GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Primary Care Obesity Prevention Action Plan – Progress, Reflections and Recommendations

Implementing the All Wales Weight Management Pathway in Primary and Community Care (2022-24)

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Primary and Community Care Development and Innovation Hub
Developing Primary Care in Wales

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Executive Summary

The adult All Wales Weight Management Pathway (AWWMP) (2021) focuses on an individual's weight management journey from early intervention to specialist support. It recognises the importance of primary and community care, describing these settings as the first point of contact for people with health and wellbeing concerns.

Led by the Primary Care Division within Public Health Wales (PHW), a multi-professional Primary Care Obesity Prevention (PCOP) Steering Group was established in September 2021 to support the primary and community care elements of the AWWMP, through the development and implementation of a two-year Primary Care Obesity Prevention (PCOP) Action Plan, covering April 2022 - March 2024. The PCOP Action Plan identifies four aims with a series of once-for-Wales actions, designed to support the implementation of the primary and community care elements of the AWWMP, in line with the Healthy Weight Healthy Wales (HWHW) Delivery Plan 2022-24. The four aims include:

1. The person-centred journey
2. Primary and community care workforce
3. Data and digital
4. Leadership and governance.

The purpose of this report is to bring together the key activities, barriers and facilitators, in relation to the actions in the PCOP Action Plan (2022-2024), providing an overview of the achievements of the Action Plan. Key achievements are highlighted in the report as 'Spotlights' on the following areas:

1. Supporting obesity prevention and postnatal weight management in women up to 5-years after birth
2. Integrating the AWWMP into clinical pathways – supporting prevention and management of MSK conditions

3. Resources to support the primary and community care workforce
4. Supporting primary and community care infrastructure to implement the AWWMP

Preventing obesity is a complex challenge, with many contributing factors acting at individual, community, societal and global levels. It is recognised that many stakeholders at the local and national level are working to halt the rise and reverse the trend in levels of overweight and obesity in Wales. The focus of this report is on the specific activities related to the Primary Care Obesity Prevention Action Plan (2022-24). Substantial activity has occurred in relation to 24 out of 29 actions set out in the action plan, however, there is still much more to do, especially in areas that are wider in scope than obesity prevention.

The key recommendations identified by this report are as follows:

1. Maintain and build on the momentum achieved in key areas of work (identified as 'Spotlights' within this report) where significant progress has been made to date. For example, the foundations have been laid for postnatal health and wellbeing, including obesity prevention, to be addressed in collaboration with the National Strategic Clinical Networks in Wales.

2. Address challenges identified in this report through action on prevention more broadly and through a more holistic health and wellbeing approach that includes action to support obesity prevention. This could apply to challenges related to digital developments, contracts, workforce wellbeing, and the need for the workforce to recognise their role in prevention. However, the complexities of overcoming these challenges also need to be recognised.

3. Recognise the need for evaluation of activities and explore how to assess their impact. For example, understanding the impact of both contractual changes and the activities undertaken to support them, could identify learning to inform future contractual developments across a breadth of contractors.

Purpose and Scope of the Report

The purpose of this report is to bring together the key activities, barriers and facilitators, in relation to the actions in the PCOP Action Plan (2022-2024), providing an overview of the achievements of the Action Plan.

Preventing obesity is a complex challenge, with many contributing factors acting at individual, community, societal and global levels. It is recognised that many stakeholders at the local and national level are working to halt the rise and reverse the trend in levels of overweight and obesity in Wales. Therefore activities and impacts that have not involved the PCOP Steering Group and/or are outside the remit of primary and community care will be out of scope of this paper.

The audience for this report is primarily the PCOP Steering Group members and their respective networks, as well as the governance bodies with responsibility for overseeing this area of work. In addition the findings will be of relevance to strategic and operational leads in the health and care system in Wales.

Background

Development of the Primary Care Obesity Prevention Action Plan

The adult All Wales Weight Management Pathway (AWWMP) (2021) focuses on an individual's weight management journey from early intervention to specialist support. It recognises the importance of primary and community care, describing these settings as the first point of contact for people with health and wellbeing concerns.

Led by the Primary Care Division within Public Health Wales (PHW), a multi-professional Primary Care Obesity Prevention (PCOP) Steering Group was established in September 2021 to support the primary and community care elements of the AWWMP. The Primary Care Division developed and presented two reports to the PCOP Steering Group highlighting how primary and community care can support obesity prevention and weight management, and the support that the workforce needs to fulfil this important role:

- The primary care needs of people living with obesity: Summary
- Behavioural insights from the primary care workforce on supporting weight management: Summary.

Recommendations from these reports along with PCOP Steering Group member's expertise and engagement were used to inform the development of a two-year Primary Care Obesity Prevention (PCOP) Action Plan, covering April 2022 - March 2024. The PCOP Action Plan identifies four aims with a series of once-for-Wales actions, designed to support the implementation of the primary and community care elements of the AWWMP, in line with the Healthy Weight Healthy Wales (HWHW) Delivery Plan 2022-24. The four aims include:

1. The person-centred journey
2. Primary and community care workforce
3. Data and digital
4. Leadership and governance.

The timeline of the development of the PCOP Action Plan, from June 2021 to March 2024 is illustrated in Figure 1.

