



**CYFARFOD BWRDD PRIFYSGOL IECHYD**  
**UNIVERSITY HEALTH BOARD MEETING**

<b>DYDDIAD Y CYFARFOD:</b> <b>DATE OF MEETING:</b>	27 November 2025
<b>TEITL YR ADRODDIAD:</b> <b>TITLE OF REPORT:</b>	HDdUHB Director of Public Health Annual Report 2025: Prevention of Ill Health – Everyone, in every service, all the time: 20-4-7
<b>CYFARWYDDWR ARWEINIOL:</b> <b>LEAD DIRECTOR:</b>	Dr Ardiana Gjini, Executive Director of Public Health
<b>SWYDDOG ADRODD:</b> <b>REPORTING OFFICER:</b>	Dr Ardiana Gjini, Executive Director of Public Health

**Pwrpas yr Adroddiad** (dewiswch fel yn addas)

**Purpose of the Report** (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA**  
**SBAR REPORT**

Sefyllfa / Situation

Directors of Public Health publish an independent, annual report on the health issues of their population, with the authority to comment publicly in a professional capacity on matters pertinent to the health of the local population.

The Board is invited to discuss this year’s Director of Public Health annual report ‘Prevention of Ill Health – Everyone, in every service, all the time: 20-4-7’ which calls for a fundamental rebalance of our services, moving prevention from the margins to the centre of clinical leadership and everyday health care. As stated by the UK Chief Medical Officers, "The greatest contribution the NHS can make to improving the nation’s health is to prevent as much illness as it treats."

The Board is invited to discuss and endorse the framework to ensure system sustainability and health equity.

Cefndir / Background

Preventable illness and health inequality place unsustainable pressure on our services across Hywel Dda. We are all too often intervening too late in disease progression. To help people stay well for longer, reduce avoidable demand, and use resources prudently we want to redefine prevention as a core part of clinical leadership and everyday health care.

The 20-4-7 model translates this aim and the NHS Wales Planning Framework 2025-28 into regional action, aligning with the Wellbeing of Future Generations principles.

**The 20-4-7 Model**

The report sets out three non-negotiable, interlinked priorities for every part of the system:

- Focus on the 20% most socioeconomically deprived people in the population ('20')

- Address four modifiable risk factors ('4'): Smoking, poor Nutrition, harmful Alcohol use, and Physical inactivity (SNAP)
- Reduce the burden in seven priority areas ('7'): Cancer, Cardiovascular disease, Respiratory disease, Diabetes, Mental Health, Children/Young People, and Older People

### Asesiad / Assessment

The attached Director of Public Health Annual Report 2025 provides the evidence-base and rationale for focusing our efforts on the 20% most socioeconomically deprived groups in the population, the 4 biggest modifiable risk factors for avoidable disease, and the 7 priority areas for prevention.

#### Key Findings and Rationale:

- Equity Gap ('20'): The gap in healthy life expectancy in the region is approximately 12 years for men and 9 years for women. Tackling this inequality is fundamental to improving population health outcomes for everyone and sustaining services
- Risk Burden ('4'): The 4 SNAP behaviours drive a substantial proportion (around a third) of preventable illness
- System Pressure ('7'): Early intervention in the 7 priority areas will reduce major avoidable demand. For instance, tooth decay remains the leading cause of hospital admissions for children aged 5-9, and effective dementia prevention could halve the burden of the condition on our health economy

The report outlines recommendations that are focused, ambitious, and feasible, designed to shift the organisational mindset and accelerate existing good practice:

1. Within annual planning cycles all teams, services, clinical networks and Clinical Care Groups will identify areas and actions to accelerate successful prevention efforts, shifting our organisational mindset so that equity, behavioural risk reduction, and focused action become the routine, measurable foundation of all care delivery.
2. A comprehensive programme of staff engagement and training to strengthen the approach so that prevention becomes part of every role and every care setting
3. Empower clinicians and managers the flexibility and ability to embed prevention in the most timely and effective way.
4. A commitment to sustainable funding of prevention activities in a planned and managed way including development a 3-year invest to save approach to support reducing future demand

These actions move the 20-4-7 model from strategy to practice, making prevention the routine foundation of care delivery across Hywel Dda.

The report also makes some specific recommendations for each of the 20-4-7 model components:

#### **1. The 20 – Equity: reaching the 20% most socioeconomically deprived**

To reduce the unfair and unacceptable gap in health outcomes, our prevention efforts must begin by targeting action and resources towards the most socioeconomically deprived of our population:

- Integrate Health Equity Impact Assessments (EIAs) into strategic planning and budget processes

- Empower Primary Care Clusters (PCCs) to use local data to target action by place, background, and circumstance, recognising intersectionality
- Empower Primary Care Clusters (PCCs) for strengthened delivery of prevention activities – analyse local intelligence and data to target action by place, background and circumstance - use Welsh Index of Multiple Deprivation (WIMD) quintiles and GP cluster data in addition to equality assessment defined by protected characteristics to identify those most at risk, recognising intersectionality as a key driver of disadvantage
- Establish a strengthened Health Equity Oversight Group as the coordinating mechanism for multi-agency work on equity, aligning efforts with Public Service Boards and Regional Partnership Board
- Finalise and publish a Health Equity Dashboard to monitor inequalities in outcomes, access, and experience across the 7 priority health areas

## **2. The 4 – Behavioural risk factors: tackling the drivers**

Addressing the underlying behaviours that drive preventable illness is essential:

- Make *Making Every Contact Count (MECC)* a core competency across the workforce, empowering every member of our workforce to have the confidence and skills to identify risk behaviours and offer brief advice or referral
- Establish and expand a dedicated Health Coaching service with Primary Care, making it the primary, first-step intervention for adults managing multiple health risks
- Enforce supportive environments for healthy choices – develop leadership skills and ability to ensure health board sites actively promote and enforce supportive environments for healthy choices, including smoke-free and healthy food environments
- Integrate data systems that automatically capture prevention activity at the point of care

## **3. The 7 – Priority Health Areas: focusing for impact**

To deliver maximum benefit, we must integrate these equity-led, behaviour-focused actions and evidence-based interventions across the 7 major conditions:

- Work with partners to conduct a system-wide review of all major clinical pathways, mandating the integration of upstream risk reduction, comprehensive screening, and targeted health coaching/behavioural interventions at every relevant clinical touchpoint
- Establish prevention and population health plans for each of the 7 priority areas to coordinate system action, identify opportunities for prioritising prevention and align clinical protocols and our wider efforts
- Create the case for further developing the workforce aligned with the 20-4-7 model and scope roles that are dedicated to leading prevention across the 7 prevention priority areas

These recommendations will be followed up with the development of an action plan with SMART (Specific, Measurable, Achievable, Realistic/Relevant, Time-bound) objectives and deliverables. Progress against the report recommendations will be monitored and reported on through the following established arrangements within the Health Board and regional partnerships:

- Public Health Directorate: 20-4-7 programme
- UHB Health Improvement and Equity Oversight Group: Oversight and monitoring of health improvement and equity initiatives, including the recommendations of the report relating to health improvement and health inequalities
- A Healthier Mid and West Wales executive group

- Overall governance and oversight via the Strategy and Planning Committee

These structures will ensure that progress and outcomes are tracked and aligned with strategic priorities.

Following endorsement of the report by the Board, the report design will be finalised, to support publication, promotion, and engagement of partners with the report and next steps.

### Argymhelliad / Recommendation

The Board is asked to **CONSIDER** and **ENDORSE** the HDdUHB Director of Public Health Annual Report 2025 and join the Director of Public Health in recognising the recommendations outlined therein.

