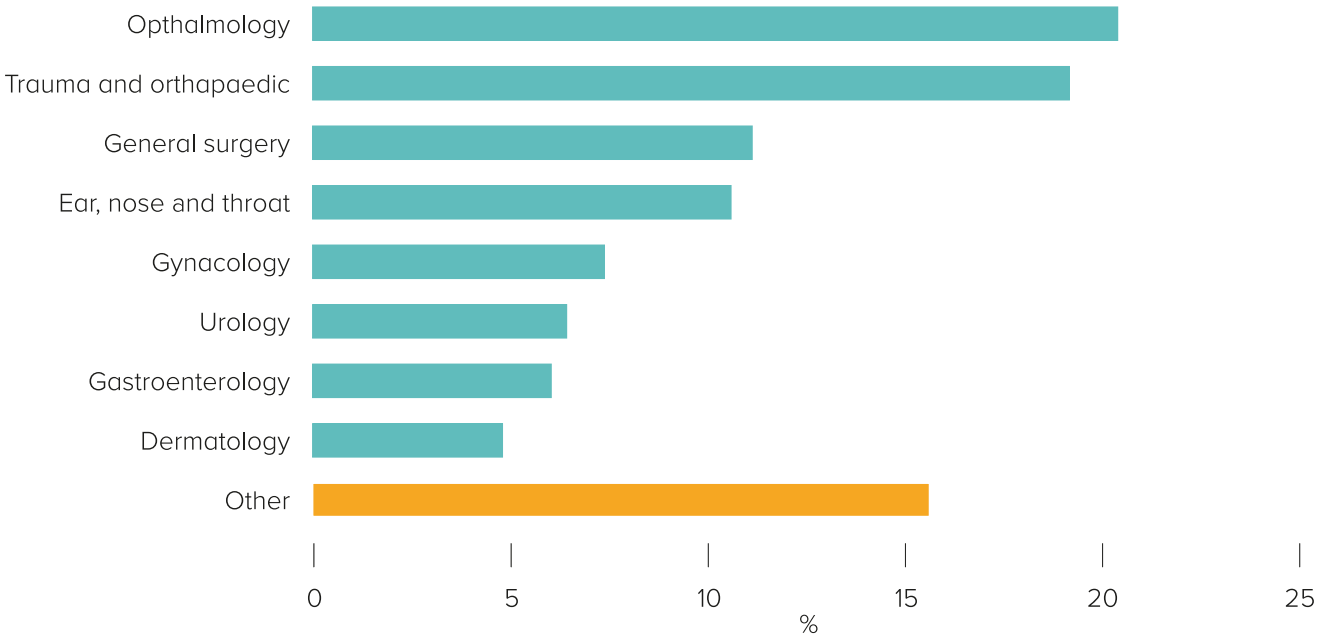
Effective inclusion health interventions incorporate the use of models such as GP outreach, hospital in-reach, multi-disciplinary teams, specialist inclusion health services, opportunistic testing and treatment, intermediate care facilities, housing assistance, find and treat exercises, and walk-in appointments with co-location of services. These interventions improve health and social outcomes and reduce inequity.

Another example can be seen in Welsh Government's '3P' approach to NHS Wales waiting lists: promote, prevent and prepare for planned care.

As a form of tertiary prevention, the programme offers a range of resources from information up to specialist support to certain patients on waiting lists to ensure they are in the best health for their treatment and to maximise their outcome and reduce possible post operative complications.

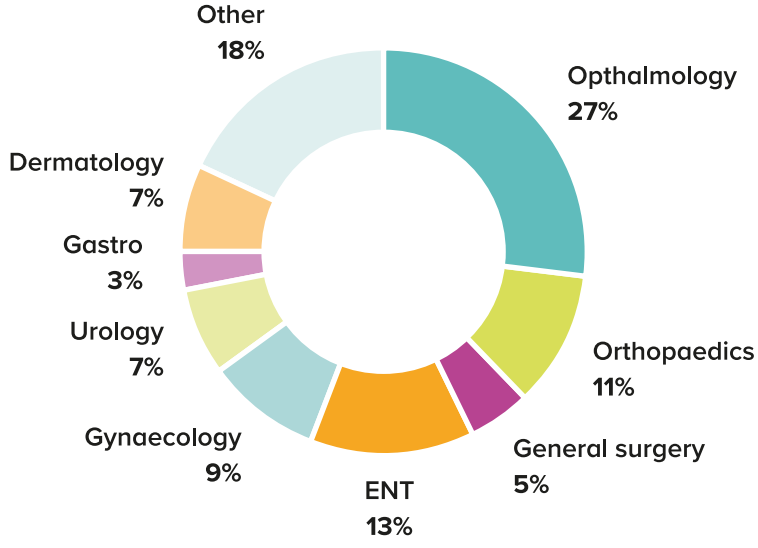
In May 2025, there were just over 796,000 patient pathways waiting to start treatment which equates to around 614,300 individual patients or almost a fifth of the Welsh population. A fifth of the waiting list had been on a waiting list for over a year, and 85% of those waiting fell under 8 high-demand treatment specialties.

**Figure 13: Percentage of referral to treatment pathways waiting over 52 weeks by the top eight treatment specialties, May 2025**




Source: Welsh Government published data for Referral to treatment times (RTT), Digital Health and Care Wales (DHCW).

**Figure 14: Pie chart showing the share of people in Wales waiting over 52 weeks for treatment, by speciality**




Source: Welsh Government published data for Referral to treatment times (RTT), Digital Health and Care Wales (DHCW).

The data also tells us that between April 2024 and March 2025, of the 88,000 procedures postponed, nearly 38,000 were postponed at the last-minute across Wales (87). Of these:

- **4,718** were because the patient said they were unfit to undergo the procedure
- **232** were cancelled because the patient had a pre-existing medical condition
- **1,307** were cancelled because the hospital said the patient was unfit due to illness.

There are of course, occasions where cancellation is unavoidable, for example, if a person has an acute illness when they are due to undergo their procedure. However, many of these last-minute cancellations were due to deterioration in the patient's health – an area of potential focus for tertiary prevention.

The hypothesis is that the majority of those cancelled as outlined above may potentially have been avoided if people were provided with information and support to ensure they were ready for their treatment and provided with early pre-optimisation, pre-habilitation and assessment of their needs which, evidence shows, can identify previously undiagnosed underlying conditions such as hypertension (88). Evidence also tells us that early support can reduce patients' length of stay in hospital by up to 2 days, releasing bed capacity to admit other patients sooner, and if a person is fitter, they are more likely to be eligible for a day procedure where clinically appropriate (89).

Providing people with a single point of contact (SPOC) on referral is a key part of the 3Ps offer (90). A single point of contact will improve communication with people before they access care and during the period they are waiting. The single point of contact can provide advice on actions people can take to keep them well and fit enough to benefit from their treatment.

This can help to change the narrative, and culture, from a 'waiting list' where patients are passive recipients of care to a pro-active 'preparation for treatment' opportunity to work in collaboration with health services to maximise their health and well-being outcomes.

The 3Ps policy was developed in line with the commitments made in '**Our programme for transforming and modernising planned care and reducing waiting lists in Wales**' to ensure that support and information is easily accessible to those who are waiting for their appointments and interventions in secondary care services and their carers (91).

It is anticipated that the 3Ps policy will result in improvements around hospital cancellation rates and length of stay, whilst improving the uptake of secondary prevention services such as weight management and stop smoking support.

**Figure 15: The 3P policy aims to empower people to take preventative action to improve their health and prevent deterioration**