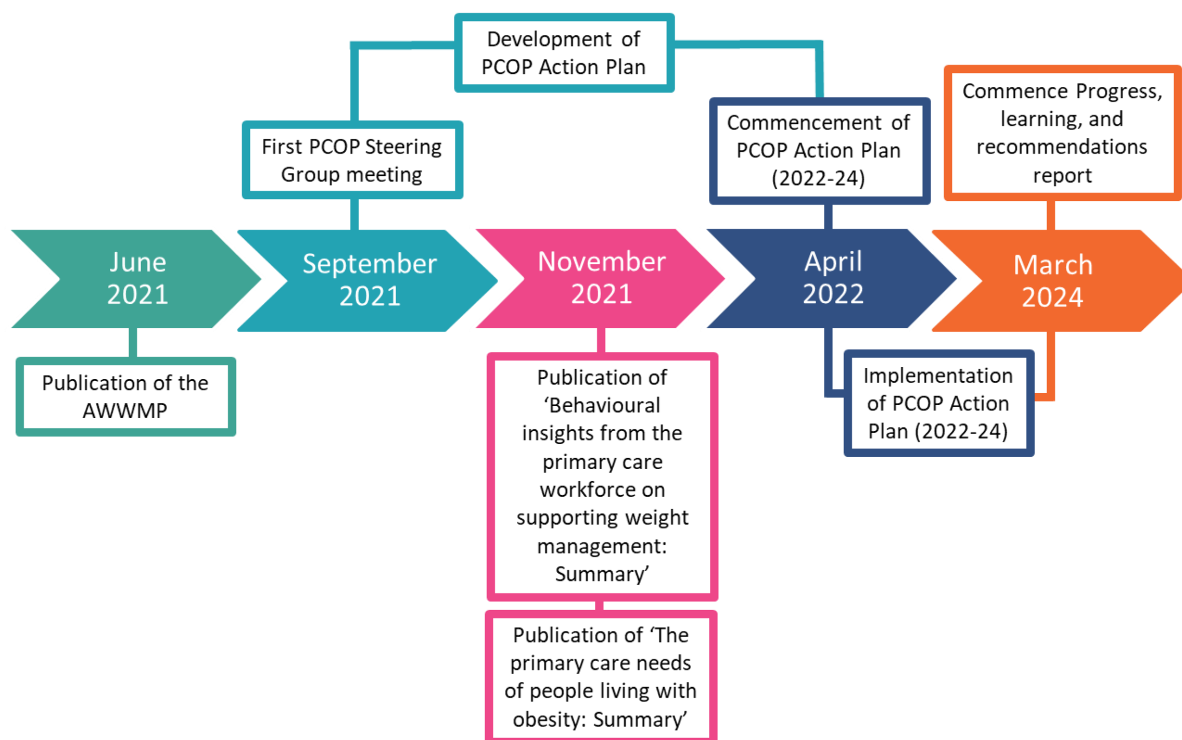

Figure 1: Timeline of PCOP Action Plan (2022-24)

Primary Care Obesity Prevention Steering Group

The PCOP Steering Group had responsibility for overseeing and implementing the Action Plan, reporting to the National Healthy Weight Pathway Steering Group, which subsequently fed into the Healthy Weight National Implementation Board. In addition, the PCOP Steering Group reported to the Strategic Programme for Primary Care (SPPC) Programme Board via the Prevention and Wellbeing workstream, and subsequently into the National Primary Care Board.

Steering Group representation was drawn from:

- Royal College of General Practitioners in Wales
- GPC Wales
- Community Pharmacy Wales
- British Dental Association
- Optometry Wales
- Royal College of Nursing
- Primary Care Clusters
- Heads of Primary Care
- Midwifery
- Welsh Dietetic Leadership Advisory Group
- Welsh Allied Health Professional Committee
- Local Public Health Team
- Public Health Wales
- Welsh Government
- Strategic Programme for Primary Care
- Health Education Improvement Wales

Eleven virtual meetings were held, with the Steering Group's final formal meeting held in January 2024. Connections were made with a range of teams, networks and initiatives who presented at PCOP Steering Group meetings, including:

- MSK Strategic Clinical Network
- Fuse
- PHW Health Improvement
- PHW Behavioural Science Unit
- Digital Health & Care Wales
- GMS Quality Improvement Project
- SPPC Fund

The Primary Care Division would like to thank members for their continued support and valued input into the development and implementation of the Action Plan.

Progress and Reflections on PCOP Action Plan

Intended Aims

The PCOP Action Plan (2022-24) had four main aims as illustrated by Figure 2.

Figure 2: Four Aims of Primary Care Obesity Prevention Action Plan

Each aim comprised of objectives with a series of once-for-Wales actions, in summary these include:

- **Aim 1** looked to **the 'person centred' journey** in primary and community care, by helping to: join up care across a person's life course; avoid fragmentation of care; strengthen obesity prevention within long term condition management; and consider how better to support equitable access to the AWWMP.
- **Aim 2** focused on supporting the **primary and community workforce** to confidently have compassionate weight management conversations, free from stigma or bias, as well as, supporting and enabling the workforce themselves to have a healthy weight and access to weight management as needed.
- **Aim 3** looked to **optimise overweight and obesity data usage and digital healthcare technologies**, for example, by providing opportunities for people to use accurate, valid self-reported weight/ height/ body mass index (BMI) in primary and community care conversations and supporting the development of the NHS Wales app

and other quality assured digital resources with the intention of helping primary and community care to help those living with overweight or obesity.