### Amcanion: (rhaid cwblhau)

#### Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality <a href="#">Quality and Engagement Act (sharepoint.com)</a>	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: <a href="#">Quality and Engagement Act (sharepoint.com)</a>	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	10 Population health
Amcanion Llesiant BIP: UHB Well-being Objectives: <a href="#">Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022</a>	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives

### Gwybodaeth Ychwanegol:

#### Further Information:

Ar sail tystiolaeth: Evidence Base:	Outlined within the report
Rhestr Termiau: Glossary of Terms:	Outlined within the report

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A
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<b>Effaith: (rhaid cwblhau)</b> <b>Impact: (must be completed)</b>	
<b>Ariannol / Gwerth am Arian:</b> <b>Financial / Service:</b>	Not applicable
<b>Ansawdd / Gofal Claf:</b> <b>Quality / Patient Care:</b>	Not applicable
<b>Gweithlu:</b> <b>Workforce:</b>	Not applicable
<b>Risg:</b> <b>Risk:</b>	Not applicable
<b>Cyfreithiol:</b> <b>Legal:</b>	Not applicable
<b>Enw Da:</b> <b>Reputational:</b>	Statutory requirement to publish annually.
<b>Gyfrinachedd:</b> <b>Privacy:</b>	Not applicable
<b>Cydraddoldeb:</b> <b>Equality:</b>	Not applicable

**Hywel Dda University Health Board**  
**Director of Public Health Annual Report 2025**

**Prevention of ill health – everyone, in every  
service, all the time**

‘20-4-7’ A model for embedding prevention as the  
foundation of health services across Hywel Dda



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## Foreword

“The greatest contribution the NHS can make to improving the nation’s health is to prevent as much illness as it treats.” — The UK Chief Medical Officers, BMJ, January 2024

The four UK Chief Medical Officers, in their joint paper published in the BMJ (January 2024), challenged every part of the health system to rebalance towards prevention. Their message was clear: our sustainability and impact as a health service depend not only on how well we treat disease, but on how successfully we prevent it.

In Hywel Dda University Health Board, this message has particular resonance. Across our diverse and beautiful region — from rural Ceredigion to the coastal communities of Pembrokeshire and the urban heart of Carmarthenshire — we see daily the impact of health inequality and preventable illness. The impact is on individuals, on our communities, and in our health and care system. Our clinicians and teams deliver outstanding person-centred, compassionate care, often under intense pressure. Yet too often, we meet people much later and in much progressed illness and debilitations than we should — at the point where prevention has already failed.

“Reducing health inequalities is a matter of social justice — but it is also a matter of good clinical practice.” — Professor Sir Michael Marmot

Our services and our communities face real pressures. Demand is high, our geography is rural and spread out, and money and staff time are limited. The Health Board’s strategy refresh sets a simple aim: help people stay well for longer, reduce avoidable demand, and use our resources prudently. The 20-4-7 model will help us turn that aim into everyday action, joining up what already works, removing duplication, and making it easier for teams to “do the right thing” first time.

NHS Wales Planning Framework 2025-28 enhances the role of prevention: more prevention, earlier help, and better outcomes for everyone. 20-4-7 turns that national direction into regional healthcare practice. It supports the Wellbeing of Future Generations principles: thinking long-term, preventing problems, working together, involving people, and joining up services.

With this report I am calling on us to act together to change that. It is a call to redefine prevention as a core part of clinical leadership and everyday health care. Every service, every team, every professional has a role to play — not as an extra task, but as part of what it means to provide high-quality, person-centred care.

I have set out three interlinked priorities for prevention in health care across Hywel Dda. These priorities are intertwined with our commitment to the Social Model for health and wellbeing across our region.

## **1. Focus on the 20% most deprived areas – the ‘20’**

The strongest lever for improving health outcomes is to focus where the need is greatest. The 20% of our population living in the most deprived communities face higher risks of illness and shorter lives. These are not inevitable differences — they are preventable, and we can act on them.

Clinical services can make an enormous contribution: by reaching out to under-served groups, by designing pathways that remove barriers to access, and by strengthening the proportionate universalism approach of fundamental preventative programmes, and by delivering care that recognises and responds to the wider determinants of health.

When clinical teams understand the social context of their patients’ lives, they can make interventions that are more effective and equitable. This inevitably results in less need and demand for our pressured healthcare services and improved health outcomes of our population.

## **2. Address the four modifiable risk factors – the ‘4’**

Four modifiable behaviours — smoking, poor nutrition, harmful alcohol use, and physical inactivity — drive most of the preventable burden of disease. These factors are the common ground between every service and every long-term condition.

The opportunity before us is enormous. Every engagement, every consultation, every ward round, every discharge summary is a potential moment for prevention. Whether it is a nurse offering brief advice on quitting smoking, a physiotherapist promoting physical activity, or a consultant reinforcing healthy eating and exercise after surgery — these actions multiply across the system to save lives and reduce suffering. Ensuring that clinical protocols integrate evidence-based interventions to modify these behaviours during the over 4,500 contacts with our patients a day will undoubtedly make a population level improvement.

Embedding this approach into clinical pathways makes prevention systematic, not incidental. It turns the health service into a true engine of wellbeing.

## **3. Reduce the burden in seven major disease areas - the ‘7’**

Our focus for prevention aligns with the seven domains that cause the greatest pressure on our system and greatest harm to our population:

cancer, cardiovascular disease, respiratory disease, diabetes, mental health, and the health and wellbeing of children, young people, and older people.

In each of these areas, evidence shows that earlier intervention and risk reduction make the biggest difference — clinically, economically, and socially.

- For cardiovascular and respiratory disease, stopping smoking, reducing salt, and managing hypertension earlier and better are powerful clinical tools of prevention.
- For cancer, encouraging screening uptake and tackling obesity, shift the focus towards and enable access in its full meaning earlier diagnosis can save more lives than many therapeutic innovations.
- For mental health, prevention means recognising distress early, strengthening social connection, and creating supportive environments.
- For children and young people, it means giving every child the best start. This does include wide ranging but tangible interventions like – prevention of tooth decay which is the leading cause of unplanned hospitalisations for children under 10 in Wales, screening and testing for hearing which is one of the leading causes of behavioural issues in children with direct impact in their life course.
- for older adults, it means extending healthy life, not just life expectancy.

Prevention is not a public health concept alone — it is a clinical imperative that sits at the heart of quality and safety.

### **A call to clinical leadership**

The NHS faces immense pressures — workforce, demand, and financial challenge. But prevention is not a luxury for when times are easy, its neither in competition with the delivery of care services: it is the foundation for a sustainable future. By preventing illness, we reduce demand, we restore justice in health equity, we enable dignity, we support a wellbeing economy, and we improve outcomes. By promoting wellbeing, we reconnect with the purpose that drew us all into health care: to help people live well, not just longer.

This is a shared mission for every clinician and leader in Hywel Dda. Together, we can build a health system that does more than treat disease — one that creates health, supports resilience, and gives every person in our communities the best chance to thrive.

Prevention is not a separate agenda — it is the essence of good medicine and compassionate care.



Dr Ardiana Gjini

Executive Director of Public Health

# Executive Summary

## ***Prevention of Ill Health – Everyone, in Every Service, All the Time***

My 2024-25 annual report marks a pivotal moment and a call to everyone within Hywel Dda University Health Board to fundamentally rebalance our services towards prevention. Our sustainability and impact as a health service depend not only on treating disease but on successfully preventing it. This requires a fundamental shift, moving prevention from the margins to the centre of clinical leadership and everyday health care.

## The problem we face: an unacceptable health equity gap

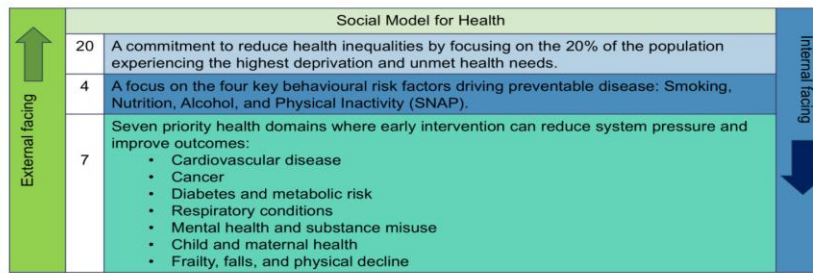
Our teams and clinicians deliver outstanding person-centred care, yet the majority of our resources are consumed by treating conditions that could have been avoided or managed earlier. A reactive approach to health care drives significant, avoidable demand and places unsustainable pressure on our health and care system. The burden is not shared equally amongst our population:

- Stark inequality - the gap in healthy life expectancy for people in our region is approximately 12 years for men and 9 years for women
- Growing pressure - preventable poor health is driving significant, avoidable demand on our health and social care services, placing an unsustainable pressure on our system
- Our goal - we must systematically shift our focus from treating illness to proactively promoting health and preventing disease to reduce this unacceptable gap and ensure the long-term sustainability of the services we provide

## The solution: 20-4-7

The 20-4-7 model is our evidence-based guide for systemic action across the health board and with our partners. It ensures that prevention becomes central to all our service planning and delivery.