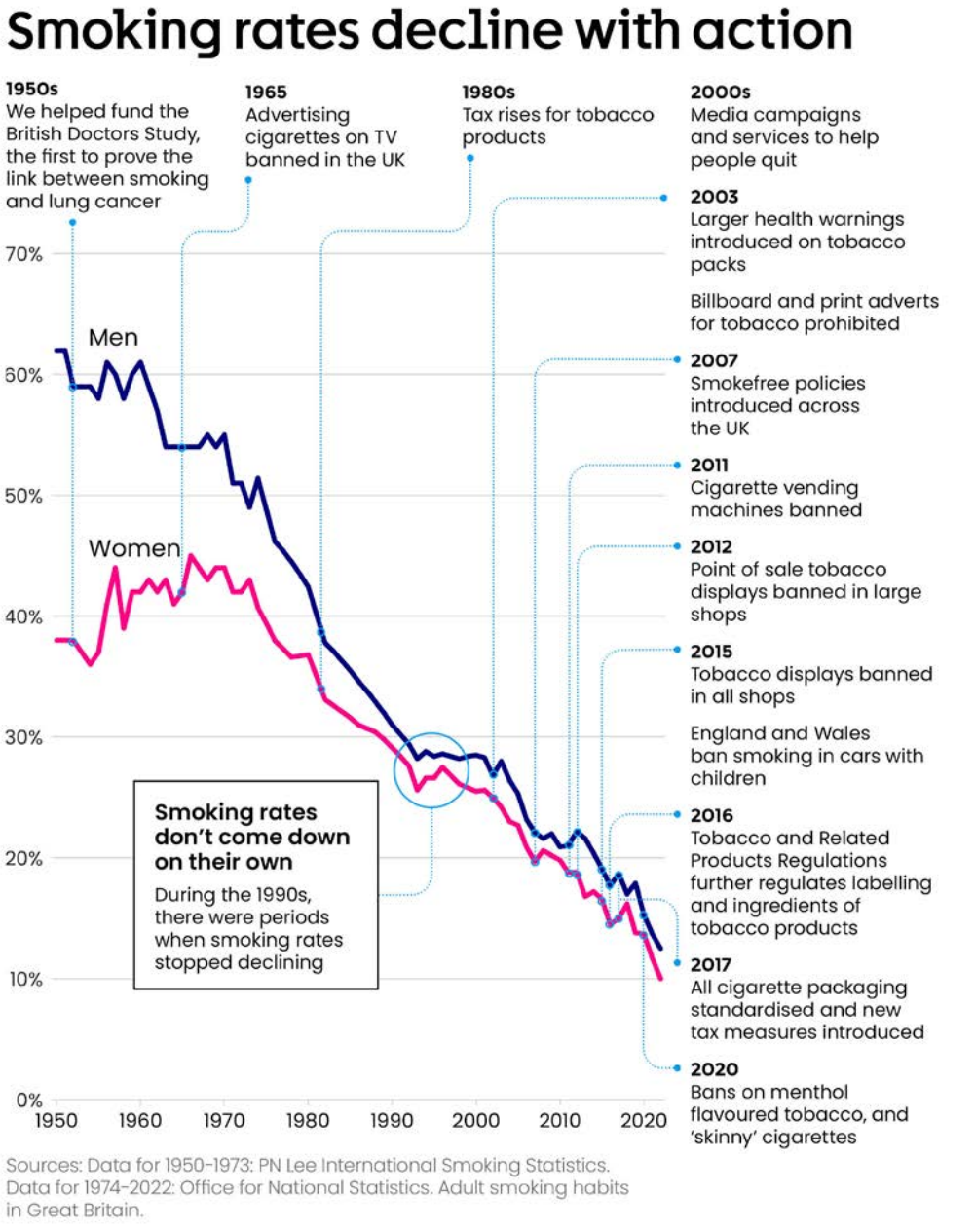

## What good prevention looks like

Tobacco control demonstrates the potential for success in prevention in Wales and internationally and has helped to support the continued decline in premature mortality over many decades even as disease burden has shifted to non-communicable diseases. Cultural attitudes to tobacco use have shifted over time in response to health advocacy leading to increased knowledge of the individual and societal impacts. Tobacco control provides clear evidence of the effectiveness and impact of regulatory approaches in changing behaviour. As referenced earlier, my last report explored the commercial determinants of health and the strategies and tactics of the tobacco industry in fighting against regulatory approaches in the face of clear evidence of harm: creating the 'playbook' that informs the approach of many other industries responsible for producing products that can be harmful to health (31). Smoking reduces a person's life expectancy by decades. As tobacco prevalence has declined, it has been followed by marked declines in premature mortality and morbidity attributable to smoking, especially for men. The reduction in ill-health related to smoking has benefits for individuals and families, communities, and wider society, such as through a healthier workforce and reducing the demand that would otherwise increase pressures further on NHS Wales.

## Tobacco control

There are 320,000 smokers aged 18+ in Wales (2023) (92). This is 170,000 less than we might expect if the percentage of smokers had not changed since 2014.

**Figure 16: Line chart showing how smoking rates in Great Britain have declined between the 1950's and 2010's, with significant events noted during this time. From Cancer research UK (93).**



The success of tobacco control policy has been attributed to a current small evidence-policy gap and favourable policy processes (94). The small gap reflects the stream of specific policy solutions produced by tobacco control researchers, the high public literacy on tobacco harms, political enthusiasm and appetite for tobacco control measures, and measures taken to reduce tobacco industry influence (notably the World Health Organisation Framework Convention on Tobacco Control Treaty (95)).

Key policy processes have included:

- Clear institutional leadership from Departments of Health with tobacco being recognised as a health issue.
- A clear tobacco control agenda that has been framed in public health terms and given urgency.
- Effective networks and coalitions that are large, broad, ambitious and largely agree on their aims and policy solutions.
- A favourable socio-economic context where most tobacco control measures are known to be highly cost-saving with few adverse economic consequences, with some also directly raising revenue i.e. tobacco duty.
- An abundance of ideas due to a rich, developed evidence base of epidemiology and interventions characterised by consensus, as well as many international comparators and examples.

The successes of tobacco control are a reminder of the importance of persistence, optimism, acting boldly and working at many levels. There has been consistent effort over time, representing many decades and still ongoing. There has been to date no silver bullet, but rather multiple windows of opportunity at multiple levels through this period and this should continue. For example, I have noted a renewed visibility of smoking on television and in the cinema which is of concern. We know from many years of experience in Tobacco Control that tobacco imagery in the media can normalise smoking, particularly among adolescents and young adults. I am calling on OFCOM and the UK Government to redouble their efforts to enforce the broadcasting code. The prevalence of tobacco in programmes on television drives the normalisation of smoking, which we know is devastating to individual health and that of wider society. An up-to-date study of broadcasting prevalence should be undertaken to reassess the extent of the problem, and rigorous enforcement action taken where breaches are found. As the expected Tobacco and Vapes Bill becomes law in both England and Wales, we hope to see a smoke-free generation, gradually ending the sale of tobacco products across the country and breaking the cycle of addiction and disadvantage by making it an offence to sell tobacco products to anyone born on or after 1 January 2009.

## An architecture for prevention

If we are to secure the benefits from prevention approaches, we need to have the architecture in place to ensure our prevention work is evidence informed, resourced, coordinated, sustainable and has impact.

Welsh Government is committed to preventing ill-health. This is at the heart of A Healthier Wales and is embedded in the Well-being of Future Generations Act. As this chapter demonstrates, much work is ongoing to prevent ill-health in health services, early years settings, government and across systems.

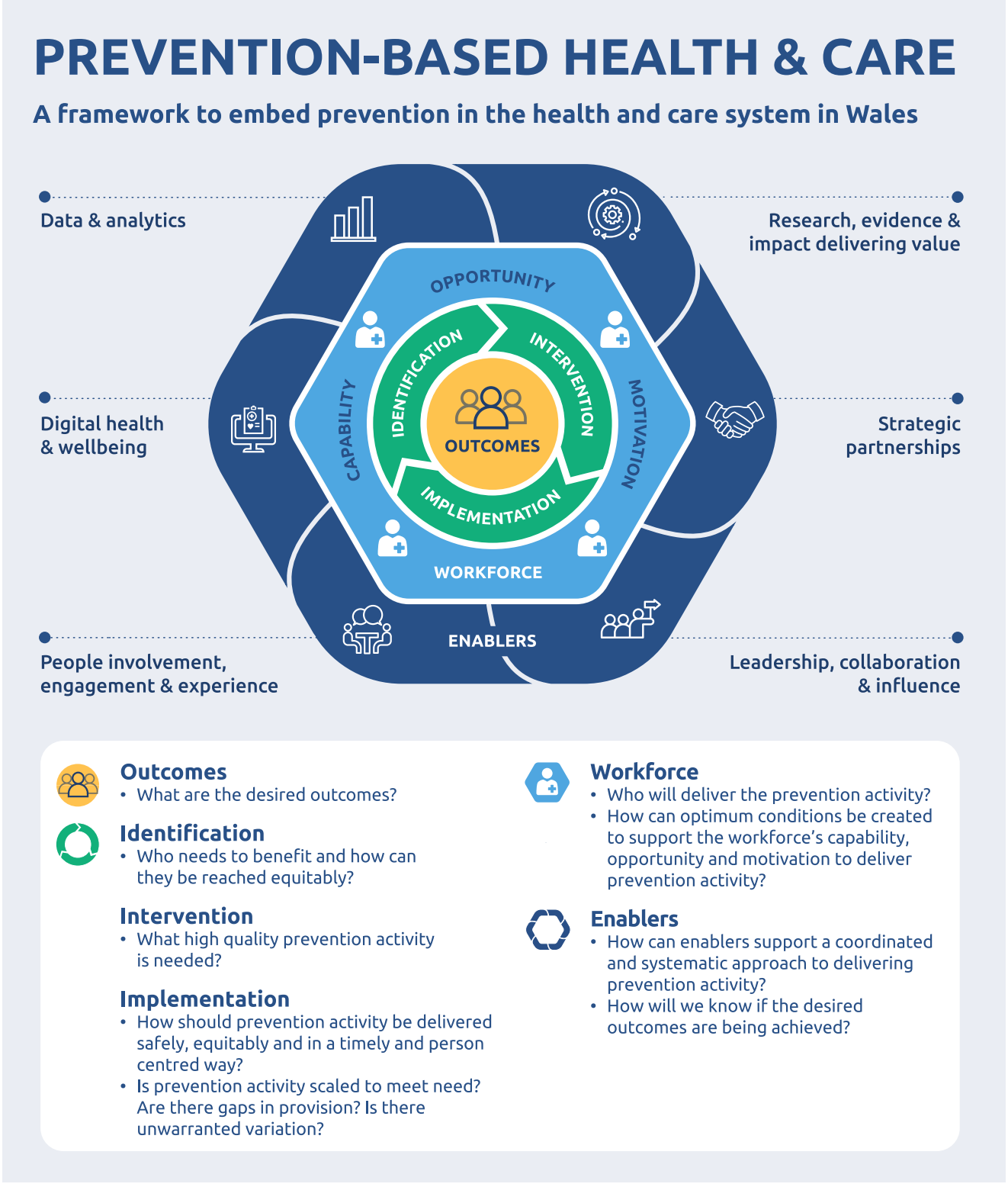

However, the urgent demands within the health and social care system can too often draw attention from prevention. Failing to focus on prevention will lead to an overburdened, unsustainable health and social care system. Too often we see attention of senior decision makers focused on responding to demand without taking sufficient advantage of opportunities to prevent ill-health in the first place. This can be seen in how we measure success for our services, the guidance we give them, and what gets funded in our healthcare services.

The architecture we need is reflected in some of our successes, such as tobacco and vaccination. This includes:

- Leadership, coordination and articulated, clear roles at multiple levels
- Commitment to tackling the issue through action across the system
- Understanding the issue, use of evidence informed decision making, engaging citizens, and a flow of intelligence
- Expectations and accountability, national standards and frameworks
- Enabling infrastructure including quality data and surveillance, including on health equity, sustained and predictable funding, trained and supported workforce and continuous improvement.

These features have been incorporated into a framework for health and care, developed by Public Health Wales, see on the following page.

Figure 17: A framework to embed prevention in the health and care system in Wales, produced by PHW (96).



To strengthen this architecture, I have established a Preventing Ill-Health Advisory Group to support my role as the chief adviser on health across Welsh Government. This group will develop approaches that bring evidence and external expertise to direct an explicit 'prevention of ill-health' agenda to the work across health and care and, over time, the whole of government.