- **Aim 4** centred on developing **leadership and governance** mechanisms to drive implementation of the AWWMP in primary and community care, by collaborating with all partners involved, supporting integrated approaches, embedding quality improvement to support person-centred weight management, and promoting a culture that supports person-centred weight management e.g., influencing communications to and engagement with the primary and community workforce.

Progress on Action Plan: (1) 'Spotlights'

The action plan was intentionally broad and wide ranging in its scope, reflecting the complexities of factors which need to be addressed to effectively support implementation of the AWWMP in primary and community care. A full list of the actions against each aim can be seen in Appendix 1.

As implementation of the plan commenced, the synergies and overlaps between actions within different aims became increasingly apparent, and it was evident that activities being undertaken would contribute to multiple actions and aims. It was also clear that many activities aligned to developments in four key areas. The section which follows will highlight the activities undertaken in these key areas as individual 'Spotlights':

1. Supporting obesity prevention and postnatal weight management in women up to 5-years after birth
2. Integrating the AWWMP into clinical pathways – supporting prevention and management of MSK conditions
3. Resources to support the primary and community care workforce
4. Supporting primary and community care infrastructure to implement the AWWMP

The table in Appendix 1 also outlines how the activities described within the 'Spotlights' contributed to all the individual actions within the PCOP action plan.

Progress on Action Plan: (2) Additional activity

As can be seen from the table 'Progress mapped against PCOP action plan' in Appendix 1, there has been activity towards addressing the majority of actions within the 'Spotlights'. In addition, there are a few areas of activity which are not within the scope of the four 'Spotlight' areas described, and these are as follows:

- ***Action 1.4 Map a person's weight management journey from their first point of contact with primary and community care***

To understand primary and community care involvement in local level 1 & 2 weight management pathways across Wales, meetings were held with each of the 7 health boards. Discussions, which were facilitated by an intervention flow chart (see Appendix 2), identified the following common themes:

- Consensus and clarity on the definition of the 5A's framework is needed (which was also identified within 'Spotlight 1'
- Recognition that multiple referral routes (including self-referral) exist, and primary and community care are not the primary route
- Training need to confidently raise healthy weight conversations was identified
- Weight management service demand and capacity issues exist.

- ***Action 1.6 Consider the role of primary and community care in supporting weight management in elements of the children, young people and families AWWMP, and in the transition to adulthood, including preconception health***

As highlighted in the PHW consultation response to the Senedd enquiry into the 'Prevention of ill health – Obesity', services for children with overweight and obesity are less developed in Wales and work is still needed to support families to access services at an earlier point in time. To support this, PHW has developed a new Primary Care Clusters

Dashboard which brings together data on a range of indicators to enable clusters to assess the needs of their population compared to other areas and the Welsh national average. Included within this dashboard are indicators from the Child Measurement Programme.

- ***Action 3.4 Support and enable consistent collection of relevant data in primary and community care for the AWWMP minimum data set***

During 2022-2024, a workstream to develop a minimum data set for the AWWMP was led by the Health Improvement Division, Public Health Wales, and to support the delivery of action 3.4, primary and community care perspectives were provided to support the development of the data set.

- ***Action 4.1 Work with Health Board Pathway Delivery Groups and primary and community care, to align the all-Wales approach with Health Board Pathways***

A National HWHW Pathway Board was established by Welsh Government, and membership comprised of multidisciplinary colleagues from across Wales, working both at local and national levels. This board has been supporting the alignment of work within health boards with an all Wales approach.

- ***Action 4.5 Advocate for a whole systems approach to supporting the public to access the AWWMP, including system leaders in both health and non-health sectors, as well as the community***

Co-ordinated by the Health Improvement Division, Public Health Wales, a Whole System Approach to healthy weight is being adopted in Wales, with partnerships established across each health board area in Wales including health organisations, local councils, businesses, and schools, and supported by funding from Welsh Government. The Whole Systems Approach recognises the complexity of the systems that affect our health, and works with everyone in the system to create changes that meet stakeholders' needs.

Progress on Action Plan: (3) Actions still requiring development

Whilst 24 out of the 29 actions within the action plan have been progressed to some extent, there have been barriers to progressing five of the actions within the action plan. The challenges to progressing these are considered in the section which follows, ‘Reflections on Barriers and Facilitators to Progress’. The five actions which have not progressed as yet are:

- ***Action 2.4 Produce plans for supporting and enabling the primary and community care workforce to have a healthy weight and access weight management as needed***
- ***Action 3.5 Consider digital inclusion approaches to support equitable uptake and access to the AWWMP in primary and community care***
- ***Action 3.7 Consider approaches that support primary and community care to undertake virtual weight management conversations, including how weight/height/BMI can be proactively assessed***
- ***Action 3.8 Understand and integrate the role of digital solutions within primary and community care systems to support personalisation of interventions***
- ***Action 4.3 Align implementation of AWWMP with Accelerated Cluster Development (ACD)***

Reflections on barriers and facilitators to progress

Recognising the complex nature of the actions with the action plan, challenges were inevitably faced in the progression of all action areas.

