Bundle BCU Planning, Population Health and Partnerships Committee 3 September 2026

1 09:15 - PRELIMINARY MATTERS

1.1 09:15 - PP26.90 Welcome and Apologies
Clare Budden, Chair

1.2 09:16 - PP26.91 Declarations of Interest
Clare Budden, Chair

1.3 09:17 - PP26.92 Consent Agenda
The Committee Chair will note that there is a Consent Agenda (Section 3) and that any member of the Committee may request that an item be removed from the Consent Agenda and considered under the main agenda. Unless otherwise requested, the Committee will be asked to approve and note all Consent Agenda items in a single motion.

2 09:20 - STRATEGIC PRIORITIES

2.1 09:20 - PP26.93 Estates Strategy - Update
Stuart Keen, Director of Environment & Estates
PP26.93 - Estate Strategy SBAR Cover sheet
PP26.93.1 Estate Strategy SBAR - v1.0 - final draft

2.2 09:45 - PP26.95 Planning Maturity Matrix Self-Assessment 2026
Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning
PP26.95 FINAL - Planning Maturity Matrix Self Assessment Coversheet
PP26.95.1 PPHP - PMM Self-Assessment 03.09.26

2.3 10:05 - PP26.96 Quarter 1 Report - Annual Delivery Plan
Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning
PP26.96 FINAL - ADP Q1 Report Sept 2026

2.4 10:25 - PP26.97 Enhancing Care through Digital Development Report
Justine Parry, Acting Director of Digital, Data and Technology
PP26.97 Enhancing Care through Digital Development Report DDaT PPHP PPJ

2.5 10:45 - BREAK

2.6 10:55 - PP26.98 North Wales Approach to Prevention: Wellbeing, Prevention, Anchor Framework and Marmot Place
Jane Moore, Executive Director of Public Health
PP26.98 Prevention Framework Marmot PPHP Paper v1

2.7 PP26.99 Winter Resilience Planning 2026/27
Item Withdrawn

2.8 11:15 - PP26.100 North Denbighshire Sustainability Programme: Healthy Prestatyn Iach Boundary Change
Alison Kemp, Associate Director, Primary Care and Community Services
PP26.100 Healthy Prestatyn Boundary Change Sep 26 v0.3 ppj

2.9 11:35 - PP26.107 Pharmaceutical Needs Assessment
Jane Moore, Executive Director of Public Health

PP26.107 Pharmaceutical Needs Assessment
PP26.107.1 Appendix 1 - BCUHB PNA 2026 post consultation draft v1 copy

3 11:50 - CONSENT AGENDA

3.1 PP26.101 Unconfirmed Minutes of Meeting held on 02.07.26
Clare Budden, Chair
PP26.101 Minutes from PPHP Committee 02.07.26 V0.2 (Public)

3.2 PP26.102 Matters Arising & Action Log
Clare Budden, Chair
PP26.102 Summary Action Log PPHP Committee (Updated 27.08.26) Public

3.3 PP26.103 Citizen Experience and Engagement Report
Helen Stevens-Jones, Director of Partnerships, Engagement and Communications
PP26.103 Citizen Experience Report PPHP

3.4 PP26.104 Executive Director of Public Health Report
Jane Moore, Executive Director of Public Health
PP26.104 EDoPH Report Sept 2026 v2
PP26.104.1 Q1 Performance Report FINAL

3.5 PP26.105 Annual Update from the Health Protection Service 2025-2026
Jane Moore, Executive Director of Public Health
PP26.105 Annual Update from the Health Protection Service 2025-2026

3.6 PP26.106 Health Improvement Menu of Interventions Report
Jane Moore, Executive Director of Public Health
PP26.106 Draft BCUHB Health Improvement Menu of Interventions v4 - PPJ

3.7 PP26.94 Director of Planning Report
Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning
PP26.94 FINAL - PPHP Director of Planning Report

3.8 PP26.108 Welsh General Ophthalmic Services (WGOS) Annual Report 2025-2026
Chief Operating Officer
PP26.108 WGOS Annual Report Coversheet
PP26.108.1 Appendix 1 - WGOS Annual Report Template 2025-26 final

3.9 PP26.109 Board Assurance Framework 2026-2027
Pam Wenger, Director of Corporate Governance
PP26.109 Board Assurance Framework Report

3.10 PP26.110 Corporate Governance Report
Pam Wenger, Director of Corporate Governance
PP26.110 Corporate Governance Report

4 12:05 - CLOSING BUSINESS

4.1 12:05 - PP26.111 Agree Items for Referral to Board / Other Committees
Clare Budden, Chair