Initially this group will be established within the Health, Social Care and Early Years group within Welsh Government. This is to provide an explicit national leadership function to the prevention agenda in health and social care at a strategic level and to ensure that prevention considerations are a key component of ministerial advice. This will also allow approaches including the accountability and performance assessment aspects of prevention, any reforms to roles and responsibilities within the system and how we can use data informed approaches to be trialled within a single sector. Looking ahead the further phase of the work will be how we use the initial learning to design an approach that entrains the efforts of all of government in aid of prevention. This will include embedding approaches such as Health Impact Assessment, and wider consideration of resource allocation across government budgets including analysis of social return on investment, as well as further consideration of the role of regulation.

The Future Generations Commissioner's Office's *Ways of working progress checker* outlines a specific role for Government leading the way on prevention:

> ***"Government is using financial levers to encourage preventative spend and setting out a clear guidance on what they expect to see from public bodies."*** (97)

The Future Generations Commissioner, Derek Walker, has set out his strategy until 2030 – **Cymru Can** – with a clear focus on achieving impact (98). This contains a direct challenge to the public sector about how well we are delivering on our statutory requirements to consistently work in a sustainable way and plan longer term to deliver improved well-being.


The strategy identifies increasing levels of preventable illness and worsening health inequalities as a threat to the sustainability of the current health and care system. It calls for a move to a more prevention-oriented system in Wales and a renewed discourse to ensure that public bodies understand their role in prevention and the promotion of well-being. Additionally, it highlights the need for continuing attention to identifying what works, promoting and sharing; effective collaboration on ensuring that the building blocks of good health are in place in our communities; and a purposeful future focus.

In seeking the impact of reductions in the incidence of preventable diseases and of being a high performed on this measure it calls for demonstrable reductions in inequalities in health within our communities. I support both his analysis of the issues – his 'diagnosis' – and his outline of the required actions – his 'prescription'.

The proposed introduction of the Health Impact Assessment Regulations will help to address this by mandating a Health in All Policies lens for strategic decision making in the public sector and force organisations to demonstrate how they have considered the longer-term impact of their strategic decisions to health and well-being.

The Preventing Ill-Health Advisory Group will help to facilitate the shift in planning for prevention from being principally a Health and Social care responsibility to one which is more explicitly recognised as being a whole of Government responsibility. It will provide more explicit guidance to and seek more accountability from the health and care sector in their prevention actions – focused on outcomes rather than central direction.

Effective central action needs to be joined with local collaboration – genuine sharing of missions, resources and efforts at community level. This approach recognises that most of the factors that create and support good health are beyond the direct reach of NHS Wales but also that the benefits of good health and well-being accrue to communities as a whole.

> *"Across Cymru we have created environments for good that promote well-being – not cause illness."*
>
> Cymru Can (98)

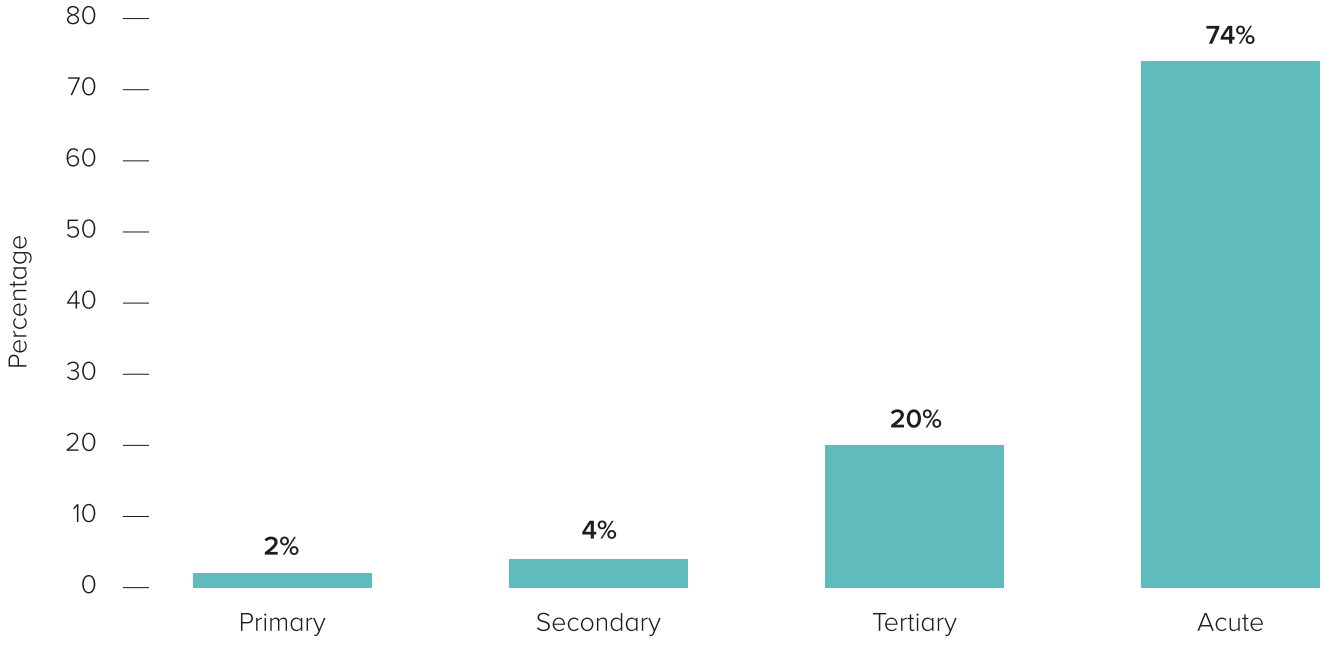
## Investing in prevention

### NHS Wales Prevention Spend

In 2018–19 Welsh Government Health analysed the £6.1bn NHS spend in Wales, against prevention categories which was published by the Office of Future Generations Commissioner (see graph below) (98).

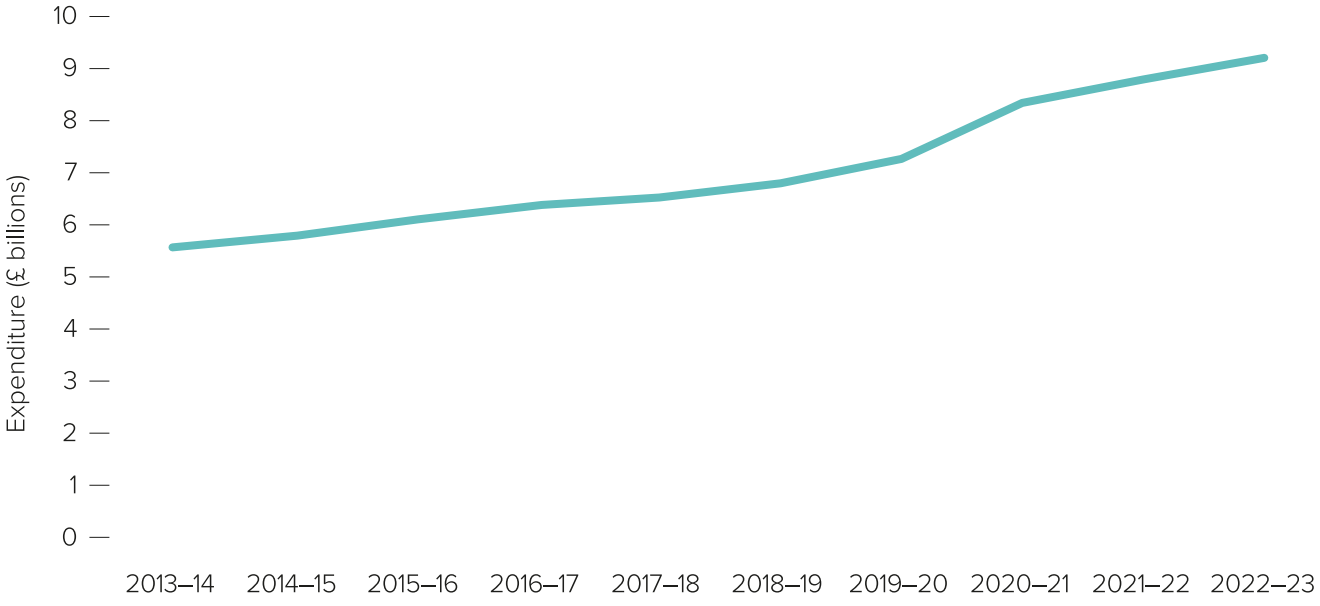
Indicative findings show about six per cent of spend was on preventing problems occurring, and a further 20% on intervening to stop problems from getting worse after they occurred, whilst 74% was spent on acute issues – much of which could be prevented upstream. This work is to be repeated in 2024–25 to assess whether preventative spend has increased.

**Figure 18: Bar chart showing percentage split of prevention spend in NHS Wales expenditure by level of prevention (primary, secondary, or tertiary, vs acute spending) (99). Note this is based on data prepared for the Health & Social Care Committee on the Draft Budget for 2019–2020, the most recent for which this information is available. The reference relates to the evidence presented to the scrutiny committee, but the graph was produced for this report.**