Vision: "A culture of population health and prevention across HDdUHB that delivers sustainable, high-quality, and equitable care."



## Key recommendations: a call to action

The recommendations set out below are a call to action designed to strengthen, standardise, and accelerate successful prevention efforts, shifting our organisational mindset and embedding prevention as a measurable foundation of care.

Within this report I have made focused, ambitious and feasible recommendations to establish the structural, cultural, and operational conditions needed to make prevention a measurable and sustainable reality across Hywel Dda:

1. Every team, service, and clinical network will integrate prevention actions into annual planning cycles, supported by a 20-4-7 checklist and review process
2. A comprehensive programme of staff engagement and training to strengthen the approach so that prevention becomes part of every role and every care setting
3. Empower leaders to support and strengthen clinical teams in embedding prevention in their everyday work and in all decision-making and performance frameworks
4. Develop a 3-year invest to save approach to support reducing future demand

These actions move the 20-4-7 model from strategy to practice, making prevention the routine foundation of care delivery across Hywel Dda.

I have also made some specific recommendations for each of the 20-4-7 model components:

### 1. The 20 – Equity: reaching the 20% most socioeconomically deprived

- Integrate Health Equity Impact Assessments (EIAs) into strategic planning and budget processes

- Empower Primary Care Clusters (PCCs) to use local data to target action by place, identity, and circumstance, recognising intersectionality

## **2. The 4 – Behavioural risk factors: tackling the drivers**

- Make *Making Every Contact Count* (MECC) a core competency for the workforce
- Develop and scale Health Coaching within Primary Care as the first-step intervention for adults with multiple behavioural risks
- Integrate data systems to capture prevention activity at the point of care

## **3. The 7 – Priority Health Areas: focusing for impact**

- Support partners across the system to review clinical pathways, integrate upstream risk reduction and targeted behavioural interventions at every relevant clinical activity
- Further develop the workforce to be aligned with the 20-4-7 model and scope roles that are dedicated to leading prevention in health care

The successful implementation of the 20-4-7 model requires a collective commitment and accountability across the health board and with our partners. Done well, this will not only improve the health and well-being of the people we serve but will also safeguard the future of our health and care services by reducing avoidable demand and using public resources wisely.

Prevention is the foundation of a sustainable future for Hywel Dda, and must be done by *Everyone, in Every Service, All the Time*.

# Chapter 1 - Introduction

## Introducing the 20-4-7 Model

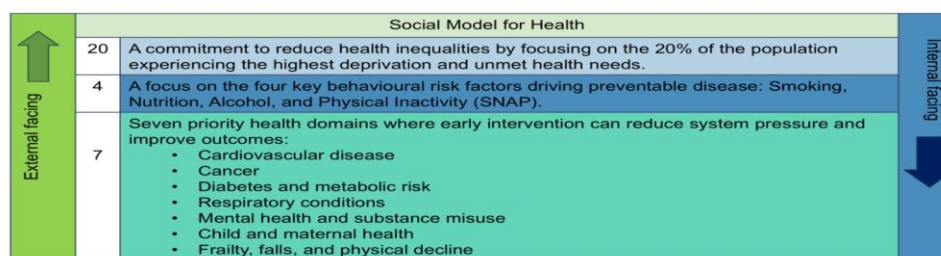
Despite decades of progress, a gap of over 10 years in healthy life expectancy exists between our most and least deprived communities. The 20-4-7 model is HDUHB's evidence-based strategic framework designed to close that gap by systematically shifting our focus from treating illness to promoting health.

The 20-4-7 model aims to guide action across the organisation, enabling every service, team, and professional to play their part in prevention. Embedding prevention systematically will deliver immediate benefits to patients and the organisation, while driving a long-term transformation of the health and care system.

The model aligns with *A Healthier Mid and West Wales*<sup>1</sup> strategy, the *Social Model for Health*<sup>2</sup>, and *Value-Based Health Care Strategy*<sup>3</sup>. It also reflects the direction set nationally through Public Health Wales's *Prevention-Based Health and Care Framework*<sup>4</sup>, ensuring our local action supports and complements wider system change.

## The 20-4-7 Model

Vision: "A culture of population health and prevention across HDdUHB that delivers sustainable, high-quality, and equitable care."



The 20-4-7 model brings together three interconnected priorities that can make the greatest difference to population health and wellbeing:

### 20 – Equity

Almost 80 years after the NHS was founded on the principle of equal access to care, we still see a steep socio-economic gradient in who becomes ill, the conditions they face,

and their outcomes. The '20' focuses our efforts on the 20% of people most affected by health inequalities, particularly those living in our most deprived communities.

## 4 – Behavioural Risk Factors

Four modifiable lifestyle factors - Smoking, poor Nutrition, Alcohol, and Physical inactivity (SNAP) - are the leading drivers of preventable disease, premature death, and widening health inequalities<sup>5</sup>.

## 7 – Priority Health Areas

Analysis of population health data identifies seven conditions and groups where prevention, early intervention, and system transformation can deliver the most significant impact:

- Children and Young People
- Older People and Frailty
- Cancer
- Cardiovascular Disease
- Mental Health
- Respiratory Conditions
- Diabetes

The 20-4-7 model moves prevention from the margins to the centre of how we plan, design, and deliver services. It also provides a common language and shared direction for partners across health, social care, and the wider system, enabling us to focus collective resources where they can make the biggest difference.

The following chapters explore each element of 20-4-7 in greater depth, beginning with the 20, and how targeted action to reduce inequalities and address the needs of those most affected can deliver the greatest impact. We will then turn to the 4, examining the key behavioural risk factors that drive preventable disease and how systematic action across services can reduce their impact. Finally, we will look at the 7- the major health areas and population groups where prevention and early intervention offer the greatest opportunities to transform outcomes. These three pillars set out a roadmap for a health and care system that is proactive rather than reactive, one that focuses not just on treating illness, but on creating the conditions for longer, healthier lives.

This model, 20-4-7, is not framed in isolation, it is one part of the umbrella approach which includes the Social Model for Health and Wellbeing, the development of the tailored Population Health domain within our health board escalation framework, development of the bespoke Health Equity Assessment Tool, development of training

programmes for our workforce on core public health skills, increased engagement of the skilled public health teams with and in our clinical and corporate services. Full development, implementation, and optimised utilisation of all these elements will take time, it will require passion, commitment, leadership, and tenacity – qualities that are in abundance amongst our workforce. Health services and the NHS alone will not be able to turn the tide, to shift left, to reduce inequalities, to improve population health – whatever the buzz word or the focus of the moment might be – which is why we are strengthening the work with our partners through Regional Partnership Board and the three Public Service Boards through our Social Model for Health to fuel the sparkles, kindle the energy, empower the assets of our individuals and our communities to enable true community health where our people enjoy good healthy lives.

## Chapter 2 – ‘20’ A Focus on Equity

### Why equity matters

Health inequalities are not inevitable. They are unfair and preventable differences in health between groups in society, arising from social, economic, and environmental conditions in which people are born, grow, live, work, and age<sup>6</sup>. These conditions shape outcomes, such as how long people live and how many years they live in good health, and opportunities to live well, including access to healthcare, housing, education, and supportive environments.

Action to reduce health inequalities is more important than ever. At a global level, the World Health Organisation (WHO) has identified climate change as the one of the greatest health threats facing humanity, with its impacts expected to fall disproportionately on those already experiencing poor health and disadvantage<sup>7</sup>.

The Covid-19 pandemic and cost of living crisis have deepened existing inequalities. For example, when inflation rose to 9.4% in June 2022, it was estimated that 1.3 million people in the UK, including half a million children, were pushed into poverty<sup>8</sup>. Around 22% of the Welsh population live in poverty - the highest poverty rate among all UK nations. Ongoing poverty snapshots show that many households still struggle to afford essentials<sup>9,10</sup>.