Particular barriers to making significant progress included:

- Dependence on prioritisation and infrastructure of other organisations as well as limitations in PHW capacity to support specific actions within the action plan, e.g. for actions 3.7 and 3.8, capacity and resource to support the development of virtual weight management conversations and digital solutions within primary and community care systems; for action 2.4 capacity and resource to support action on workforce wellbeing

- Certain actions being dependent on the progress of other actions or external dependencies of the action plan e.g. for action 3.5, developing digital inclusion approaches necessitated the progression of digital solutions, for action 4.3, the timescales for the development of ACD aligning with any implications for the implementation of the AWWMP.

There were also challenges in the pace of progress. In areas where progress was made, the degree of progress was limited due to the following barriers:

- For many of the actions, the progress has not been maximised due to limitations in capacity both within PHW as well as across partner organisations including in primary and community care, clinical networks, and other enabling functions, including those supporting digital and workforce developments. Whilst it may not have been realistic to expect maximum progress to be achieved within 2 years due to the time needed for developments, the scale and pace of progress needs to be accelerated to successfully implement the AWWMP. For example, in relation to action 3.6 PHW have developed the Healthy Weight Healthy You website as a digital resource. However, NHS app developments to support AWWMP implementation, were also in scope of this action but were not achieved within the two years of the action plan.
- However, even if progress in some of these actions had been maximised, there are external dependencies that would still hamper the overall impact of these actions. For example, the short fixed term nature of certain funding e.g. the SPPC Fund, presented challenges to the progression of a number of projects, due to staff recruitment and retention issues, and procurement timescales. Also ongoing challenges with capacity of weight management services continues to be an issue limiting the ability of primary and community care to implement the AWWMP.

Despite the challenges described above, there were also a number of facilitators which enabled significant progress to be made, as demonstrated in the 'Spotlights' section which follows.

The PCOP steering group and corresponding governance arrangements, ensured oversight and input from representatives across the primary and community care community to help shape the development of the action plan and the activities undertaken. The establishment of steering groups for specific areas of work was also beneficial, and enabled primary care and public health perspectives to be included e.g. Healthy Weight MECC Conversations eLearning, coproduction of the key communications messages, development of the postnatal behavioural systems map, and sharing experiences and challenges in the SPPC Obesity Prevention Peer Network.

Interest from partners in progressing a broader agenda on prevention in the health and care system has also been a facilitator for this work, as demonstrated by the development of a GMS QI Project focused on Supporting Healthy Behaviours, development of the MSK Conditions Framework which embeds prevention, and recognition of the need to broaden work on postnatal weight management to address broader health and wellbeing. This has been complimented by the parallel development of the Prevention-Based Health and Care Framework (PBHC), led by PHW, and establishment of a PBHC Steering Group to take forward embedding prevention in the health and care system.

Implementing the PCOP action plan has also demonstrated the central importance of resourcing infrastructure developments. For example, contract developments in both GMS and optometry services have provided levers for services to support healthy behaviours, including achieving or maintaining a healthy weight. Also, the use of the SPPC Fund to expand provision of the AWDPP is an example of how the scale and pace of developments can be increased.

Spotlights

As described above, activities undertaken in key areas are highlighted in the following ‘Spotlights’:

1. Supporting obesity prevention and postnatal weight management in women up to 5-years after birth
2. Integrating the AWWMP into clinical pathways – supporting prevention and management of MSK conditions
3. Resources to support the primary and community care workforce
4. Supporting primary and community care infrastructure to implement the AWWMP

1. Supporting obesity prevention and postnatal weight management in women up to 5-years after pregnancy

The term women is used throughout this 'Spotlight' to refer to pregnant women or people, and postnatal women or people who have had a pregnancy.

Associated Aim(s):

1. Person-centred journey
2. Primary and community care workforce
3. Data and digital
4. Leadership and governance

Overview

Pregnancy is a significant event for many women in their life course and is frequently the point at which a woman's weight may start to increase. Pregnant women routinely have their height and weight measured, and BMI calculated at their initial antenatal assessment. In 2022, 31% of pregnant women in Wales had a BMI of 30kg/m^2 or greater (WG, 2023). However, despite identifying a high prevalence of obesity in this population, women are not routinely supported with weight management after pregnancy or with a view to benefitting their longer-term health.

Approach

To enable better joined-up care and more equitable access for women when they are discharged from maternity services to primary and community care, the Primary Care Division developed a postnatal weight management workstream. Its vision was to develop an integrated pathway for supporting women's weight management from the antenatal period through to 5-years after pregnancy.

To develop the workstream, a public health approach was applied, comprising the following elements:

- **Prevention** – Early intervention and preventative action on weight management in the postnatal period were prioritised. The focus was on primary prevention i.e. preventing

the onset of overweight or obesity, and secondary prevention i.e. preventing the progression of obesity and associated harms.