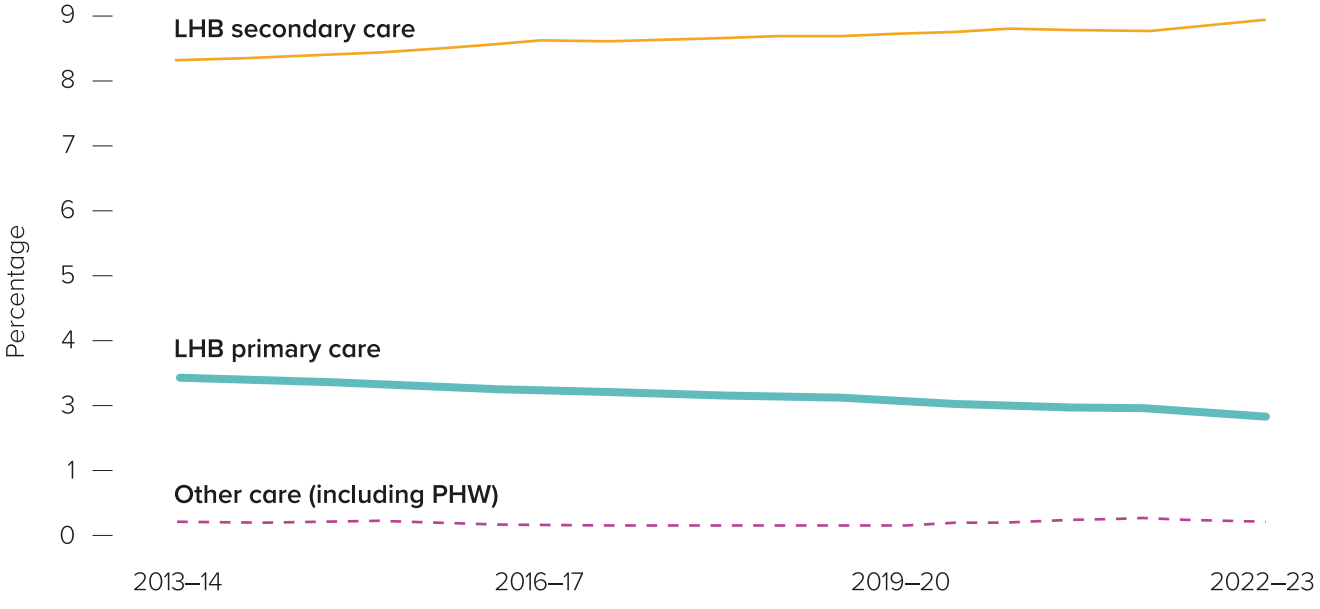

We need sufficient capacity in services close to populations, including primary healthcare, and early years, so as people's needs in the round, including for prevention, can be assessed and met. However, we also see the draw of acute demand in the split of funding between primary and secondary healthcare. Nearly four-fifths of NHS Wales expenditure relates to secondary care. The proportion of expenditure for secondary care has increased since 2013-14 whilst the proportion for primary care has decreased.

**Figure 19: Line chart of total NHS Wales expenditure on programmes of care, 2013–14 to 2022–23 (£ billion), showing that total expenditure has increased over the last 10 years, with a sharper increase between 2019–20 and 2020–21.**




Source: Programme Budgeting (WCR13) submission, NHS Wales Executive (99).

**Figure 20: Line chart of NHS Wales programme of care expenditure by commissioner (2013–14 to 2022–23), showing that the proportion of spend by secondary care has increased (100)**



Preventative initiatives are often supported by dispersed, temporary and insecure funding, be this in efforts to tackle a whole system approach to obesity or ensuring children and families get the support they need through interventions such as Flying Start. This undermines longer-term planning, retention of skills and knowledge and diverts the focus of permanent staff.

This pattern of spend makes it clear that we have a long way to go within NHS Wales itself, to meet A Healthier Wales's long-term future vision of a whole system approach to health and social care focussed on health and well-being, and on preventing illness.

**Extract from Health Foundation and Demos report** (101)

'Spending on prevention is often the first to go when the UK faces challenging fiscal conditions …

Successful prevention initiatives require time to work. The Supporting Families Programme, began at a relatively small scale in 2006, but then subsequently grew substantially from 2010 to 2012 when hundreds of millions of pounds was invested into the programme. The programme targeted additional support for families facing multiple complex challenges … An evaluation of the programme in 2019 found that for every £1 spent £2.28 of public value was created …

The point is that consistent investment in prevention has been shown to deliver results, however, we lack the architecture to do this systematically. Cultural and institutional change is required, but we also need to change the way that we spend public money to prioritise prevention …

The current system incentivises decision making which undermines the allocative efficiency of public spending. Whilst money isn't everything, it is a big part of the challenge. Ultimately, it is true that governments measure what they value and value what they measure. We currently do not have the ability to accurately measure the investment in prevention. As a consequence, despite regular calls from politicians for greater investment in prevention, little has changed in practice and in many cases the reality of funding flows is at odds with the stated policy intent.'

While the text box above relates to the situation in England, there are themes that are applicable to the Welsh context. Wales has had a stable government and a policy environment that is strongly supportive of action to improve health and reduce inequalities. Despite this, as Chapter 1 made clear, we have not yet had success in improving the health of all the people in Wales.

I fully support the work that the Health Department are doing to analyse prevention spend and the work that Welsh Government is doing to look beyond the Welsh Government 2025–26 Budget, to the next Welsh Spending Review. This is a hugely important strategic exercise which will look at medium to longer-term fiscal planning for Wales. This work will enable consideration of a more preventative approach to the well-recognised challenges that Wales will face in the coming years and address how future plans are formulated for spending, tax raising, and income generation. Improving the overall health of the people of Wales will be a key theme within this work.

The challenge to system leaders is to reflect the current positive legislative and policy environment in sustained action, supported by investment, across the public sector and beyond. This will require a change in behaviours within the health system and across wider government. It will also require a conversation with the public to explain the importance of an approach that emphasises health over healthcare. Such a conversation is needed because the current trajectory of increasing demand on the health service is unsustainable.

## Using evidence to invest in prevention

Public Health Wales recently published an updated report to their previous work **"Making a Difference: Investing in Sustainable Health and Well-being for the People of Wales"** (2017) ((102), (103)). The report focuses on public health programmes (longer-term initiatives) and interventions (targeted, often short term) that aim to improve health and well-being and reduce the financial cost of ill-health to the health and social care system in Wales. This ensures decisions are based on evidence and provide the best value for our current resources.

> *"We need to invest in prevention, not just despite the challenging financial position of public services in Wales, but because of it."*
>
> Investing in a Healthier Wales: Prioritising Prevention (103)

The key finding, not surprisingly, is that public health programmes offer a large return on investment (14 to 1 on average) and reduce health inequalities. The benefits of investment in public health are felt far outside of the health system and programmes delivered at scale typically achieve greater returns on investment, although smaller scale programmes still hold much value. The report breaks down interventions by life stage, setting out quality ideas for improving health in the early years, helping adults become healthier, and ensuring that people age healthily.

**Figure 21: Explanations and examples of the latest evidence on where investment in prevention can have the greatest impact in the early years and children, for healthy adults and for healthy ageing. Adapted from Investing in a *Healthier Wales: Prioritising Prevention* (102).**

## Early Years and Children

Programmes to support parents and the early years are effective and set the foundation for good health and well-being in the longer term, bringing substantial return on investment. Addressing inequalities enable all children and young people to maximise their capabilities and achieve their potential into healthy adulthood.

Examples of evidence identified with a positive impact and positive return on investment include:

**Integrated services for maternal and parental mental health**

**Early years education programmes especially for low income families**

**Programmes to support women to quit smoking during pregnancy**

## Healthy Adults

The findings emphasise the need to support healthy behaviours, mental well-being and addressing the wider determinants of health. The programmes reflect a cross-sector approach providing effective services and supportive, enabling environments.

Examples of evidence identified with a positive impact and positive return on investment include:

**Multi component approaches to reducing self-harm and suicide**

**Physical activity programmes to mitigate against obesity and associated diseases such as diabetes**

**Data sharing between organisations reducing the costs associated with violence**

## Healthy Aging

A holistic approach is required to ensure healthy aging with a recognition of the value of older people and their contribution to society. Social return on investment provides evidence for the wider social value of healthy aging.

Examples of evidence identified with a positive impact and positive return on investment include:

**Programmes and interventions to promote independent living of older people**

**Programmes to address loneliness and isolation**

**Pre-diabetes management programmes**

I welcome the latest report from Public Health Wales. It describes how investing in prevention sets the foundation for good health throughout people's lives, showcasing areas that could have the greatest impact. It focuses on both long-term programmes and targeted interventions that aim to improve health outcomes, reduce inequalities and lessen the financial impact of poor health on NHS Wales and wider society in Wales. The report adopts a life course approach, starting in the early years, to healthy adults and healthy ageing emphasising interventions that reduces the cumulative impact of health risks throughout life and across generations, and supporting policy and decision-makers to make the most of every pound spent on prevention in Wales. I hope organisations across Wales can look to it for direction, and mobilise the evidence contained within to renew a focus on effective prevention.

## Recommendations

1. **Welsh Government must take a leadership role in prevention, as envisioned in A Healthier Wales, ensuring it is prioritised, evidence-based, well-resourced, and sustained. Welsh Government should set clear expectations, manage performance where appropriate, and hold organisations to account for prioritising prevention, including through innovative approaches to measurement.**
2. **Welsh Government should work with NHS Wales organisations to agree a method and baseline for the regular measurement and benchmarking of prevention spend in NHS Wales, aiming to increase it annually based on evidence of effectiveness. Prevention funding should be sustained, secure, and increased over time, led by the evidence base.**
3. **Welsh Government must prioritise primary prevention, including renewing its focus on preventing major drivers of ill health – unhealthy weight and nutrition, tobacco, physical activity, alcohol, and substance misuse – by leveraging its unique powers to shape healthy environments and counteract unhealthy commercial influences.**
4. **Welsh Government and public agencies should prioritise prevention in the early years, following the principles adopted as Wales signed up to become a 'Marmot Nation'. Evaluation and monitoring should be built into this process to ensure equitable progress for all children.**
5. **Welsh Government and public bodies should prepare for and implement health impact assessments effectively and proportionately, ensuring that policies with the greatest potential impact on health and health inequalities are subject to robust assessment, supported by outcome modelling.**

Chapter 3:

# Workforce

## State of the workforce

The health and social care workforce in Wales is one of our most important assets. It has never been larger, with over 112,000 staff working in NHS Wales and over 84,000 working in our social care system (104). Every day, this workforce delivers hundreds of thousands of appointments, procedures, operations and care interactions, with record levels of delivery being set year on year. In 2022–23, the total workforce cost (including agency and locum) was £5.6 billion, more than half of the NHS Wales budget (105). As part of the 'quadruple aim' set out in the long-term plan for health and social care ('A Healthier Wales') (9), these services need a motivated, sustainable workforce. However, staff working in these services undoubtedly face significant and growing challenges (106).

Amidst record waiting lists and a global healthcare worker shortage (an 11 million shortfall by 2030), NHS Wales faces several challenges, as does the NHS across the UK (107). Between 2009 and 2018, the NHS Wales workforce increased by 8.7%. Since 2018 it increased by a further 24.0%, with the largest relative increases being seen in ambulance staff (43.4%), administration (33.9%), and medical and dental (31.0%). Nursing and midwifery remains the largest staff group. 76.6% of the workforce is female varying across staff groups, from 89.0% in nursing and midwifery,46.9% in medical and dental, to 43.0% in ambulance staff.