4.2 12:07 - PP26.112 Review of Meeting Effectiveness
Clare Budden, Chair

4.3 12:09 - PP26.113 Date of Next Meeting - 05.11.26

4.4 12:10 - PP26.114 Resolution to Exclude the Press and Public
"Those representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Planning, Population Health & Partnerships Committee

ESTATE STRATEGY – UPDATE

Dyddiad y Cyfarfod Date of Meeting	03 September 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Commercially Sensitive
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Stuart Keen; Director of Environment and Estates
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Stuart Keen; Director of Environment and Estates

Pwrpas yr Adroddiad Report Purpose	For Noting

**Crynodeb Gweithredol
Executive Summary**

The attached Situation, Background, Assessment and Recommendations (SBAR) paper and annexed copy of the Estate Strategy lists progress as well as examples where the Health Board has not met metrics. In addition, there has been a Audit Wales report from August 2026 on the NHS Estate.

Whilst the Health Board has made progress on the delivery of the objectives it recognises that the current Estate Strategy needs to be revised to align with the current development of Health Board Strategies as well as delivering operational efficiencies.

Until such time as a new Estate Strategy is developed and approved, the Health Board continues to follow the 2023-2033 Estate Strategy as approved 26th January 2023. This would be subject to the development and approval of specific Business Cases to ensure a process of review, alignment with strategies and monitoring.

In the meantime, the Health Board will be mobilising the review of the current strategies to include the Estate Strategy and commence data collection to inform future strategy setting.

The Committee is asked to note the contents of this report.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
N/A		

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
N/A	

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	3. Improve Access, Outcomes and Experience
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

Yr Egwyddorion Dylunio **Design Principles**	People First Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	All estate risks

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality**	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Part of implementation plan.
	Os naddo, dylech gynnwys y rheswm:	

Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)	If no, please include rationale:	
Asesiad o'r Effaith Economaidd-gymdeithasol *A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?* **Socio-Economic Impact Assessment** *Have you undertaken a Socio-Economic Impact Assessment*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Part of implementation plan.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	**Galluogwyr Ansawdd Enablers of Quality** Data to Knowledge	**Meysydd Ansawdd Domains of Quality** Person Centred
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: **Armed Forces Covenant Due Regard Duty** Have you considered the Armed Forces Covenant Due Regard Duty?	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	No impact
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	Yes (Include further detail below)	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Public accountability and image. Performance.	

Estate Strategy Update - SBAR

SITUATION

The Health Board has an Estate Strategy which was approved by the Board on 26th January 2023.

The Estate Strategy has been published and is used to some degree by the Health Board. However, in a healthcare environment which is dynamic for a number of reasons, the Estate Strategy needs review and updating. This has also been acknowledged by a draft All Wales Audit Report for August 2026 titled 'Are NHS estates fit for purpose?' It is anticipated that the Recommendations from that Audit will change a number of approaches and reporting/monitoring.

In parallel, the Health Board is reviewing the current Estate strategy and this is subject to on going discussions and will be included in wider conversations at Board Development Session on 27th August 2026 under the Interim Executive Director Transformation and Strategic Planning.

In the meantime, the current Estate Strategy remains valid and this paper reports on progress as well as the actions proposed to support the ongoing review.

BACKGROUND

The current Estate Strategy, included at Appendix 1 to this SBAR follows best practice as defined in Welsh Health Building Note 2018 – Estatecode Wales WHBN 00-08 namely the approach of defining:

1. Where are we now.
2. Where do we want to be.
3. How are we to get there.

Progress against delivery of the current Estate Strategy is summarised in the table below:

Estate Strategy Content	Requirement	Progress
2.1 Existing Estate Overview	The Estate Strategy stated c.238 properties.	According to Audit Wales, the number of properties is now 278 (2024-2025) an increase of 16.8%.
2.2 Estate Condition and Profile	The Estate Strategy lists a number of metrics for instance: Percentage Functional Suitable – 74% Space utilisation – 93%	According to Audit Wales, the same metrics for 2024/25 are: Percentage Functional Suitable – 80% Space utilisation – 95% Actual evidence from Royal Alexander Hospital Rhyl site monitoring reported an average utilisation of c.43%.