- **Data & evidence** – A mixed methods approach was undertaken to understand the postnatal weight management landscape as it is now and how it could develop, as well as what interventions are effective within primary and community care settings.
- **Partnership working** – Views from key stakeholders from across the health and care system were elicited, including women, families and the public, to incorporate their insights and perspectives.
- **Population** – Evidence on both universal interventions (e.g. for mothers attending childhood immunisation appointments) and targeted interventions (e.g. for women with gestational diabetes) were considered.
- **Underlying causes** – Challenges of losing weight gained during pregnancy e.g. child caring responsibilities, mental wellbeing, and competing priorities for women, were addressed.

Outputs and outcomes

Behavioural system mapping

An in-person behavioural system mapping workshop was held in April 2023, with key stakeholders, in collaboration with PHW Behavioural Science Unit. The workshop considered the postnatal weight management journey and consisted of three interactive sessions to capture: the who, what and influences.

Image: Visual minutes from April 2023 workshop

The information gathered in the workshop, and a subsequent online workshop, was used to develop a behavioural system map which highlighted actions needed in this area e.g. engagement with women, consensus and clarity on the definition of the 5A's as applied for postnatal women.

System developments

Connections were made and relationships established to align work, with a range of relevant stakeholders:

- Discussions were held with Improvement Cymru resulting in support for postnatal weight management being identified as one of the priority actions for safe and effective care within the Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (2023)
- Regular discussions were held with Digital Maternity Cymru and proposed weight management data to be included in new maternity system was identified
- Quarterly meetings were established with PHW early years obesity programme focused on postnatal weight management to ensure alignment between workstreams

Systematic review: Implications for practice and future research

Through a grant collaboration with Fuse, the Centre for Translational Research in Public Health, a mixed-methods systematic review was undertaken on the 'Effectiveness and implementation of lower-intensity weight management interventions delivered by the non-specialist workforce for postnatal women'.

The findings have been shared at PHW Research & Evaluation Conference, December 2023, published in a journal article in Frontiers in Public Health, part of the research topic Obesity Across the Life Course, March 2024, and at the UK Congress on Obesity conference, September 2024 .

The review found:

- A need for more UK based studies, including qualitative studies, with longer follow-up in the postnatal period
- Interventions delivered within 12-months, and particularly those at around 6-months, following pregnancy, delivered in routine healthcare appointments, may hold the most promise

An infographic on supporting postnatal weight management for the primary and community care workforce has also been published, and a webinar sharing learning and developments hosted for stakeholders.

Time to Talk Public Health - A population panel

Time to Talk Public Health is Public Health Wales' national panel of Welsh residents aged 16+ years to enable regular public engagement to inform public health policy and practice. Questions relating to postnatal weight management were developed and submitted to the Public Health Wales August 2023 Time to Talk Public Health Panel Survey, published October 2023. The survey was completed by 1,113 people, and unless stated, data are weighted to reflect national population demographics by age, sex, and deprivation.

The survey reported:

- 69% of people think a healthcare professional should have a healthy weight conversation with women in the first 12-months after giving birth
  - Of those that responded to have given birth within the last 5-years (n=70) 79% said they have not had a healthy weight conversation with a healthcare professional
    - Of those that have not had a healthy weight conversation (n=55) 65% would have found it helpful

Next steps

Given the insights from stakeholders, views of people in Wales and the evidence generated, the next steps for this area of work are as follows:

- To collaborate with the Women's Health Network, the Maternity and Neonatal Network, and the Child Health Network on establishing a workstream across the networks on holistic postnatal health and wellbeing, also linking to work on preconception health.
- To develop a pathway for those experiencing gestational diabetes into the All Wales Diabetes Prevention Programme (AWDPP), to start demonstrating the art of the possible in supporting postnatal weight management.

2. Integrating the AWWMP into clinical pathways – supporting prevention and management of MSK conditions

Associated Aim(s):

1. Person-centred journey
3. Data and digital
4. Leadership and governance

Overview

In Wales, it is estimated that 974,000 people are living with a Musculoskeletal (MSK) condition, with obesity being one of the risk factors for the development of MSK pain. MSK conditions have been identified and prioritised as a comorbidity within the AWWMP due to the MSK consequences associated with obesity and the potential benefit to MSK health from moderate weight loss.

To enable life-long optimal MSK health for all, the national strategic clinical network for MSK conditions have developed Living with Arthritis and Musculoskeletal Conditions in Wales: a framework for the future 2024-2029 . This presented the Primary Care Division with an opportunity to advocate for obesity prevention to be incorporated into the development of the framework.

Approach

To advocate for obesity prevention to be incorporated into the development of the MSK framework, a public health approach was taken through:

- **Informing and influencing decision makers** to support people living with, and at high risk of, developing MSK conditions to maintain a healthy weight by embedding obesity prevention within the new MSK framework. Established working relationships, partnership approaches and regular communications with MSK network leads to incorporate obesity prevention and broader early intervention and prevention into the MSK framework.

- **Aligning prioritisation of MSK health within PHW** to agree need for deep dive into MSK data on prevalence, as part of series of long-term condition deep dives being undertaken by PHW. MSK deep dive analysis will support decision makers to address public health issues and improve health and healthcare services related to MSK health.
- **Raising the profile of prevention within the MSK network** by presenting on prevention, including obesity, at the MSK Innovations in Wales Conference on World Arthritis Day 2023, and at the launch of the MSK Clinical Network in October 2024 where a workshop was also delivered to facilitate conversations regarding priorities for MSK prevention.