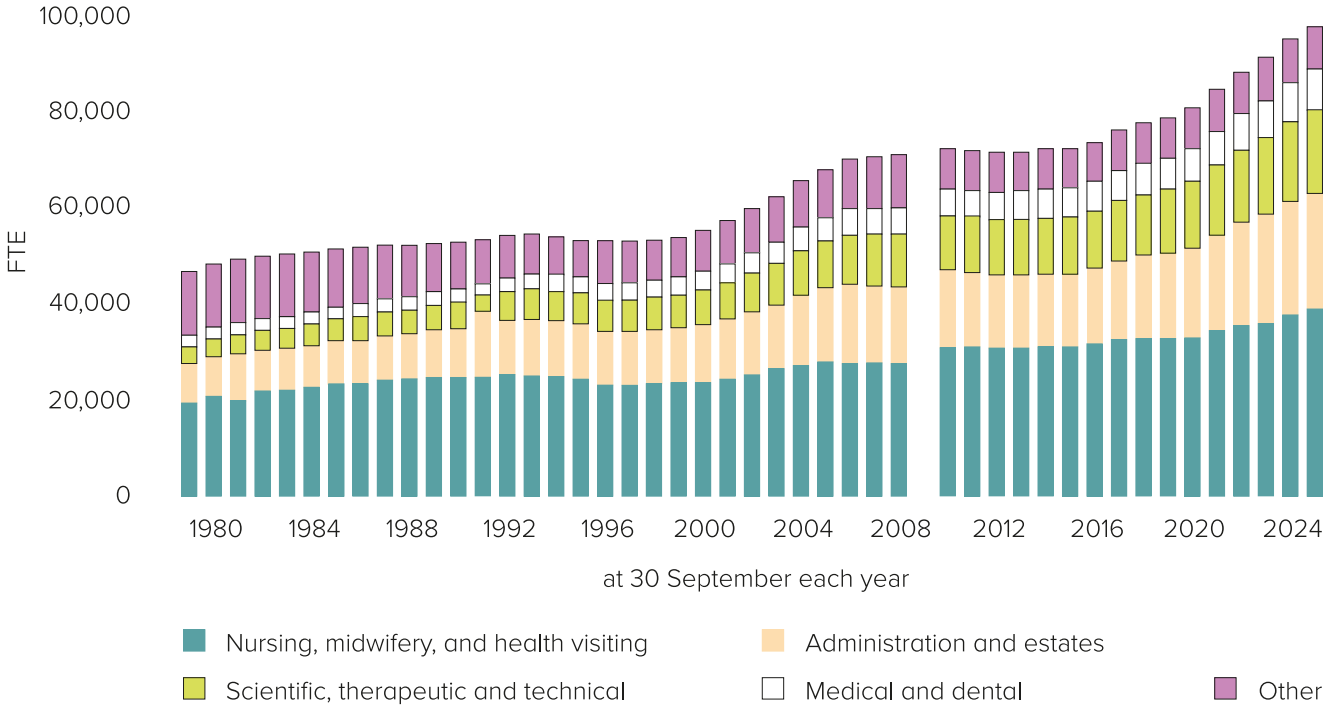
Roughly a third of the workforce are over the age of 50 with increasing numbers reducing their hours or planning retirement. Around a quarter of staff are 30 years old or younger (24.5% in 2024). Agency and locum spend has significantly increased, from around £10 million each month in 2018 to nearly £35 million each month in 2022–23.

Many of these shared issues in relation to staffing are also explored in detail at a UK-level by the NHS England Long-Term Workforce Plan and the recent report by Lord Darzi into the state of the NHS in England (108), (109). Whilst staff numbers across the UK have risen over the last decade, especially in the last few years, this has not been even and has mainly focused on hospitals. Much of this growth has also come via international recruitment and temporary staffing which can introduce potential ethical problems such as contributing to workforce shortage in home low- and middle-income countries and leave us vulnerable to rapidly rising market costs.

Sickness absence remains above pre-pandemic levels, and the Welsh economy faces a rising number of working-age people who are economically inactive due to long-term sickness, reducing productivity and increasing health and benefit related costs (104), (110). Sadly, bullying and harassment also remain clear issues, and leaver and turnover rates could and should be much lower. There is also still progress to be made on creating truly bilingual health and care services as we work towards the Cymraeg 2050 vision (111).

Looking at other staff groups, the number of Health Visitors has been stable in recent years but has grown over the longer term, and while the overall number of community and district nurses has increased over the long term, there have been decreases for those specialising in community services in recent years. The wider primary care workforce has seen welcome growth, and the number of GPs (headcount of partners and salaried total) has increased by 5.5% between September 2010 and September 2024. Full Time Equivalent (FTE) equivalent data for GPs is only available since December 2021, but numbers have been stable since this date. Amidst rising demand, vacancies in social care remain high even after recent improvements and the number of unpaid carers in Wales also continues to grow (104). The Bevan Commission has also highlighted that the current workforce is struggling to meet rising community expectations, utilise prevention and digital technologies effectively or to include the wider workforce, such as carers and the third sector (112).

**Figure 22: Full time equivalent (FTE) NHS Wales Staff, by staff group, 1979 to 2024**
**Note – data for 2009 not available from Health Education and Improvement Wales (HEIW)** (104)



Meeting these challenges sustainably will require building on recent expansions in training and development in Wales. We also need to ensure our health and social care workforce is happy, flexible, diverse, healthy, productive and empowered and that we successfully integrate new roles, ways of working, and technology, including the use of artificial intelligence. The health and social care system also has a crucial role to play in supporting the wider workforce to become healthier and more productive too, helping Wales to become a more prosperous and wealthy country.

The health and social care workforce are integral to realising the visions of A Healthier Wales, underpinned by the Wellbeing of Future Generations Act. They are a necessary part of our combined endeavours to ensure that our communities are healthier, with people living more fulfilling lives. The need to fully embrace all types of prevention and actively contribute to efforts to ensure a shift to providing more care in our communities will require the development of additional skills, new ways of working and new collaborations by our clinical teams. Care pathways need to reflect the patient journey and incorporate clinically-led prevention approaches, not just brdge the gap between primary and secondary care. The system will then work to reduce the pressure on hospitals so that they can focus on treating those who need specialist care that can only be provided in hospital. This system re-orientation and the reshaping of the clinical workforce that accompanies it requires trust, strong relationships, and shared purpose across care teams, effective communication, and new staffing models with roles that work across services and sectors.

## A sustainable and flexible workforce

In my previous special report, I discussed the positive response seen in Wales during the COVID-19 pandemic, where thousands of additional health and social care workers were mobilised alongside many new volunteers (113). I have also highlighted the need for long-term workforce planning to ensure sustainability and a need to strengthen worker well-being and occupational health services (31). As detailed in this chapter, significant work has occurred in these areas since.

I have also highlighted workforce challenges within social care and have regularly advocated social care as a critical challenge to address. Positively, there is now a Real Living Wage in social care, implemented via the Fair Work Forum made up of government, employers and trade unions. Welsh Government's Strategy for Unpaid Carers delivery plans are working to identify, value and support unpaid carers. Social Care Wales, as part of a 10-year workforce strategy, has recently worked with Welsh Government to produce a 2024–2027 delivery plan addressing key themes such as recruitment, education, and staff well-being.

In NHS Wales, Health Education and Improvement Wales (HEIW) has produced several strategic plans as part of an overarching 10-year workforce strategy for health and social care that include a focus on excellent education and training and the attraction, retention, and sustainable supply of professionals (114). These plans include primary care, pharmacy, dentistry, mental health and diagnostics with plans under development for genomics, nursing and perinatal care.

**Figure 23: HEIW stated 2030 ambition for the NHS Wales workforce** (115)


The National Workforce Implementation Plan (NWIP), sets out practical actions to improve retention, including improving staff well-being, and continued investment in education and training, see figure below (115). Through its actions, the Plan sought to tackle many of the issues that impact our ability to recruit and retain staff in NHS Wales and build capacity whilst maintaining a focus on the health and well-being of the workforce.

Most of the actions have been completed, however, there is still significant progress to be made with workforce supply and career progression being outstanding issues.

## North Wales Medical School

Each year, HEIW and Welsh Government commission training places for health professionals in NHS Wales (circa £283m). Additional funding delivered a major expansion of nursing, allied health professional, healthcare sciences, dental and medical places in 2023–24 though some targets for 2024–25 have since reduced slightly, and other professions have not seen any significant expansion in recent years (116). Wales also faces a distinct challenge in attracting and retaining health professionals in certain rural areas. However, evidence clearly shows that people will typically stay where they train. Within the *Programme for Government 2021–2026*; the then First Minister set out his commitment to establish a new medical school in North Wales by way of a partnership between Welsh Government, Bangor University, Cardiff University and Betsi Cadwaladr University Health Board (117).

The new independent North Wales medical school will expand our capacity to train the medical staff we need for the future and enable us to train more medical students here in Wales and ensure we distribute both training opportunities and the provision of well qualified doctors across Wales. This is good news for the students, the people of North Wales and for Betsi Cadwaladr University Health Board. Direct intake to Bangor commenced in September 2024 with 80 students successfully recruited. Student numbers will gradually increase until reaching optimum capacity from 2029 (140 students per annum). The official launch of the north Wales Medical School took place on 3 October 2024 at Bangor University.

## GP initiatives

Similarly, HEIW has had success with several initiatives for GP registrars through financial incentives aimed at encouraging them to stay in rural areas on completing their training (118).

In addition, an Academic Fellows Scheme was established by the Cochrane Institute of Primary Care and Public Health and is sponsored by Welsh Government (119). This scheme is aimed at GPs who have recently completed vocational training and who want to get a taste of academic general practice. The Academic Fellows spend two days a week as supernumerary GPs in practices based in deprived areas of South Wales. The rest of their time is spent learning about, and participating in, research and teaching.

The increasing number of practices across Wales showing both interest and enthusiasm in wishing to host an Academic Fellow reflects the commitment of general practice to improving and developing services for patients. It also highlights a desire to address the challenges of increasing needs and staff shortages. The Academic Fellows Scheme has played a pivotal part in the career path that the fellows have taken. The scheme has enabled them to undertake projects to improve patient care, whilst learning to teach and embark on research. This has in turn broadened their professional skills base. The increasing number of Fellows that continue to work within areas of deprivation having completed the scheme reflects the rewarding nature of general practice within these areas.