Across Wales, men in the most deprived areas live on average 7.5 years less than those in the least deprived areas, while women live 6.3 years less. The healthy life expectancy gap is even starker: over 13 fewer years in good health for men, and 17 fewer years for women<sup>11</sup>. People in Hywel Dda live slightly longer than the Welsh average and close to UK levels. Life expectancy at birth is about 79 years for men and 84 for women locally, compared with 79 and 83 across the UK. However, these averages hide big differences. The gap in life expectancy between the most and least deprived areas has widened over the past decade, from about four years to nearly five years for men and from just over three years to four and a half years for women. The gap in healthy life expectancy - the years lived in good health- is even larger: about 12 years for men and nine years for women. These inequalities shape quality of life, mental wellbeing, and the ability to work, and they place significant demand on health and social care services.

Addressing these inequalities is essential to improving population health, sustaining health and care services, and ensuring that investment delivers maximum impact<sup>12</sup>. This is why the first pillar of the 20-4-7 model focuses on equity and directing our attention and resources towards those most affected by avoidable ill health - the 20% most socioeconomically deprived.

Defining the 20% most socioeconomically deprived of our population using the Welsh Index of Multiple Deprivation (WIMD) considers income, employment, housing, access to services, and education, yet deprivation is not only about where people live. Health inequalities are also shaped by factors such as race and ethnicity, gender, disability, sexual orientation, and other protected characteristics, which can influence health outcomes and access to care, sometimes overlapping and compounding disadvantage.

In practice, this means that while we continue to focus on the most socioeconomically deprived populations, we also recognise that inequality exists within communities, not just between them. Taking an intersectional approach helps ensure that our work addresses inequities by place, identity, and circumstance, reaching those who are most at risk of being left behind, regardless of postcode.

## What this means for Hywel Dda

In Hywel Dda, life expectancy and healthy life expectancy for both sexes are either similar, or significantly better, than the Wales average. Yet, there are differences between the three counties.

### Comparing life expectancy and healthy life expectancy in the three counties of the Hywel Dda University Health Board area and in Wales<sup>11</sup>

	Compared to Wales				
	Wales	Hywel Dda UHB	Ceredigion	Pembrokeshire	Carmarthenshire
Healthy life expectancy at birth (females), 2015 to 2017 (Years)	62.0	62.0	65.8	62.7	59.7
Healthy life expectancy at birth (males), 2015 to 2017 (Years)	61.4	62.5	67.4	62.5	60.4
Life expectancy at birth (females), 2015 to 2017 (Years)	82.3	82.9	84.2	83.3	82.2
Life expectancy at birth (males), 2015 to 2017 (Years)	78.3	78.6	79.5	78.9	78.0

Our health board serves one of Wales's most rural and ageing populations, and we see significant differences in health outcomes across our three counties. Premature mortality from preventable conditions such as cancer and cardiovascular disease remains highest in more deprived areas. Access to services can also be more difficult due to transport barriers, rising fuel costs, and digital exclusion, which further compound inequalities.

These differences are avoidable and reflect an unequal distribution of the wider determinants of health, such as income, employment, housing, and education, and

unequal access to timely, high-quality care. Tackling them requires a fundamental shift in how we plan, design, and deliver services.

## The 20-4-7 model

The 20% element of our 20-4-7 model directs our prevention efforts towards the 20% of the population facing the greatest health barriers, primarily those in the most deprived communities. This focus aims to maximise the impact on reducing health inequalities.

Our strategy has three main strands:

### *1. Coordinating multi-agency action*

We established the Health Improvement and Equity Oversight Group, expanding from the Health Equity group formed during COVID-19, to drive the implementation of evidence-based services that improve health and ensure equitable access to services. This group brings together colleagues across the region to design and support initiatives that tackle health inequalities. Coordination of multi-agency action will allow us to better address the complex, interlinked drivers of inequality that no single organisation can solve alone.

### *2. Ensuring equity in our pathways*

As and when we redesign clinical pathways – we will take them through an equity lens to ensure that prevention and early intervention reach those at highest risk, not just those who access services first.

Equity Impact Assessments (EIA) play an important role in ensuring that health equity considerations are integrated into budgeting and planning processes as they can help to identify potential disparities in health outcomes and resource allocation. However, given the resource-intensive nature of these assessments it is important to ensure that we prioritise their application to contexts where they can have the greatest impact. Therefore, EIA should be undertaken during periods of significant organisational change, this may include strategic planning for large scale service transformation or as part of regular annual planning cycles. By focusing on these critical moments, health care organisations can effectively leverage EIAs to inform decision-making and promote equitable health outcomes while managing the time and resources required for detailed assessments.

At an operational level the rapid EIA tool, which is part of the EIA toolkit, can be used to quickly evaluate the potential effects of a policy, programme or initiative on health equity within specific populations. The rapid EIA tool can help with the early identification of potential disparities and can inform decision making to enable timely

adjustments to interventions to maximise positive impacts and mitigate adverse effects on vulnerable populations.

### *3. Equity in all we do*

We are asking all services and programmes to apply an equity lens at the design stage. Health Impact Assessments (HIAs) should be a routine part of planning and commissioning decisions, ensuring that all new initiatives consider how they will reduce, or risk widening, inequalities. We will also support teams to carry out health equity audits (HEA) to examine how health determinants, access services, and outcomes are distributed across the population.

This approach will be piloted in a clinical service in the coming months and scaled across the organisation. We have already taken meaningful steps to embed equity across our work, from targeting smoking cessation services in areas with the highest prevalence, to tailoring alcohol harm reduction campaigns for specific communities, and delivering social prescribing projects that tackle isolation and access barriers.

However, we know there is more to do. Our next steps include:

- Expanding data-driven approaches to identify and proactively support people and communities most at risk
- Strengthening partnerships with local authorities, schools, housing, and voluntary organisations to address the root causes of poor health
- Developing targeted prevention programmes that address specific needs within underserved groups, such as ethnic minority communities, people experiencing homelessness, those with mental health conditions, and young people not in education or training
- Building equity measures into performance dashboards and routinely reporting on progress

## **Building the Foundation**

Focusing on the 20% most socioeconomically deprived communities is not only a matter of fairness, but fundamental to improving population health outcomes for everyone. Addressing the root causes of inequality, designing services that reach those who need them most, and embedding equity into every decision we make, is how we will ensure that everyone has the same opportunity to live a long, healthy life. Equity is not a separate strand of work, it is the foundation of our prevention approach and the driving force behind our vision for a healthier, fairer Mid and West Wales.

Addressing the injustice of poor health in our most socio-economically deprived communities requires an accessible, evidence-based preventative service. Health coaching is a credible, person-centred service that empowers patients to take an active role in their health care, leading to improved outcomes. HDUHB should invest in this service, which is a functional expansion of our smoking cessation service, to support demand management and population health improvement. HDUHB should invest in this service to support demand management and population health improvement.

Health coaching service would work closely with and be embedded in the Social Model for Health and Wellbeing work to be strengthened by Asset Based Community Development initiatives, refocused services of Social Prescribing, Digital Level 2 Weight Management Pathway (as part of follow-on support) and our Arts and Health Creative Prescribing Programme.

As we work to build a prevention-first system, focusing on equity is only part of the solution. To reduce the health gap and reduce avoidable demand on services, we must also tackle the underlying behaviours that drive poor health - recognising that these behaviours are shaped by the wider social, economic, and environmental conditions. The next chapter explores the second pillar of the 20-4-7 model - the four key behavioural risk factors: Smoking, poor Nutrition, Alcohol, and Physical inactivity (SNAP). Embedding action on these modifiable risks throughout our pathways and services is key to preventing disease and closing the health gap between different communities.

## Chapter 3 – ‘4’ SNAP risk factors

To make a real difference to health outcomes, we must address the four major modifiable behavioural risk factors- Smoking, poor Nutrition, Alcohol, and Physical inactivity (SNAP)- which together drive a substantial proportion of preventable illness, early death, and health inequality. These behaviours are not merely individual choices, they are shaped by the social, economic, and environmental conditions that underpin inequality. By combining targeted action for the 20% most at risk with comprehensive action on SNAP, we can significantly improve population health and narrow the health gap.

This chapter highlights the burden of SNAP behaviours in our region, the inequalities they reinforce, and the ways we and our partners are working through evidence-based, person-centred, and community-led approaches to create environments that make healthier choices easier.