Outputs and outcomes

Quality Statement
Welsh Government's Quality Statement for MSK Health has incorporated a focus on prevention e.g., quality statement 4: Where possible, populations at high risk of developing MSK conditions are identified through local needs assessments and actively supported with primary prevention strategies before the onset of symptoms of MSK conditions.

MSK Framework
Feedback was provided on Welsh Government's formal consultation on 'Living with Arthritis and Musculoskeletal Conditions in Wales: a framework for the future 2024-2029'. Following this, the national strategic clinical network have incorporated prevention, including in relation to obesity prevention in their publication Living with Arthritis and Musculoskeletal Conditions in Wales: a framework for the future 2024-2029.

Strategic Clinical Network
PHW Primary Care Division are represented on and provide input to the Prevention, Early Diagnosis and Treatment Clinical Reference Group, which reports to the MSK Strategic Clinical Network Group.

Next steps

- Support MSK National Strategic Clinical Network colleagues to identify actions to embed obesity prevention within MSK services
- To aid decision-makers to utilise the new Prevention Based Health Care (PBHC) Framework (2024) to determine the desired outcomes, identify evidence-based interventions, consider effective implementation approaches and address behavioural barriers and facilitators for the workforce as well addressing enablers to embed MSK preventative action.

3. Resources to support the primary and community care workforce

Associated Aim(s):

1. Person-centred journey
2. Primary and community care workforce
3. Data and digital
4. Leadership and governance

Overview

One of the reports which fed into the development of the Primary Care Obesity Prevention Action Plan, was a report on behavioural insights from the primary care workforce on supporting weight management. This identified that whilst some professionals' felt that they had the knowledge/skills/confidence to support weight and weight management, as well as the intention to carry out weight management conversations, some of these professionals often experienced barriers, preventing them having weight management conversations e.g. signposting and availability of services, time constraints, societal stigma surrounding obesity, and education and training.

The behavioural insight report therefore identified the following recommendations to address factors that contribute towards the potential intention-action gap:

- **Recommendation 2 -** Increasing primary care professionals' awareness of available services and resources to provide weight management support could increase the frequency of weight related conversations.
- **Recommendation 3 -** There is a need for further education and training to support workforce knowledge/skills/confidence and to challenge bias.

Approach

- To address the recommendations above, the Primary Care Division developed an area of work on resources for the primary care workforce through the following approaches:

- **Applying behavioural science** to identify barriers experienced by the workforce in having weight management conversations by using the APEASE criteria (Acceptability, Practicability, Effectiveness, Affordability, Side-effects, Equity) to analyse and rate barriers, informing intervention type (e.g. education and training).
- **Adopting the OASIS (Objectives, Audience, Strategy, Implementation and Scoring) communication planning framework** to develop a systematic communication and engagement plan for the primary and community care workforce.
- **Co-producing key messages with and for health and care professionals** to inform content of resources and shape language of communications.
- **Working in partnership** with a range of partners including, PHW Health Improvement Division's social marketing team, PHW nutrition and obesity team, PHW Behavioural Science Unit, HEIW and Wales General Ophthalmic Services to inform development of outputs. This also involved utilising networks to disseminate resources effectively and efficiently to the primary care workforce.

Outputs and outcomes

Key messages
Co-produced key communication messages with and for health and care professionals aligned to the newly developed Healthy Weight Healthy You website. Through an interactive workshop the messages listed below were developed, which aim to promote person-centred approaches, free from stigma and bias: • Getting to, and maintaining, a healthier weight can be challenging and influenced by the conditions in which we are born, grow, live and work. • It is important to understand a person's weight journey from their perspective, free from judgement and bias. • Compassionate conversations and access to support, can help people to have a healthier weight. The messages have been utilised in the Supporting Healthy Behaviours resources, Healthy Weight Conversations MECC e-modules, and related communications.

Communication and engagement plan

Developed a communication and engagement plan that outlined the activities required to support delivery of the PCOP Action Plan. The plan identified three phases of proactive communication and stakeholder engagement, utilising professional channels for the dissemination of information and messaging as the main vehicle for interaction.

Developed SBAR (situation, background, assessment and recommendations) report on planned communication resources to support General Medical Services (GMS) quality improvement project.

Supporting Healthy Behaviours

Produced resources to support the workforce in general practice and optometry to have conversations with individuals to enable adoption of healthier behaviours, and to provide information to support the workforce with their own health and wellbeing, which included healthy weight. The resources include areas of quality improvement activities; links to training and resources for the workforce; brief information about the benefits of adopting healthy behaviours and harms of unhealthy behaviours; and signposting information for individuals to access further support.

- Supporting Healthy Behaviours – A Guide for General Practice
- Supporting Healthy Behaviours – A Guide for Optometry

Making Every Contact Count (MECC)

Advocated for the need for an e-learning module to support the workforce to have healthy weight conversations with individuals and to address some of the barriers identified in the Behavioural Insight report. SBAR report produced and presented to PCOP Steering Group.

Supported establishment of and contributed to the development of Healthy Weight Conversations MECC Level 1 and 2 modules via PHW’s steering group, associated MECC communication plan and evaluation.