The Welsh NHS Bursary was introduced in 2017, following agreement of funding from Welsh Government, for a range of health professional courses with the aim of bolstering the healthcare workforce in Wales. Students who take the Welsh bursary benefit from significant financial support during their programme in return for committing to work in Wales for at least 2 years on graduation. Welsh Government has maintained the NHS Wales bursary package for students starting their studies in the academic year 2024–2025.

## Flexible working

Our workforce, whichever stage of their life and career they are at, are often looking for a more flexible approach to their employment. Traditional job roles and employment models need to be modernised to target different life and career stages. Welsh Government have worked in Social Partnership to create an **NHS Wales Flexible Working Policy.pdf (nhsconfed.org)**. The new policy aims to support managers to make the necessary cultural and practical changes required. Wales is committed to promoting and encouraging different ways of working to recruit excellent people and retain the wealth of knowledge, skills and experience of its current workforce. Going forward, the default position will be that a request for flexible working will be approved, and every possible avenue explored to facilitate this.

## Other views

The Royal College of Physicians recently worked with several other professional associations and health groups in Wales to produce recommendations for addressing our workforce challenges that NHS Wales employers may wish to consider (120). These included the provision of rest facilities and well-being support, personal and professional development opportunities, and targeted support for individuals and teams including individuals at risk of leaving.

## Public health workforce spotlight

To deliver a shift to prevention in NHS Wales and meet population health challenges, it is crucial to recognise and invest in both our public health workforce and in new models of prevention in clinical services. Our public health workforce consists of those who define public health as the primary part of their work and includes school nurses, health visitors, public health nurses, environmental health professionals, public health managers and scientists, and public health practitioners (121). Several of these groups have seen their numbers decline or plateau in recent years. The number of public health specialists (professionals on the specialist register for public health who would normally act as system leaders and advocates for public health) was assessed in 2021 by the Faculty of Public Health as 24.8 FTE per million population in Wales (122). We would ideally have 30 FTE specialists per million population with a healthy mix of medically qualified consultants and consultants from other backgrounds (122).

Local Government makes critical contributions to public health and undertakes delivery of key health protection functions. The Directors of Public Protection Wales (DPPW) published a report on Public Protection Services in Wales highlighting the vital role of public protection services and calling for a comprehensive workforce development strategy (123).

Beyond specialists and core public health professionals, there is also a far greater role for the wider public health workforce. This is defined by the Royal Society of Public Health (RSPH) as workers engaged in or who want to be engaged in public health activities, encompassing a range of occupations including teachers, dentists, charity workers, allied health professionals, social workers, doctors, carers, midwives, nurses, mental health professionals and others.

The RSPH has recommended that more is done to upskill and develop the public health skills of this wider workforce (including work on making every contact count and advocacy on the building blocks of health), that more is done to recognise and celebrate its role in prevention, and that routes into the core public health workforce are better defined and highlighted.

Aligned with this, and considered in the chapter on Prevention, is how we might engage with our populations in ways that allow us to consider their risk of poor health, identify risk factors earlier and provide appropriate support and interventions – clinical, social, environmental and fiscal as required. There is a need to consider how we can generate models of support and interventions that have more of a focus on keeping people healthy, who is best placed to deliver these and what skills are required. Such an approach is vital to secure our aspirations for the people of Wales but it needs a dedicated, skilled and supported workforce to deliver, drawn from multiple sectors.

Additionally, there is a need to consider how the required shift towards 'Improved health and well-being with better prevention and self-management' might be realised: who will deliver this and what skills are needed (9). This asks questions of our current clinical workforce and their capacity and skills to deliver prevention approaches but also what type and size of workforce we need to deliver effective prevention upstream of conventional clinical services.

This will require a re-examination of how clinical professionals and clinical teams contribute to identifying opportunities for prevention as an integral and vital element of providing effective and equitable patient-centred clinical care. This goes beyond (but includes) initiatives such as MECC 'making every contact count' (as a formal structured approach to providing brief advice in clinical settings) to a point where, as routine, clinical pathways include holistic assessment of peoples' needs and direct delivery, referral and signposting to effective interventions. Such an approach is in line with clinical quality and prudent healthcare approaches, concerned as it is with delivering clinical interventions in a patient centred way, addressing needs important to individuals.

The workforce involved in looking after the public's health is large and diverse. There is a need to consider the right size, distribution and roles of the formal and specialist public health workforce. The system also needs to give attention to identifying, supporting and facilitating the actions of the wider public health workforce to achieve the step change in delivery and health status that we seek, which requires engagement beyond the boundaries of the NHS Wales workforce and a genuine partnership approach at a community level.

## Workforce well-being

Workforce well-being is a central theme in 'A Healthier Wales: Our Workforce Strategy for Health and Social Care Workforce' (114). Ensuring that our workforce is healthy and engaged is crucial to achieving our ambitious plans for NHS Wales recovery and delivering the best care for the people of Wales. By adopting a proactive and preventative approach to health and well-being, we can help our staff maintain their own health, which is essential for retaining our workforce in the highly competitive international and local labour markets. In my 2023 report, I wrote about the importance of the NHS Wales supporting its own sick staff back to health (31).

During the pandemic, Welsh Government made substantial investments in workforce health and well-being in acknowledgement of the significant adverse effects the pandemic had on staff. As the long-term impacts become clearer, Welsh Government remains committed to supporting

health and well-being, working with social partners to implement tools that complement local organisational offerings, and ensuring staff have access to proactive, high-quality support when they need it most. We know that a proactive approach to health and well-being is best for service delivery, individuals, and their colleagues, helping to prevent absences and enabling a rapid return to work when necessary.

As part of the National Workforce Implementation Plan (NWIP) (115), a core standard model for Occupational Health (OH) services was established by a tripartite group consisting of trade union representatives, Welsh Government, Workforce Directors, and NHS Wales Employers.

The tripartite group agreed a specification for OH services, detailing essential services that should be accessible to all employees. Minimum service standards were developed, aligned with the core specification, and based on Safe Effective Quality Occupational Health Servic standards, with a goal for all services to achieve accreditation by 2026–27.

A Welsh Health Circular – WHC (2024) 017 – was issued to ensure implementation of NHS Wales Occupational Health Delivery Framework for NHS Wales through local action plans (124). As part of the WHC requirements, employers provided Welsh Government with benchmarked information against the minimum service standards in September 2024. Health Boards and Trusts in Wales were additionally asked to undertake internal self-assessment against these standards by 30 November 2024, with a view to developing plans to achieve accreditation by 2027 as part of their Integrated Medium-Term Plans for 2025-2028.

Following the report of the Fair Work Commission, Welsh Government is committed to the principle of fair work as part of its well-being economy approach (125). Fair work is “the presence of conditions at work that ensure workers are fairly rewarded, heard and represented, secure and able to progress in a healthy, inclusive working environment where rights are respected”.

Fair work enables workers to meet their own and their family’s needs and well-being, and to contribute, develop and grow. There is also an economic and business case because it can contribute to increased workforce commitment and morale, lower rates of absenteeism, more effective recruitment, lower staff-turnover, and improved productivity and other aspects of performance. To support NHS Wales and care providers, amongst other workplaces, Welsh Government has worked in partnership with Public Health Wales to produce case studies and guidance on implementing fair work for health, well-being and equity in the workplace (126). It is vital that all businesses and organisations in Wales continue to progress their fair work journey.

Fair work also means that workers are empowered and represented in workplaces. Welsh Government, health and care employers, and the relevant trade unions work together in social partnership. Through structures such as the NHS Welsh Partnership Forum (127), these parties can achieve mutually agreed outcomes, to the benefit of all involved groups.

**What is fair work** (125)

Fair work is the presence of observable conditions at work which means workers are fairly rewarded, heard and represented, secure and able to progress in a healthy, inclusive working environment where rights are respected.

Fair work enables a working environment which is attentive to the well-being of workers. The actions deployed by an organisation in their pursuit of fair work will depend on the specific circumstances of that organisation. Some actions may not be appropriate or feasible for all organisations, it is for each organisation to determine which actions are.

Here are some practical examples of what fair work could look like in a working environment:

- Enabling workers to meet their basic living costs and deliver wider benefits such as sick pay and pensions.
- Offering workers the opportunity and choice to be represented collectively, ensuring workers are informed about proposed decisions that may affect them, and providing workers with the means to participate in and influence those decisions.
- Providing work and income security, including in relation to hours and earnings and affording workers the opportunity to work flexibly to secure a good work-life balance.
- Delivering inclusive opportunities to obtain work, to acquire and develop skills and learning, and to progress in work.
- Ensuring work is carried out within a safe and healthy environment, where bullying, harassment and all forms of discrimination are tackled.
- Guaranteeing that rights and obligations are recognised and adhered to at all times.

## Leadership and Management

Good, and empowered, leadership and management can demonstrably lead to significant improvements in clinical outcomes, efficiency, quality, and safety whilst also helping to drive innovation and culture change. Strong clinical leadership is associated with some of the best performing health organisations across high-income countries (128). Conversely, ineffective leadership can lead to serious safety and organisational failures, as set out in the Francis Inquiry report following the Mid-Staffordshire scandal (129).

HEIW has been clearly committed to supporting leadership skills development for both clinicians and non-clinicians, and now offers leadership fellowships, a graduate management programme, and a learning portal on leadership (Gwella) (130). It has also worked with Social Care Wales to develop and embed compassionate leadership in health and care in Wales where leaders attend to and understand the needs of their staff and patients with empathy and a commitment to help. Growing our management capacity, supporting compassionate leadership and setting out further standards, qualifications and opportunities for leaders and managers will be crucial to unlocking

our workforce potential and the HEIW remit letter for 2025-26 specifically references delivery of a number of leadership programmes. The UK government have indicated that they will establish a new College of Clinical Leadership and explore regulation of managers, both of which are potential opportunities for us here in Wales.

## Safety

A focus on safety and quality in Wales can be seen with the development of national quality statements for many conditions and services, a new 'Speaking up Safely Framework', and the passage of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and subordinate legislation which have introduced statutory duties of candour and quality and a new Citizen Voice body (Llais) (131), (132). Improvement Cymru is also working to support quality, safety and improvement across NHS Wales.