### Social and Environmental Context

Addressing SNAP behaviours can significantly improve population health, but they do not exist in isolation. Wider social, economic, and environmental factors, such as income, education, housing, and community support, also shape people’s health and opportunities to make healthy choices. Evidence shows that multi-level interventions, combining individual support with community and system-level change, are most effective in creating sustainable improvements.

Addressing the four SNAP behaviours builds on the equity foundation established in Chapter 2. By combining targeted action for the 20% most at risk with comprehensive, evidence-based interventions on smoking, nutrition, alcohol, and physical activity, we can significantly reduce preventable disease and narrow the health gap across the region.

### Smoking

Smoking remains the single biggest preventable cause of ill health and death in Wales, with the greatest harms falling on our least deprived communities. In Hywel Dda, smoking prevalence ranges from under 13% in some areas to over 40% in others.

Preventable and unfair harms are driven by the tobacco industry, but change is possible, and Hywel Dda’s Smoking and Wellbeing team<sup>13</sup> has led the way nationally, being the first in Wales to reach the target of treating 5% of smokers and continuing to grow. In 2024/25, the service received over 6,700 referrals, with more than 1,400 clients also receiving alcohol-related support.

## Nutrition

Poor nutrition is a major challenge in Hywel Dda. A healthy diet plays a vital role in lifelong health, helping to prevent obesity, type 2 diabetes, heart disease, oral diseases such as tooth decay, and certain cancers. Yet increasing reliance on ultra-processed foods, more frequent eating outside of the home, and larger portion sizes makes healthy eating more difficult.

Obesity is the second biggest preventable cause of cancer and having a higher Body Mass Index (BMI) is the leading risk factor for long term illness<sup>14</sup>. In Wales, two thirds of men and just over half of women are overweight or obese, and 1 in 3 children start primary school living with overweight or obesity<sup>15</sup>. There are a strong social gradient and the gap between the most and least socioeconomically deprived has been increasing year on year.

In Hywel Dda, only 32% of adults eat five portions of fruit and vegetables daily, and less than half of all children under 16 years old report eating at least one portion of fruit or vegetables daily<sup>16</sup>. Babies that are breastfed and weaned at the right age are more likely to be a healthy weight, yet Wales has the lowest breastfeeding rates in the UK. In HDUHB the rates drop from 71% at birth to 37% at six months<sup>17</sup>. Breastfeeding has many benefits for both the infant and the mother<sup>18</sup>.

In response to these challenges, we must consider the obesogenic environment, which refers to the critical role environmental factors play. This includes the widespread availability of high-calorie foods, the inflated cost of healthy options, aggressive marketing, and limited access to safe, active spaces. The Food Foundation's Broken Plate report<sup>19</sup>, highlights that in 2023 it was more than twice as expensive to purchase healthier food. Additionally, evidence suggests that fast food outlets are growing in number and more of them clustered in our most deprived areas and within 400 meters of schools<sup>20</sup>.

These are issues that the Regional Whole Systems Approach to healthy weight team are focussing on. Established under the 'Leadership and Enabling Change' theme of the Welsh Government Healthy Weight Healthy Wales strategy<sup>21</sup>, the team works across the Swansea Bay and HDUHB areas with the five Public Services Boards in Swansea, Neath Port Talbot, Carmarthenshire, Ceredigion, and Pembrokeshire. They are focussed on building a collaborative approach to improving the environmental conditions for healthy weight and to reducing the unfair differences in health and wellbeing outcomes associated with healthy weight across different population groups.



Local programmes support healthier eating across the life course, from early years initiatives (e.g., Healthy Snack Award and Foodwise in Pregnancy) to school-age programmes (e.g., 'Food and Fun' and 'Fit and Fed'), alongside weight management services and community food partnerships.

## Alcohol

Alcohol misuse is a major preventable cause of ill health, contributing to 2.6 million deaths each year globally. In Wales, there were 562 alcohol-specific deaths in 2023 - a 15.6% increase from the previous year. In Hywel Dda, rates of drinking above recommended guidelines have risen to 17.5%, with variation by locality<sup>22,23</sup>. In Hywel Dda, rates of drinking above recommended guidelines have risen to 17.5%, with variation by locality<sup>24</sup>.

Opportunities exist to strengthen Alcohol Care Teams, expand routine screening, and focus community interventions on higher-risk groups and areas.

## Physical Inactivity

Physical inactivity is a major public health concern in Hywel Dda. Rurality and the age profile of our population increase inactivity and falls risk, creating barriers to physical activity. Meeting recommended activity guidelines improves overall health and function, particularly in older adults, and reduces falls - a major driver of avoidable hospital admissions.

Hywel Dda supports physical activity through targeted weight management pathways, exercise referral in long-term condition programmes, and emerging Health & Wellbeing Hubs integrating movement into care. Local initiatives include:

- Carmarthenshire (Actif<sup>25</sup>): multi-site leisure offer, “Actif Anywhere” live/on-demand classes, 60+ gentle exercise sessions, beginner strength programmes
- Ceredigion (Ceredigion Actif<sup>26</sup>): five leisure centres and wellbeing centre; programmes encouraging physical activity and play
- Pembrokeshire (Pembrokeshire Leisure / Sport Pembrokeshire<sup>27</sup>): teen Gen Active 12-week programme, active travel and community activity resources, 60+ scheme

The next chapter will explore the seven priority health areas identified in the 20-4-7 model, where focused prevention, early intervention, and system transformation can deliver the greatest outcomes.

## Chapter 4 – ‘7’ The seven prevention priority areas

Having explored equity ('20') and key behavioural risk factors ('4'), we now present the final part of the 20-4-7 model: the seven prevention priority areas. These areas are identified through local needs assessments and strategic planning as conditions and population groups where early intervention offers the greatest impact on improving outcomes, reducing system pressures, and supporting healthier lives. Each area is deeply interconnected with wider determinants of health, such as poverty, housing, and access to services.

This holistic understanding reflects the Social Model for Health<sup>2</sup>, which recognises that health is created not just in hospitals or clinics, but in the communities, environments, and everyday conditions people experience.

Across the Health Board, key enthusiastic and expert colleagues from planning, finance, value-based health, clinicians (primary and secondary care), communications, the people directorate, and public health will be brought together to develop each of the 7 areas: Children and Young People, Older People and Frailty, Cancer, Cardiovascular Disease, Mental Health, Respiratory Conditions, and Diabetes.

### *Cross-cutting themes:*

- Women's Health- Impacts children and young people (maternal health, early years), cancer (breast, cervical), cardiovascular disease, and diabetes
- End-of-Life- Impacts older people and frailty, cancer, cardiovascular, and respiratory conditions

This chapter provides an overview of the burden associated with each priority area, drawing on local data and evidence to highlight trends, inequalities, and opportunities for action. It outlines how HDUHB, in collaboration with partners, is working to embed prevention across the life course from early years support and healthy ageing initiatives to targeted interventions for long-term conditions and mental wellbeing.

### Children and Young People

Building on last year's Director of Public Health Annual Report, *Their Health, Our Future*<sup>28</sup>, we have made considerable progress in implementing its 16 recommendations. Key messages have been shared widely, leading to stronger collaboration across School Nursing, S-CAMHS, Immunisation, and maternity services. The Regional Partnership Board's CYP Board has now aligned five regional priorities with the report, driving action across the system.

Many initiatives are already contributing to progress. In the *First 1,000 days*, new infant feeding pilots and nutrition programmes have been launched. In *early years*, universal parenting programmes, school readiness projects, and the Healthy and Sustainable Pre-School Scheme are underway. For *school-age children*, whole-school approaches to emotional wellbeing and health promotion are embedding prevention into education settings. Work is also progressing for *adolescents and young adults*, including a rapid evidence review on supporting those not in education, employment, or training (NEET).

Despite strong progress, capacity remains a key challenge, especially in early years and for the 16–24 age group. Sustained funding, additional workforce capacity, and a robust evaluation framework are essential to accelerate delivery and measure impact.