Next steps

- Develop bespoke versions of supporting healthy behaviours guide for community pharmacy and dental settings, aligned to contractual levers as opportunities arise.
- Share learning from the communication and engagement plan and developing resources with the Primary Care Division's Prevention Based Health and Care workstream.
- Continue the delivery of the communication and engagement plan through the broader prevention-based health and care communication and engagement plan.
- Include obesity prevention and healthy weight within broader prevention packages aimed to support the primary and community care workforce to have conversations with people about health behaviours e.g. resources, communications and training.

4. Supporting primary and community care infrastructure to implement the AWWMP

Associated Aim(s):

1. Person-centred journey
3. Data and digital
4. Leadership and governance

Overview

There is strong evidence that infrastructure developments, including contractual changes within NHS services, can lead to systematic delivery of quality interventions at scale in primary and community care. The Stop a Stroke service is an example of this, where workforce education, resources and data tools, packaged with Local Enhanced Services across all health boards in Wales, has reduced stroke risk through improved management of Atrial Fibrillation.

There are a number of levers that can be used to achieve sustainable change and improvement in primary care e.g. financial incentives, contractual levers and national targets, and professional accountability. Levers utilised to support change in regards to obesity prevention have included:

- Funding for specific new services or interventions at the local level
- Quality improvement developments within the GMS contract
- Influencing content of service specifications

Approach

To develop the infrastructure in primary and community care to support implementation of the AWWMP, a public health advocacy and peer support approach was taken through:

- Maximising local activity following national funding allocation, by **leading and facilitating a peer network** for Health Boards to enable peer support, sharing of learning and overcoming challenges, support with measuring outcomes and evaluation,

and to ensure that SPPC funded projects are aligned with HWHW strategy and AWWMP.

- **Influencing Welsh Government** to strengthen the focus on prevention and early intervention within the 2023-24 and 2024-25 GMS contracts. Tripartite negotiations take place on a yearly basis between Welsh Government, NHS Wales and General Practitioners Committee (Wales) to agree what services all GP practices in Wales must provide and how they evidence assurance of delivery. A briefing paper was developed and meetings were held to advocate for obesity prevention in 2023/24 GMS contract negotiations.
- **Reviewing and analysing** the 2023-24 GMS Unhealthy Behaviours QI project posters to gather insight at an all-Wales level, providing recommendations to inform the 2024-25 GMS contract.
- **Influencing strategic nursing leads** through consultation on the development of the National Community Nursing Specification, of the importance of weight management related activities being a core function of community nursing roles.

Outputs and outcomes

SPPC Funds Obesity Prevention Projects:

The 2022-23 Strategic Programme for Primary Care (SPPC) Fund of £3.8 million was agreed to be used by Health Boards to support two investment areas. One of which was to invest in primary care projects to support obesity prevention, aligned to the HWHW strategy. Investment was agreed by the Directors of Primary Care Peer Group and endorsed by the National Primary Care Board.

- 10 project proposals were endorsed to address obesity prevention (2022-24 investment across 7 Health Boards), with 1 project withdrawal in Year 1.
- Of the original projects, proposals were reviewed to identify anticipated individual, population and system benefits and outcomes.
- The SPPC Fund 2022-2024 Final End of Programme Report presented project progress against the anticipated benefits and outcomes, displaying a mixed picture i.e., some projects appeared to have fully or in part achieved the benefits and outcomes whilst others reported a lack of achievement in certain areas.
- In 2023, the National Primary Care Board endorsed obesity prevention/All Wales Diabetes Prevention Programme as an area for investment in 2024-26. 7 project proposals across 6 Health Boards have been approved.

Supporting Healthy Behaviours Quality Improvement Projects

The 2023-24 GMS contract incorporated an Unhealthy Behaviours Quality Improvement project focussed on new patients and those with certain chronic conditions. The behaviours specified were in relation to: (1) obesity/high BMI, (2) high risk alcohol intake, and (3) tobacco use.

351 QI project posters from practices across Wales were reviewed and thematically analysed:

- 85.0% of all practices targeted all three behaviours within their QI project.
- 38.0% of all practices reported an improvement following intervention implementation.
- 4 key themes were reported: data reporting, data collection, empowering people to make healthier choices and NHS services that support healthy behaviours.

A series of recommendations were identified to ensure that (1) the workforce has access to resources and training on healthy behaviours and quality improvement methodology, (2) data and reporting systems are effective, and (3) improvements are made to national project guidance.

The 2024-25 GMS contract has incorporated the Unhealthy Behaviours Quality Improvement project for a second year, but renamed it Supporting Healthy Behaviours. The Supporting Healthy Behaviours resource produced by PHW for general practice has been included in the guidance for practices, which has been updated to incorporate recommendations from review of year 1 posters.

Community Nursing Specification

The National Community Nursing specification outlines at a strategic level the overarching principles, characteristics, and functions of Community Nursing in Wales for individuals aged 16 and over. Following advocacy, the inclusion of height and weight observations were included as a fundamental area of practice & skills for all registered Community Nurses and Health Care Support Workers into National Community Nursing Specification (2022).

Next steps

- Review 2024-25 Supporting Healthy Behaviours Quality Improvement projects and share learning.
- Continue to advocate for contract action and inclusion of activities within service specifications, related to healthy weight within broader prevention work.