## Productive workforce

Productivity is a key challenge for NHS Wales. We face record waiting lists and rising demand for services, and despite increases in workforce and other resources productivity remains low and below pre-2020 levels (133). This is particularly marked in the hospital sector where productivity has been especially poor in recent years despite significant staff recruitment and funding investment.

As discussed in my 2023 report, one key factor contributing to poor productivity is the lack of capital investment for many years (31). This has led to an alarmingly large and growing maintenance backlog, which can threaten business continuity. Sustained and significant capital investment will be required to give staff the facilities and equipment they need to perform effectively.

In addition, staff turnover and sickness absence both continue to be high and serve as significant productivity drains, both require significant action. Whilst new staff recruitment into the hospital sector during and following the COVID-19 pandemic has been welcome, these new staff have replaced large numbers of highly experienced and skilled workers who have left the health and social care system to either retire, work abroad or work in another sector. Retention plans and a national retention hub have recently been developed by HEIW and Social Care Wales in collaboration with Welsh Government and the workforce themselves, with further plans on the way. Retaining our staff and supporting them to develop their knowledge and skills so they can work 'to the top of their license' will be crucial for productivity, as I have written about before.

As discussed in previous reports, technology, including artificial intelligence, can offer enormous potential for improving productivity and well-being of our staff whilst enhancing quality and safety for patients. Research and development by NHS Wales, for example via Health and Care Research Wales, and from a thriving life sciences sector could also help to deliver future productivity boosts (134).

One of the mechanisms that can be used to aid with workforce challenges for NHS Wales is by embracing digital transformation. Welsh Government's refreshed digital and data strategy for health and social care in Wales sets out key

aims and actions, such as the development of the NHS Wales Application and roll-out of electronic health records and prescribing, building on the recent creation of Digital Health and Care Wales (134). By developing digital services, there are opportunities to join up services and increase staff capacity by avoiding duplication of data entry. Investing in digital transformation of services, such as histopathology, will support flexible working and enable a more efficient distribution of work across Wales that in turn will encourage greater staff retention.

Artificial Intelligence (AI) is growing rapidly in many sectors, and has the potential to improve healthcare, for example by increasing the speed of diagnostics and streamlining clinical note taking. While the use of AI and the potential of applications are growing quickly, we must ensure that any new developments have appropriate regulation and that both the workforce and patients are engaged from an early stage (135).

We must continue to make progress in these areas and, as technology is developed and implemented, it is vital that there is meaningful staff and patient engagement, that the existing digital infrastructure is fit for purpose and invested in, that ongoing piloting and robust evaluation is used, and that our workforce are also equipped with the skills to utilise this new technology (135).

I wish to highlight a number of other initiatives and projects in relation to NHS Wales workforce and staffing, below.

## Staff Registration

The majority of clinical professions in NHS Wales are protected titles that have statutory regulation under UK Law. Anaesthesia Associates and Physician Associates have been covered by statutory regulation under the General Medical Council (GMC) since December 2024. In July 2025, the UK Government announced plans to introduce regulation under the Health and Care Professions Council (HCPC) for all NHS Wales senior managers, extending oversight to those without current regulation from a clinical background.

This leaves the Healthcare Science workforce as the only clinical NHS Wales workforce without full statutory registration anywhere in the UK. Biomedical Scientists, Clinical Scientists in specific specialisms, Operating Department Practitioners and Radiographers have statutory regulation. However, there is no mandated registration for Healthcare Scientists in physiological or physical sciences, or genetic technologists.

Moving towards mandatory registration for the entire clinical NHS Wales workforce, including all Healthcare Scientists will support the improved patient safety, professional pride and aid in staff development by allowing work towards Patient Group Directives (PGDs).

## Anti-Violence Collaborative

Sadly, NHS Wales staff do face violence and aggression during the course of their employment. The Anti-Violence Collaborative (AVC) is made up of representatives from NHS Wales, the Police, CPS, Welsh Government and trade unions (136). The purpose of the AVC is to support NHS Wales and Emergency Services organisations to reduce and manage violent and aggressive incidents against NHS Wales staff and by so doing to protect staff and increase staff well-being. A refreshed Obligatory Responses to Violence (ORV) Document in Healthcare was issued to NHS Wales in May 2024 informing organisations of their responsibilities in supporting staff who are the victims of violence at work and for reporting on violent incidents towards staff (137). The approach is supported by the four Police forces in Wales, the Crown Prosecution Service and NHS Wales. The agreement aims to bring effective and efficient communication between partners, including supporting the exchange of information at all levels.

## Workforce Race Equality Standard

The introduction of a Workforce Race Equality Standard (WRES) for Wales intends to inform efforts to address historic poor workforce data on racial disparities. It will provide a yearly cycle of reliable and robust data collection, analysis and reporting to highlight areas of disparity for Black, Asian and Minority Ethnic staff and contribute to creating a more inclusive environment for the workforce (138). This will, in turn, catalyse successful delivery of the Health and Social Care Goals within the Anti-racist Wales Action Plan and improve the experiences and outcome for people who seek care and support. Data related to directly employed NHS Wales staff based in secondary care has been collected for the first time during 2024 with 13 individual organisational reports shared with NHS Wales bodies to inform and shape their local anti-racism action plans. An all-Wales report has also been published and will enable partners greater insight to inform change at a national level.

## LGBTQ+ action plan

The national LGBTQ+ action plan also sets out several actions for the public sector in Wales that ensure the rights of LGBTQ+ people are recognised and that their needs are better met (139). It will also support the representation, safety and communities of LGBTQ+ people. We have a specific need to improve the health outcomes of LGBTQ+ people and Welsh Government is working alongside NHS Wales, Social Care Wales and social care providers to embed LGBTQ+ specific health and social care training to all staff to the benefit of LGBTQ+ patients and staff.

## Welsh language

The hundreds of thousands of staff involved in health and care in Wales have a huge role to play in providing Welsh language services and contributing to Welsh Government's ambition of reaching a million Welsh speakers by 2050 (111). Welsh language is a key theme of the overall workforce strategies set out by HEIW and Social Care Wales in collaboration with Welsh Government. *More than just words* 2022–27 sets out actions for health and care bodies to increase the number of Welsh speakers and the use of Welsh including the use of the 'Active Offer' (140).

## Pay awards 2022–24

A formal pay dispute with Welsh Government over doctors pay for 2023–24 saw industrial action being undertaken by secondary care doctors in NHS Wales. To bring an end to the pay dispute and industrial action the then Cabinet Secretary issued a final pay offer for 2023–24 to each British Medical Association (BMA) committee, which their members accepted at the end of July 2024 (141). Similarly, following a formal pay dispute involving industrial action with several NHS Wales staff groups employed on Agenda for Change, including nurses,

paramedics, physiotherapists and radiographers amongst others, a final package of measures was issued by the then Cabinet Secretary for health and social care in 2022–24 which has subsequently been accepted by the members of the respective trade unions (142).

Welsh Government listened to the concerns from NHS Wales staff, working together in social partnership to find solutions to end the pay dispute so that staff could return to work to continue delivering care and treatment to patients. The pay offers have started the journey towards pay restoration, a principle Welsh Government remains committed to. The additional investment is subject to additional contractual and operational reform which will also address productivity and efficiency along with reducing inequalities across the NHS workforce in Wales. The agreements have also included several non-pay items including new policies on flexible working, flexible pensions, and the development of an All-Wales occupational health service for NHS Wales staff.

## Positively influencing the wider workforce and economy

Finally, the health and social care sector has an important role in supporting and influencing wider than its own workforce, such as how health and care services can support and manage people back into work. This has never been more important in the context of rising economic inactivity due to illness across the UK, with mental health and musculoskeletal issues being the leading causes (110). NHS Wales especially will need to play its role in tackling these.

Our institutes and employers in the health and care sector in Wales play an important role as anchor institutes, a role I wrote about in my 2023 report, highlighting the example of the Bourneville Village (31). The term refers to 'large, typically non-profit, public-sector organisations whose long-term sustainability is tied to the well-being of the populations they serve' (143). Anchors typically don't relocate and have a significant influence on the health and well-being of surrounding communities. These opportunities include employment, supporting supply chains and local businesses, promoting fair work, providing services, offering training and skills development, research and development, offering community spaces and use of facilities/estate, providing accommodation and amenities, and procurement effects. Climate change and biodiversity loss have been recurring themes in my previous reports and there is still much to do regarding mitigation and adaption. My 2023 report highlighted several ways in which health and care employers could contribute their part to these efforts (31).

Public service boards are a particularly useful forum to consider how health and care services can positively influence their communities, and to then drive positive change. Such approaches contribute to delivery of the new 'Socio-economic Duty' and are aligned with Welsh Government's work on supporting the foundational economy. As part of this, new procurement rules have been enacted that consolidate public procurement into a single guidance regime with new statutory duties being placed on public bodies, including local health boards. These duties include considering 'socially responsible public procurement when carrying out procurement, to set objectives in relation to well-being goals, to publish a procurement strategy, and to carry out contract management duties to ensure that socially responsible outcomes are pursued through supply chain' (144).

Much of this will be familiar given the structures and ways of working set out in the landmark Welsh legislation: The Well-being of Future Generations Act (Wales) (2015) (58). The contribution that our health and social care

sector makes working together with a range of range of other organisations is written about extensively in the 'cohesive communities' chapter of the 2020 report by the then Future Generations Commissioner (145). The 2025 report reiterates the crucial role of the health and social care sector in leading action, and the need to prioritise long-term, prevention-based solutions to build a healthier, more resilient Cymru (33).