2.4.1 Physical Condition and Compliance (all Properties)	The Estate Strategy lists a number of metrics for instance: Percentage of Estate complying with statutory fire requirements – 64%	According to Audit Wales, the same metric for 2024/25 is: Percentage of Estate complying with statutory fire requirements – 76%
2.5 Estate overview	The Estate Strategy lists a number of metrics for instance: Risk adjusted backlog of £240m.	According to Audit Wales, the same metric for 2024/25 is: Risk adjusted backlog of £278m, an increase of 15.8%.
3.2 Strategic Context	The Estate Strategy refers to the June 2022 Clinical Services strategy listing 9 priorities: • Clinical, operational & financial sustainability • Holistic, person-centred care • Service user empowerment • Care closer to home • Improved population health and well-being • Integrated partnership working • Digital optimisation • Step-change towards decarbonisation • Anchor institution for social value.	These remain valid, but are to be developed as part of the ongoing Strategy Development.
4.2 Initial Agreed Priorities	The Estate Strategy listed 6 priorities: • Wrexham Maelor Hospital infrastructure continuity programme • Ysbyty Gwynedd fire compliance programme • Regional Treatment Centre programme and expanded orthopaedics capacity • Royal Alexandra Hospital development project • Replacement of the Ablett Unit at Glan Clwyd Hospital • Medical and Health Sciences School	In all cases, material progress has been made: • A revised and reduced scope programme of resilience works are ongoing. • Ysbyty Gwynedd fire compliance programme is in progress • The Llandudno Orthopaedic Hub project is in progress. • Phase 1 of the Royal Alexandra Hospital development has commenced. • Progress was made of the replacement of the Ablett Unit but this is now paused pending a developing national strategy.

		• The business case for the medical school has progressed.
4.3 Opportunities – Acute Sites	The Estate strategy listed a number of opportunities such as: • Electrical infrastructure works at Ysbyty Glan Clwyd.	Material progress has been or is being made: • A £2m programme of electrical infrastructure improvements at Ysbyty Glan Clwyd.
4.5 Opportunities – Health and Wellbeing Hubs	The Estate strategy listed 16 sites for Health and Wellbeing hubs.	Following further prioritisation, proposals are being progressed for 8 sites such as: • Caledfryn in Denbigh • Royal Alexandra Hospital in Rhyl. • Waunfawr. • Canolfan Lleu • Porthmadog • Holyhead • Bangor • Conwy
4.16 Measuring Success	The Estate Strategy listed 9 metrics to measure performance – see below.	Most metrics have a time line to 2033 but as noted above, some progress has been made. However, applying a key metric of a Planned Reduction in Property Portfolio of 5% per IMTP cycle has not been met evidenced by the increase in the number of properties.

Indicator	Definition	Target
Revenue cost	Reduction in estate revenue cost	3% per IMTP cycle
Property portfolio	Planned reduction in property portfolio	5% per IMTP cycle
Statutory Compliance	A minimum of 90% of the estate should comply with relevant statutory requirements	Meet national target within 10 years
Fire Safety Compliance	A minimum of 90% of the estate should comply with relevant statutory requirements	Meet national target within 10 years
Energy Performance	The estate should consume no more than 410 kWh/m²	Meet national target within 10 years
Backlog maintenance (BLM)	• 90% reduction in high risk BLM • 75% reduction in significant risk BLM • 70% reduction in risk adjusted BLM	Meet target within 10 years
Physical condition	A minimum of 90% of the estate should be sound, operationally safe and exhibit only minor deterioration	Meet national target within 10 years
Functional Suitability	A minimum of 90% of the estate should meet clinical and business operational requirements with only minor changes needed	Meet national target within 10 years
Space Utilisation	A minimum of 90% of the estate should be fully used	Meet national target within 10 years

ASSESSMENT

As noted in the summary above, there is evidence of progress being made against the objectives in the 2023-2033 Estate Strategy. There is also evidence that the baseline assumptions are no longer valid.

To begin to develop an fit for purpose Estate Strategy, the following Stages are being implemented:

1. <u>Where are we now (next 3 to 6 months).</u>

   The Health Board is commencing collating the following:
   a) A list of properties, age, tenure and responsible party
   a) Updating the estate utilization data
   b) Backlog cost and status
   c) Energy Performance data
   d) Functional Suitability and Zones
   e) Compliance data
   f) Risk Register and Datix/Near Miss data as well as EPR returns
   g) Infrastructure capacity
   h) Staff satisfaction data if available
   i) PFI Contract exit strategy
   j) Digital infrastructure
   k) Workforce Plan – Apprenticeships

l) Local Development Framework
m) Financial models and commercial opportunities/charity

Estates are supporting the Board Development Strategy session.