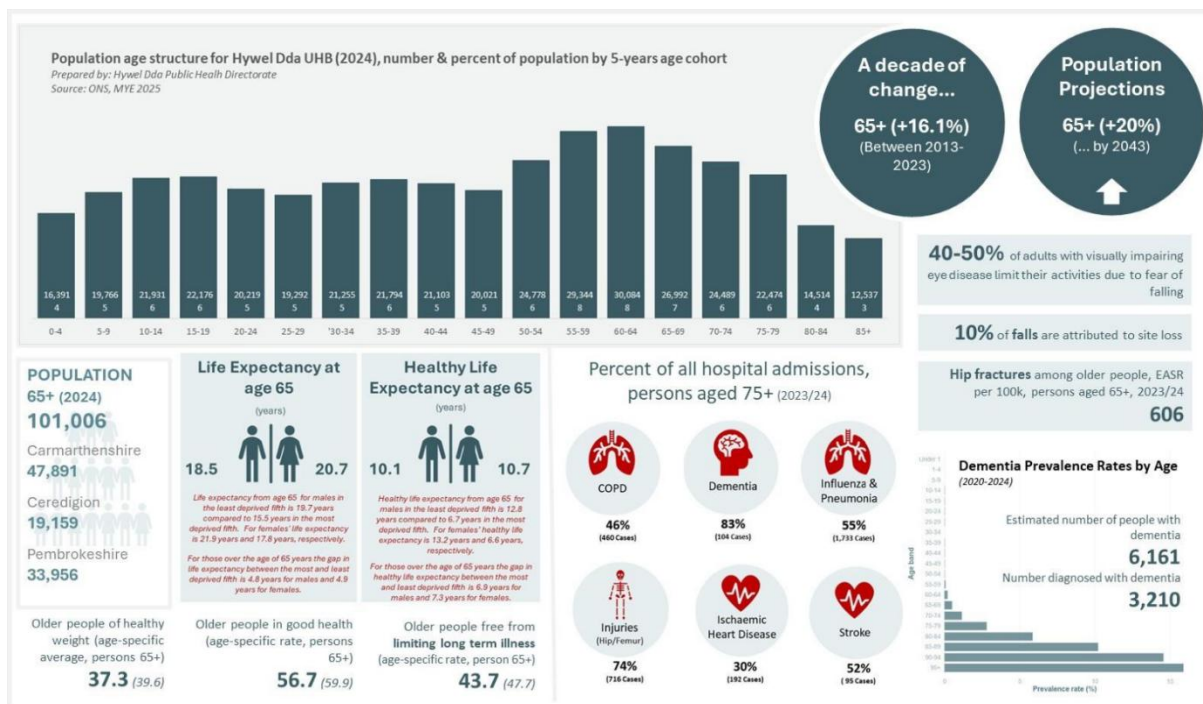
Building on the momentum of the past year, the next steps include sustaining and scaling successful programmes, investing in workforce, and commissioning, and developing a long-term strategic plan for children and young people's health.

A striking example of why prevention for children and young people is a must for us as a region is tooth decay, an almost entirely preventable condition, yet over a quarter of children are affected by tooth decay in the region<sup>29,30</sup>. Tooth decay remains the leading cause of hospital admissions for children aged 5-9 years old and Hywel Dda has one of the highest rates of children experiencing general anaesthetics for decayed tooth extraction in Wales<sup>31</sup>. By enhancing and targeting in line with the 20-4-7 model, preventative initiatives such as supervised toothbrushing in nurseries and preschools through the *Designed to Smile*<sup>32</sup> programme and community initiatives such as *Healthy Child Wales*<sup>33</sup>— we can reduce hospital admissions, school absences, and improve children's wellbeing.

## Older People and Frailty

Hywel Dda has one of the oldest populations in Wales: around one in four residents are aged 65 or over, projected to rise to one in three by 2039 (over a third in Pembrokeshire). This demographic shift increases pressure from chronic conditions, frailty, and care needs, amplified by social factors such as isolation and poor housing<sup>34</sup>.

Ageing is associated with an increased likelihood of multiple long-term conditions, including cardiovascular disease, diabetes, respiratory disease, dementia, and mental ill-health, all of which contribute to frailty. Frailty is characterised by a loss of strength, balance, and resilience, leading to higher risks of falls, hospitalisation, and mortality. These pressures are amplified by social factors such as isolation, poverty, and poor housing, demonstrating the importance of addressing the wider determinants of health alongside clinical care.



Dementia is a significant burden. Evidence shows that adopting a preventative approach - aligned with the All-Wales Dementia Action Plan<sup>35</sup> and Health Coaching - focusing on physical activity, social connection, cognitive agility, and hearing loss mitigation, could postpone the onset of dementia by an average of 5 years<sup>36</sup>. This would halve the burden of dementia in our population and health and care economy.

## Cancer

Cancer remains the leading cause of death in Wales and is a public health priority because many cases are preventable. Effective screening programmes exist for several cancers, but significant deprivation-related inequalities persist. In Hywel Dda, the most common cancers are prostate, breast, lung, colorectal, and uterine cancers. Two currently have established screening programmes, and one has a planned programme.

Screening is a key public health tool, enabling early detection and more effective treatment. Barriers to screening uptake include knowledge and awareness gaps, emotional/psychological factors, practical/logistical challenges, cultural considerations, and systemic provider issues. This leads to lower participation in younger populations, men, and individuals from more deprived communities

Inequalities in screening participation are evident: uptake is lower in younger populations, men, and individuals from more deprived communities. There is also geographical variation across health boards and local authorities.

In Hywel Dda, the Screening Oversight Group addresses local challenges, including a partnership with Cervical Screening Wales for a non-responder project in targeted GP

clusters. We will also strengthen upstream prevention efforts, recognising that up to 40% of cancer cases are preventable<sup>37</sup>. This involves embedding SNAP behaviour prevention - smoking cessation, healthy weight, and alcohol reduction - into primary care and cancer follow-up pathways.

## Respiratory diseases

Respiratory diseases - a group of diseases that includes chronic obstructive pulmonary disease (COPD), asthma, and pneumonia - contribute to hospital admissions, long-term disability, and reduced quality of life, particularly among older adults and people living in more deprived communities.

Major risk factors include smoking, air pollution, occupational exposures, and socioeconomic disadvantage - all of which increase vulnerability. People in the most deprived areas of Wales are more than twice as likely to die from a respiratory condition compared to the least deprived areas<sup>38</sup>. Effective prevention requires reducing exposure, supporting smoking cessation, improving housing/air quality, and strengthening vaccination uptake.

Effective prevention therefore depends on reducing exposure to these risks, supporting smoking cessation, improving housing and air quality, and strengthening vaccination and early detection.

### Case Study: The Direct Impact of Smoking Cessation on Respiratory Health

The integration of the SNAP focus into clinical pathways ensures patients admitted with acute respiratory distress receive immediate, targeted support. The following case study illustrates the profound and immediate benefits of this approach:

A patient with a history of asthma and severe shortness of breath was admitted following a frightening asthma attack. Although initially reluctant to engage with cessation support due to previous adverse nicotine replacement treatment (NRT) experiences, intervention by the Hospital Smoking & Wellbeing practitioner allowed the care plan to be tailored.

Following successful engagement, the patient reported significant life-changing benefits:

- The patient's persistent cough disappeared, and the patient could sleep on their back for the first time in years without struggling to breathe. They no longer feel breathless when working and can laugh without coughing
- They have avoided the need for antibiotics or steroids since quitting
- Due to improved lung capacity, the patient is now eligible for a planned surgery
- Their success also motivated their husband to cut down on smoking

This type of early, focused intervention not only transforms a patient's daily life but also delivers measurable clinical improvement, reduces the need for costly acute medications, and contributes to system efficiency.

Between 2009/10 and 2023/24, Hywel Dda saw a 12% increase in asthma cases and a 29% increase in COPD<sup>38</sup>. While numbers fell during the COVID-19 pandemic, prevalence remains above pre-pandemic levels. Public Health Wales projections suggest further increases of 7% in asthma and 2% in COPD by 2033/34<sup>37</sup>.

Deprivation continues to drive these patterns, with respiratory death rates more than double in the most deprived fifth of Wales<sup>38</sup>. Vaccination uptake for influenza and pneumococcal disease remains below the 75% target (Table 1). Targeted flu and pneumococcal vaccination uptake interventions in the most deprived communities (the 20%) can reduce avoidable respiratory admissions.