Recommendations

As this report demonstrates, a lot of activity has taken place to begin addressing the actions identified in the action plan. Given the complex nature of these actions, it was always anticipated that work would need to extend on these actions beyond March 2024.

Within each of the 'Spotlight' key areas, specific next steps have been identified for each area. However, to progress the intended aims of the action plan as a whole, the following overarching recommendations have been identified, based on the reflections contained in this report:

1. Maintain and build on the momentum achieved in key areas of work (identified as 'Spotlights' within this report) where significant progress has been made to date. For example, the foundations have been laid for postnatal health and wellbeing, including obesity prevention, to be addressed in collaboration with the National Strategic Clinical Networks in Wales.

2. Address challenges identified in this report through action on prevention more broadly and through a more holistic health and wellbeing approach that includes action to support obesity prevention. This could apply to challenges related to digital developments, contracts, workforce wellbeing, and the need for the workforce to recognise their role in prevention. However, the complexities of overcoming these challenges also need to be recognised.

3. Recognise the need for evaluation of activities and explore how to assess their impact. For example, understanding the impact of both contractual changes and the activities undertaken to support them, could identify learning to inform future contractual developments across a breadth of contractors.

Appendix 1: Progress mapped against PCOP action plan

	Action	Spotlight				+
		1	2	3	4	
Aim1 : The person-centred journey *Supporting the person centred journey in primary and community care*						
1.1	Establish a workstream to develop joined-up approaches for supporting person (and family) centred weight management, beyond the immediate postnatal period					
1.2	Align and strengthen obesity prevention within existing clinical pathways for comorbidities identified in the AWWMP					
1.3	Align the development of the All Wales Diabetes Prevention Programme with the AWWMP					
1.4	Map a person's weight management journey from their first point of contact with primary and community care					
1.5	Identify strategies to support equitable access to the AWWMP through primary and community care, to reduce the potential inverse care law effect					
1.6	Consider the role of primary and community care in supporting weight management in elements of the children, young people and families AWWMP, and in the transition to adulthood, including preconception health.					
Aim 2: Primary care workforce *Supporting the primary and community care workforce to confidently manage overweight and obesity*						
2.1	Develop, promote and disseminate training and resources to enable the frontline primary and community care workforce to have compassionate conversations to support weight management					
2.2	Scope the different functions and roles of the frontline primary and community care workforce within the AWWMP					
2.3	Develop a communication and engagement plan for the frontline primary and community care workforce to support delivery of the primary and community care elements of the AWWMP					
2.4	Produce plans for supporting and enabling the primary and community care workforce to have a healthy weight and access weight management as needed					
Aim 3: Data & Digital *Optimising overweight and obesity data usage and digital healthcare technologies in primary and community care*						
3.1	Scope opportunities for people to use accurate, valid self-reported weight/height/BMI in primary and community care conversations					
3.2	Work to normalise the measurement and use of weight/height/BMI data in primary and community care					
3.3	Support use of weight management data at population levels to inform primary and community care planning of equitable services, to provide better care based upon need					

3.4	Support and enable consistent collection of relevant data in primary and community care for the AWWMP minimum data set					
3.5	Consider digital inclusion approaches to support equitable uptake and access to the AWWMP in primary and community care					
3.6	Support the development of the NHS Wales app and other quality assured digital resources with the intention of helping primary and community care to help those experiencing overweight/obesity					
3.7	Consider approaches that support primary and community care to undertake virtual weight management conversations, including how weight/height/BMI can be proactively assessed					
3.8	Understand and integrate the role of digital solutions within primary and community care systems to support personalisation of interventions					
Aim 4: Leadership and Governance *Developing leadership and governance mechanisms to drive implementation of the AWWMP in primary and community care*						
4.1	Work with Health Board Pathway Delivery Groups and primary and community care, to align the all-Wales approach with Health Board Pathways					
4.2	Support the adoption of the AWWMP in primary care by identifying the highest value contractual models (possibly including enhanced services) to deliver care along the pathway, aligned to prudent healthcare principles					
4.3	Align implementation of AWWMP with Accelerated Cluster Development					
4.4	Provide recommendations to the Strategic Programme for Primary Care (SPPC) to inform the use of the SPPC Fund to support obesity prevention and adoption of the AWWMP					
4.5	Advocate for a whole systems approach to supporting the public to access the AWWMP including, system leaders in both health and non-health sectors, as well as, the community					
4.6	Foster collaborative working to enable sharing of approaches/learning e.g. communities of practice, networks					
4.7	Support primary and community care to adopt a continuous improvement approach using the AWWMP minimum dataset and other mechanisms e.g. patient stories					
4.8	Work with primary and community care leaders and professional bodies to help the frontline workforce understand the importance of their role in talking to people about their weight, including social prescribers and the non-registered healthcare workforce					
4.9	Assess the resource requirements needed to implement the primary and community care elements of the AWWMP e.g. accommodation and equipment					
4.10	Support the generation and application of evidence needed to implement the primary and community care elements of the AWWMP					
4.11	Identify and apply the transferrable learning from supporting smoking cessation in primary and community care					

Appendix 2: Intervention Flowchart – Mapping a person's weight management journey