*"Cymru has chosen a different path, one that looks to the future and prioritises well-being, and we must stick to it. Every action we make together makes a difference."*

Future Generations Report 2025 (33)

## Recommendations

1. **Welsh Government should support capital investment in digital transformation aiming to increase productivity at a system level and improve patient experience and health outcomes by making the NHS Wales services that people use more 'joined up'.**
2. **Welsh Government should lead NHS Wales in creating an empowered, safe, and productive health and social care workforce through prioritising growth in the primary and community care, mental health and public health workforces, supporting the long-term implementation of the NHS Wales Occupational Health Delivery Framework, and promoting the 'Active Offer' for Welsh language.**
3. **All NHS Wales Health and Social Care employers should be offered support and guidance to promote and embed fair work in their workplaces, conduct socially responsible public procurement, and to promote and work in social partnership with workers and trade unions.**
4. **Welsh Government should look to mandate professional registration as a condition of employment in NHS Wales for the healthcare science workforce and work alongside University Health Boards for implementation, and to prepare for the upcoming legislation to regulate senior managers in NHS Wales.**

# Annex A

## Update on recommendations from Shaping Our Health, CMO Annual Report 2023–24

| Chapter | Recommendation | Update |
|---|---|---|
| 2 | Welsh Government should continue to reform our health and care system in line with the ambition set out in our strategic framework “A Healthier Wales”. Despite the intensity of immediate system pressures, an ongoing focus on service re-configuration is critical for long term sustainability.<br>All partners should deliver at pace pathway redesign for planned and unscheduled care with an emphasis on upstream prevention. There should be particular focus on older people, those living with frailty and those with co-morbidities, so that people get the right care at the right time in the right place.<br>Attention should be given to shaping and articulating our ambitions for the health and care system for future generations, based on honest dialogue with the public about what NHS Wales can and cannot do. This must be informed by a deep understanding of the current challenges and future demand projections. | Welsh Government has for Planned/scheduled care, developed the national 3 Ps policy, **Promote, prevent and prepare for planned care GOV.WALES**.<br>The policy is to turn reactive waiting times into a proactive wait:<br>• promoting healthy behaviour through signposting to resources such as weight management, exercise, stop smoking<br>• prevent getting worse through discussing what matters to you conversation and identifying possible issues while they are waiting and if require escalate to the appropriate source (all health boards now have a single point of contact to manage this process)<br>• prepare through conversation encouraging and supporting self-management to improve health particularly preparing for surgery- in some cases this may be supported by dedicated preoptimization services.<br>For unscheduled care **Six goals for urgent and emergency care: policy handbook for 2021 to 2026 | GOV.WALES** has been developed.<br>Goal 1. Supporting people at more risk of needing urgent or emergency care- looks at models to prevent need for urgent emergency care by proactively supporting people to stay well at home. |

| Chapter | Recommendation | Update |
|---|---|---|
| 3 | **Tobacco**. Welsh Government should explore legislative measures to expand the range of smoke free spaces – starting with outdoor eating areas. E-cigarettes. Reports of the increase in the use of e-cigarettes by young people is of great concern. I urge Welsh Government to consider measures within its own competence to protect children and young people from these products, regulate e-cigarettes as for smoking in public places, and I to urge the UK Government to act on areas reserved to them on areas such as flavourings and advertising. I welcome the recent guidance issued to schools on vaping. Welsh Government should continue to support all actions to prevent e-cigarette use amongst children and young people, including raising awareness of the risks and helping those who have developed an addiction. | In addition to creating a smoke-free generation, we want to reduce the availability and appeal of vapes and prevent them from being targeted at and used by children and young people in Wales. The **Tobacco and Vapes Bill** was laid in Parliament on 5 November, and will, if passed, provide comprehensive powers to tackle vape advertising, flavourings and packaging as well as powers to introduce licensing for retailers of tobacco, vapes and other nicotine products. The **ban on single-use vapes** from 1 June 2025, is designed to address the environmental impact of these products, protect children and improve the nation's health.<br><br>The Bill strengthens the existing powers to ban smoking in public places to reduce harms of passive smoking, particularly around children and vulnerable people in England. Wales already has the ability to introduce additional smoke-free places in Wales. The Bill also introduces powers to extend smoke-free laws so that they could also prohibit the use of vapes and heated tobacco products in specified areas where smoking is prohibited. Minsters are keen to look at and work closely with the other nations on the introduction on additional smoke-free and vape-free public places and take a joint approach.<br><br>To support schools with the challenges around vape use we asked Public Health Wales (PHW) to develop guidance for secondary age learners on vaping. **Information and Guidance on Vaping for Secondary-aged learners in Wales** was published in September 2023 and provides evidence-based information for schools on how they can respond to and help address vaping. These resources have been promoted widely to schools and we continue to identify opportunities to develop resources on this important topic.<br><br>Any person 12 years or over who is smoking and vaping can access the same level of support as adult smokers, including the full range of behavioural support and Nicotine Replacement Therapy (NRT) tailored to their specific needs. Those over 12 who only vape can currently access one session of behavioural support through the national smoking cessation service *Help Me Quit*, without NRT provision. |

| Chapter | Recommendation | Update |
|---|---|---|
| | **Alcohol**. Welsh Government should take the most effective strategic approach to alcohol; to dilute the messaging of industry, provide accurate unbiased information and support population health interventions in order to prevent and minimise alcohol related harm. With the changing curriculum in Wales – schools need to be provided with evidence based unbiased information, free from commercial influence that will support young people to make informed choices about their health and well-being. Welsh Government should build on the example of the Irish Department of Education and Health Service Executive, which has formally advised schools against using materials funded by the alcohol industry, and issue similar advice against using any commercially funded materials. | More work is needed to address the messages provided from the industry.<br><br>Preventing the harm caused by alcohol misuse is part of Welsh Government's substance misuse agenda and we continue to promote awareness of the **4 UK Chief Medical Officers' low risk drinking guidelines** and encourage all people to make healthy choices, drink responsibly and reduce their alcohol consumption.<br><br>Welsh Government also supports Alcohol Change UK to raise awareness of alcohol misuse issues across Wales and to campaign for effective alcohol policy and improved services for people whose lives are affected by alcohol-related problems. |

| Chapter | Recommendation | Update |
|---|---|---|
| | **Food and drink**. I want Wales to be exemplar in the UK and lead the way in addressing issues related to increasing levels of obesity and tacking our food environment. Welsh Government should consider the role of future taxes on salt and sugar if the industry-led (or UK led) pace of change is not in line with public health and sustainable development priorities. The impact of our changing eating and drinking habits during the pandemic and the current cost of living crisis should redouble our efforts to ensure that people have access to healthier and sustainable food. Welsh Government should consider the range of approaches in the retail environment to make healthier choices easier for consumers, and to limit the promotion of foods high in fat, sugar, or salt (HFSS products). | Following the Healthy Food Environment consultation in 2022, we will introduce The Food (Promotion and Placement) (Wales) Regulations 2025 which will set out a series of measures to limit the promotion of HFSS products in retail settings. We are reviewing further options to make healthier choices easier for consumers and to limit the promotion of HFSS products, including potential opportunities for taxes and levies in a Welsh context as part of the development of our next delivery plan for the Healthy Weight: Healthy Wales strategy. |
| | **Gambling**. NHS Wales should develop a clear referral pathway and continue to work with the Welsh Health Specialised Services Committee to establish and deliver a specialist gambling treatment service for Wales. Our approach in Wales has always been to do what we can to protect those vulnerable to harm from the gambling industry. Welsh Government should continue to lobby the UK Government for greater controls in order to protect the population from the gambling industry's damaging practices. | We are working with the UK Government and Scottish Government to implement a new **levy** that will require gambling companies to pay a proportion of their revenue to support gambling treatment, research and prevention. We are also working closely with PHW who have been tasked with developing a gambling treatment service. |

| Chapter | Recommendation | Update |
|---|---|---|
| 4 | Climate Change. In my 2020-21 report I made a recommendation that Welsh Government and Public Health Wales should identify intelligence gaps on the current and emerging threats and work with partners to develop climate and health surveillance systems to improve understanding, generate evidence, and inform health system planning and action. That recommendation still stands, and I urge both organisations to prioritise improving our climate related health surveillance systems.<br><br>Welsh Government and business sector leaders should consider what further action can be taken to prevent 'green washing' and place requirements on commercial and other sectors to provide greater transparency on their products and practices. I reiterate my recommendation from my last report. Welsh Government and Public Health Wales should identify intelligence gaps on the current and emerging threats and work with partners to develop climate and health surveillance systems to improve understanding, generate evidence, and inform adaptation planning and action. | Public Health Wales (PHW) have recently launched the new Integrated Climate and Environmental Public Health Surveillance Team. PHW have adopted an agile approach to foster co-creation and therefore ensure surveillance products are valuable to partners. PHW are collaborating with Welsh Government, UK Public Health Organisations, the International Network for Public Health and Environmental Tracking, and other partners. PHW's current focus is an assessment of the public health impact of heat exposure in Wales. |

| Chapter | Recommendation | Update |
|---|---|---|
| 5 | Cost of living crisis. Welsh Government should continue to lead and collaborate with key partners to act on the range of public health solutions required to mitigate the cost-of-living crisis in the short, medium and longer term. The differences in premature mortality between the most and least deprived areas in Wales are stark. In order to reduce unfair gaps in health and well-being, Welsh Government should continue to prioritise and invest in interventions that address upstream determinants of health; early years, education, employment, income, housing, and the environment, in order to avoid worsening public health prospects for our citizens. | Welsh Government continues to take forward a range of public health actions to mitigate the impact of the cost-of-living crisis and reduce health inequalities. Building on the original recommendation, we are proud to have announced Wales' commitment to becoming the world's first *Marmot Nation*. This landmark initiative places health equity at the heart of government policy, recognising that the conditions in which people are born, grow, live, work and age are the primary drivers of health outcomes. It builds on the success of the Gwent Marmot region and aligns with the Well-being of Future Generations Act.<br><br>To further embed a 'health in all policies' approach, Welsh Government is progressing regulations under the Public Health (Wales) Act 2017 to make Health Impact Assessments (HIAs) mandatory for specified public bodies. These regulations will ensure that decisions in sectors such as housing, education and transport systematically consider their impact on population health, particularly for vulnerable groups. The regulations are expected to be laid before the Senedd in Autumn 2025.<br><br>Additionally, the newly established *Ill-health Prevention Advisory Group* is supporting the Chief Medical Officer in advising Ministers on effective, sustainable prevention.<br><br>Together, these developments represent a significant step forward in addressing the upstream determinants of health and reducing unfair gaps in health and well-being across Wales. |

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**Note:** all web links correct as of August 2025