Table 1. Flu vaccine uptake (in patients aged 6 months – 64 years) with chronic respiratory disease in 2024/25<sup>38</sup>

Target group	Denominator	Immunised	Hywel Dda (%)	Wales (%)
Asthma	21,634	7,441	34.4	38.5
COPD	2,622	1,058	40.4	47.8
Other Respiratory diseases	1,169	450	38.5	42.2

In 2023, respiratory disease accounted for over 11% of all deaths in Hywel Dda, with chronic lower respiratory disease, influenza and pneumonia making up four-fifths of these<sup>40</sup>. Comorbidities such as obesity, cardiovascular disease, and diabetes further worsen outcomes and hospitalisation risk.

## Cardiovascular disease

Cardiovascular disease (CVD) remains a leading cause of death and disability across the HDUHB region, responsible for over one in four deaths, approximately 110 per month<sup>41</sup>.

CVD mortality and morbidity are strongly influenced by social determinants of health, lifestyle factors (smoking, poor diet, physical inactivity), and metabolic risk factors such as obesity (affecting 63% of adults), diabetes, hypertension, and high cholesterol. A third of CVD deaths occur in people under 75, highlighting the importance of preventing premature mortality.

CVD imposes a significant burden on the healthcare system, accounting for over 10% of emergency hospital admissions and costing an estimated £97 million annually. Emergency admissions are disproportionately higher among older adults, men (59% of admissions), and residents in deprived communities<sup>42</sup>. These pressures affect healthcare efficiency, resource allocation, and population productivity.

Prevention and early intervention are central to reducing the CVD burden. Evidence-based strategies include early identification and management through screening and monitoring, smoking cessation, healthy weight management, increased physical activity, digital and community innovation (e.g., the Ceredigion Community Heart Failure Team's remote monitoring) and targeted population health initiatives (e.g., the Next Generation Population Health project).

Aligning CVD prevention and management with the 20-4-7 model supports a focus on reducing health inequalities by prioritising high-risk and deprived populations. Integrated care approaches coordinate prevention, diagnosis, and long-term management across healthcare settings.

## Diabetes

Diabetes is a growing challenge in Hywel Dda, with current prevalence at 8.4% (higher than the Wales average of 8%), equating to approximately 27,778 adults in 2020, and projected to rise to 39,444 by 2030<sup>4</sup>.

Diabetes contributes to premature mortality and morbidity as individuals with Type 2 diabetes are 50% more likely to die prematurely, two to two-and-a-half times more

likely to experience heart failure, and twice as likely to have a heart attack compared to those without diabetes.

Rising prevalence and complexity are outpacing workforce capacity, creating pressures across primary and secondary care. Hospital admissions for people with diabetes increase length of stay, risk of complications, and healthcare costs. Lifestyle risk factors such as obesity, physical inactivity, and poor diet remain prevalent, particularly in deprived communities. Variation in delivery of the NICE care processes<sup>44</sup> (a set of annual health checks for people with type 2 diabetes) and low uptake of structured education highlight inequities in care quality<sup>4</sup>.

*Addressing diabetes requires a multi-faceted approach:*

- Expand lifestyle interventions, MECC, and community-based weight management programmes, prioritising high-risk and deprived populations
- Use AI and remote monitoring digital tools for risk stratification, patient engagement, and personalised care
- Align diabetes prevention with broader cardiovascular and metabolic health strategies to maximise impact
- Ensure consistent delivery of NICE care processes, targeting clusters with lowest performance for additional support
- Scale capacity through workforce planning, joint-funded posts, and partnerships with academic institutions to meet projected demand

## Mental health

Mental health conditions are a major public health priority in Hywel Dda, affecting individuals across all age groups and contributing to morbidity, mortality, and social disadvantage. It has been reported that around a third of people accessing mental health services will experience co-occurring substance misuse, creating complex, co-occurring challenges that can worsen outcomes<sup>4</sup>.

Individuals with mental health conditions face disproportionately high risks, including social isolation, unemployment, disrupted education, relationship difficulties, stigma, and an increased risk of self-harm and suicide. Young people are particularly vulnerable, with mental health issues in adolescence strongly associated with poorer long-term outcomes. Life expectancy is reduced by 15-20 years for those with severe mental illness<sup>47</sup>.

The burden of mental health conditions extends beyond individual well-being to impact families, communities, and healthcare systems. High service utilisation, long-term support needs, and unmet social determinants - such as housing, employment, and financial insecurity - contribute to significant societal and economic costs. Despite the

prevalence of mental health conditions, services often operate in silos, limiting access to integrated care and leaving gaps in support, especially for those with co-occurring substance misuse.

*Key challenges in mental health care include:*

- Fragmented services - mental health and substance misuse services are often separate, limiting coordinated treatment for individuals with complex needs
- Access barriers - rigid service structures, office-hour limitations, geographic centralisation, and socioeconomic disadvantage can prevent individuals from accessing care
- Vulnerable populations - young people, those experiencing homelessness, and those involved in the criminal justice system face heightened barriers and poorer outcomes

Local initiatives, such as the Co-occurring Mental Health and Substance Misuse Framework, aim to develop integrated pathways and joint care planning. Trauma-informed care and peer support models are increasingly recognised as essential components of effective mental health interventions.

Focusing on these seven priority health areas allows HDUHB to target prevention and early intervention where it matters most. The next chapter will explore how 20-4-7 is embedded into practice and translating these priorities into actionable programmes, measurable outcomes, and sustainable improvements across the Health Board.

## Chapter 5 – Recommendations

The recommendations detailed below are a call to action for a fundamental, non-negotiable shift in Hywel Dda's culture, process, leadership, and resource allocation. They are designed to fully embed prevention - for everyone, in every service, all the time - as the primary driver of clinical and financial value. This is not an intangible change; it is a call to strengthen, standardise and accelerate successful prevention efforts, shifting our organisational mindset so that equity, behavioural risk reduction, and focused action become the routine, measurable foundation of all care delivery.

### Health Board Recommendations

#### *Recommendation One*

Within annual planning cycles all teams, services, clinical networks and Clinical Care Groups will identify areas and actions to accelerate successful prevention efforts, shifting our organisational mindset so that equity, behavioural risk reduction, and focused action become the routine, measurable foundation of all care delivery.

Recommendation One will be supported by:

- A 20-4-7 planning checklist and review process facilitated by Public Health to standardise the application of prevention, starting with the 2026/27 planning cycle

#### *Recommendation Two*

To embed prevention across Hywel Dda requires a strengthened and continued engagement of the workforce at all levels working in community, primary and secondary care settings. Involving active participation in delivering prevention focused pathways and supportive environment to do so, that best balance the need for prevention in clinical care, and shape future services.

Recommendation Two will be supported by:

- Digital and in-person staff engagement activities to enhance the knowledge, skills, and capacity of staff to deliver the 20-4-7 model
- A 20-4-7 toolkit featuring guides and activities teams can use to self-assess and peer review prevention activities benchmark against the 20-4-7 model
- Scope possibilities for aligning clinical workforce roles to have explicit prevention focused responsibilities

#### *Recommendation Three*

20-4-7 requires a leadership and delivery approach that provides clinicians and managers the flexibility and ability to embed prevention in the most timely and effective way. This will be best achieved through a clear line of sight to the executive from

Clinical Care Groups and Primary Care Clusters, supported by timely and appropriate indicators aligned to 20-4-7 model.

Recommendation Three will be supported by:

- A Health Board wide lead for 20-4-7 to support the Executive Director of Public Health to drive the model across the health board system
- A named lead for each of the seven priority areas with capacity to coordinate system action, reduce duplication, and align workforce and resource
- The development of a 20-4-7 Dashboard, developed tracking KPIs to monitor inequalities in outcomes, access, and experience across the seven priority health areas

#### *Recommendation Four*

Demand for healthcare will continue to grow without investment into prevention. Pilot and grant funded interventions can build an evidence base but experience shows they struggle to be adopted and delivered at scale to have sustained impact at a population level. Therefore, a commitment to sustainable funding of prevention activities in a planned and managed way is recommended.

Recommendation Four will be supported by:

- Development of a 3-year invest to save business case to provide targeted high impact prevention activity to support reducing future demand
- Undertaking a minimum of two annual Programme Based Marginal Analysis reviews of any of the 7 Prevention Priority Areas and implementing the recommendations, shifting resource towards prevention activities.

## Operationalising 20-4-7 model

### *The 20 – Equity: Reaching the 20% most socioeconomically deprived*

To reduce the unfair unacceptable gap in health outcomes, our prevention efforts must begin by targeting action and resources towards the most socioeconomically deprived 20% of our population.

#### **We will:**

1. Integrate equity as a fundamental component of budgeting and planning processes by ensuring Health Equity Impact Assessments are undertaken for strategic planning decisions, and are considered in planned service changes, to identify and demonstrate how the proposal impacts on health inequalities

2. Empower Primary Care Clusters (PCCs) for strengthened delivery of prevention activities – analyse local intelligence and data to target action by place, background and circumstance - use WIMD quintiles and GP cluster data in addition to equality assessment defined by protected characteristics to identify those most at risk, recognising intersectionality as a key driver of disadvantage
3. Establish a strengthened Health Equity Oversight Group as the coordinating mechanism for multi-agency work on equity, aligning efforts with Public Service Boards and Regional Partnership Board
4. Finalise and publish a Health Equity Dashboard to monitor inequalities in outcomes, access, and experience across the 7 priority health areas

#### *The 4 – Behavioural Risk Factors: Tackling the Main Drivers of Poor Health*

Addressing the underlying behaviours that drive preventable illness is essential. We will embed the capability to tackle these risks into every staff role and service environment.

##### **We will:**

1. Make *Making Every Contact Count (MECC)* as a core competency across the workforce, empowering every member of our workforce to have the confidence and skills to identify risk behaviours and offer brief advice or referral
2. Establish and expand a dedicated Health Coaching service with Primary Care, making it the primary, first-step intervention for adults managing multiple health risks
3. Enforce supportive environments for healthy choices – develop leadership skills and ability to ensure health board sites actively promote and enforce supportive environments for healthy choices, including smoke-free and healthy food environments
4. Integrate data systems that automatically capture prevention activity (e.g. smoking cessation, alcohol screening) at the point of care

#### *The 7 – Priority Health Areas: Focusing on Conditions and Groups Where Early Action Has the Greatest Impact*

To deliver maximum benefit, we must integrate these equity-led, behaviour-focused actions and evidence based interventions across the seven major conditions and population groups where early intervention is most impactful.

##### **We will:**

1. Work with partners to conduct a system-wide review of all major clinical pathways, mandating the integration of upstream risk reduction, comprehensive

screening, and targeted health coaching/behavioural interventions at every relevant clinical touchpoint

2. Establish prevention and population health plans for each of the 7 priority areas to coordinate system action, identify opportunities for prioritising prevention and align clinical protocols and our wider efforts
3. Create the case for further developing the workforce aligned with the 20-4-7 model and scope roles that are dedicated to leading prevention across the 7 prevention priority areas

## Embedding Prevention as the Foundation

The 20-4-7 model marks a pivotal moment to strengthen the focus on prevention by developing new initiatives, accelerating, standardising, and embedding good practice already underway across HDUHB. This report sets out a focused roadmap to implement this.

The recommendations laid out in this chapter are designed to achieve three key outcomes:

- **Tackle inequity (20):** Directing resources and targeted action to the most socioeconomically deprived 20% of our communities, we are committed to closing the gap in healthy life expectancy. Equity is the driver of our greatest potential health gains.
- **Address main behavioural causes of ill health (4):** Embedding systematic action on Smoking, Nutrition, Alcohol, and Physical Inactivity (SNAP) into every relevant pathway, we will significantly reduce the primary drivers of preventable disease and premature death.
- **Focus efforts on embedding prevention in the key burden of disease areas (7):** Aligning our work across the seven priority health areas - from early years to healthy ageing - we ensure that our limited resources are focused where early intervention will have the greatest impact on population health and system sustainability.

## A Call to Action

Successful implementation of the 20-4-7 model requires collective commitment and accountability across the Health Board and with our partners. Done well, this will not only improve the health and well-being of the people we serve but will also safeguard the future of our health and care services by reducing avoidable demand and using public resources wisely.

The journey ahead is one of systemic change, sustained partnerships, and clear accountability. By working together, we will measure our progress against these recommendations and continuously adapt our approach to secure a Healthier Mid and West Wales.

## Acknowledgements

I would like to express sincere gratitude to all those who contributed to the development of the 2025 Annual Report and the establishment of the 20-4-7 model. This report is the result of shared endeavour.

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Thank you to all my colleagues across the HDUHB, of all levels and backgrounds, for engaging with my concept, encouraging, supporting, challenging, and providing helpful suggestions to develop and strengthen it, from when I first presented it as a model in December 2024, to now proudly presenting it as my DPH Annual Report forming a key framework for our annual planning, service development, and informing the refresh of our strategy. Together, embedding this model, we will make addressing inequalities in health and preventing ill health the core of what we do every day, in every service.

# References

## Chapter 1

1. [A Healthier Mid and West Wales Our Future Generations Living Well](#)
2. [Social Model for Health and Wellbeing](#)
3. [Our Approach to Value Based Health Care 2022 – 2025](#)
4. [Prevention-Based Health and Care 2025](#)
5. [Health and its determinants in Wales Informing strategic planning](#)

## Chapter 2

6. [Fair Society, Healthy Lives – The Marmot Review](#)
7. [Climate Change and Health 2024](#)
8. [Fuel Poverty, Cold Homes and Health Inequalities in the UK](#)
9. [Dying in Poverty in Wales 2024](#)
10. [A snapshot of poverty in autumn 2024 - Bevan Foundation](#)
11. [Health expectancies in Wales with inequality gap](#)
12. [Identifying policy options to tackle health inequalities: policy analysis and opportunities for learning for Wales](#)

## Chapter 3

13. [Smoking and well-being team](#)
14. [The case for action on obesity in Wales](#)
15. [Obesity Alliance Cymru Prevention Paper](#)
16. [Adult lifestyles by local authority and health board, 2020-21 onwards](#)
17. [Breastfeeding, quarterly rates by age and LHB](#)
18. [Benefits of breastfeeding - NHS](#)
19. [The Broken Plate 2023 Food Foundation](#)
20. [A summary of trends in risk factors for non-communicable diseases - Public Health Wales,](#)
21. [Healthy Weight Healthy Wales - Our long term strategy to prevent and reduce obesity in Wales](#)
22. [World Health Organisation – Alcohol](#)
23. [Data mining Wales: The annual profile for substance misuse 2023/24](#)
24. [Adult lifestyles by local authority and health board, 2020-21 onwards](#)
25. [Actif Wales](#)
26. [Ceredigion Actif](#)
27. [Pembrokeshire Leisure](#)

## Chapter 4

28. [Director of Public Health Annual Report, 2023-24 Their health, our future: children and young people's health and wellbeing in Hywel Dda](#)
29. [Picture of Oral Health 2023 Hywel Dda](#)

30. [Oral Health of school year seven \(12 year old\) children in 2023-24](#)
31. [Referrals for the management of tooth decay in children from primary care](#)
32. [Designed to Smile](#)
33. [Healthy Child Wales Programme](#)
34. [Age friendly Wales: our strategy for an ageing society](#)
35. [Dementia Action Plan: progress update March 2025](#)
36. [Dementia prevention, intervention, and care: 2024 report of the Lancet standing Commission](#)
37. [Cancer in Wales – trends and projections](#)
38. [Respiratory disease prevalence – trends, risk factors, and 10-year projections - Public Health Wales](#)
39. [Pneumococcal polysaccharide vaccination \(PPV\) uptake in Wales in 2023/24](#)
40. [Mortality statistics - underlying cause, sex and age - Nomis](#)
41. [Cardiovascular Disease in Hywel Dda University Health Board](#)
42. [Cardiovascular disease prevalence – trends, risk factors, and 10-year projections](#)
43. [Diabetes prevalence – trends, risk factors, and 10-year projection](#)
44. [Type 2 Diabetes in adults - NICE](#)
45. [Primary Care Measures: National Variation Report](#)
46. [Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problem](#)
47. [Royal College of Psychiatrists](#)