2. Where do we want to be (timescale to be confirmed).

The Health Board develops their strategies:
a) NHS Wales Decarbonisation Strategic Delivery Plan
b) Clinical Service Plans – Regional and National
c) Alignment with other strategies, such as:
    a. TrAMS
    b. IRCF Programme alignment
    c. All Wales Mental Health Strategy
d) Financial models/funding

3. How are we to get there (estimated to be 6 to 12 months after Stage 2).

The health Board starts to develop the new Estate Strategy, perhaps in stages, to cover:
a) Strategic Retention and Disposal – Site Rationalisation Plan
b) Partnership Opportunities (One Public Estate)
c) Cost modelling; value for money and estate model
d) Option Modelling
e) Masterplan modelling
f) Risk assessment
g) Phasing
h) Commercial opportunities
i) Approval, Implementation and Monitoring together with Review processes

RECOMMENDATION

Until such time as a new Estate Strategy is developed and approved, the Health Board continues to follow the 2023-2033 Estate Strategy as approved 26th January 2023. This would be subject to the development and approval of specific Business Cases to ensure a process of review, alignment with strategies and monitoring.

The Health Board shall implement the final agreed Recommendation from the August 2026 Audit Wales report which in turn shall be subject of separate approval.

In the meantime, the Health Board will be mobilising the review of the current strategies to include the Estate Strategy and commence data collection to inform future strategy setting.

The Committee is asked to note the contents of this report.

Appendix 1 – Betsi Cadwaladr University Health Board 2023-2033 Estate Strategy

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Planning, Population Health & Partnerships Committee

PLANNING MATURITY MATRIX SELF-ASSESSMENT 2026

Date of Meeting	03 September 2026
Publication Status	Open / Public
	Not Applicable
Report Author name and title	Emma Lea, Assistant Director of Corporate Planning (Interim)
Lead Executive Team Member name and title	Paolo Tardivel, Executive Director of Transformation & Strategic Planning (Interim)

Report Purpose	For Approval

Executive Summary

This paper presents the draft NHS Wales Planning Maturity Matrix (PMM) 2026 Organisational Self-Assessment and seeks PPHP's support for onward submission to the Board for approval to submit to Welsh Government.

The assessment demonstrates significant progress within all six planning maturity domains during the past year, including strengthened strategic planning arrangements, governance and assurance processes, integration of enabling functions, stakeholder engagement, organisational learning and delivery oversight.

The 2026 refresh has adopted a more rigorous and evidence-based assessment methodology, placing greater emphasis on demonstrating implementation, organisational adoption, measurable impact and outcomes rather than the existence of planning frameworks and processes alone. Consequently, whilst overall maturity ratings remain unchanged from the previous assessment in November 2025, the review provides a more robust, balanced and defensible reflection of current organisational maturity.

This approach has been informed by feedback received from Welsh Government on the 2025 PMM Self-Assessment, which indicated that Health Boards had generally assessed themselves at a higher level of maturity than Welsh Government considered evidenced through the submissions. In response, particular emphasis has been placed on ensuring that self-assessed ratings are supported by clear, demonstrable evidence and that the rationale for each assessment is transparent and capable of withstanding external scrutiny.

The self-assessment identifies areas where significant progress has been made and highlights opportunities to further strengthen implementation, consistency and evidence of impact. The accompanying improvement actions are intended to support continued development of planning maturity and position the Health Board to demonstrate further progression in future assessments.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome, Evidence and Data**
N/A		

Acronyms / Glossary of Terms	
IMTP	Integrated Medium-Term Plan
PMM	Planning Maturity Matrix Self-Assessment
PPHP	Planning, Population Health and Partnerships
SPSCG	Strategic Planning and Service Change Executive Delivery Group

PLANNING MATURITY MATRIX SELF-ASSESSMENT 2026

1. SITUATION

1.1. To present the draft NHS Wales Planning Maturity Matrix (PMM) 2026 Organisational Self-Assessment and seek SPSCG's support for onward submission to the Planning, Population Health and Partnerships Committee (PPHP) and Board.

2. BACKGROUND

2.1. The NHS Wales Planning Maturity Matrix provides a nationally recognised framework for assessing organisational planning capability and maturity across six core planning domains. The self-assessment supports organisational reflection, identification of development priorities and continuous improvement of planning capability.

2.2. The 2026 refresh has been undertaken following completion of the IMTP 2026-29 planning cycle and incorporates learning from:

- Welsh Government IMTP feedback;
- NHS Wales Executive Rapid Assessment findings;
- Outcomes from the PMM scoring workshop held on 24 June 2026;
- Reflection and Learning exercises;
- Contributions from Executive Directors, domain leads and subject matter experts; and
- Organisational developments undertaken during 2025/26 and 2026/27.

3. SPECIFIC MATTERS FOR CONSIDERATION

3.1. The 2026 Planning Maturity Matrix refresh demonstrates that significant progress has been made across all six domains during the past 9 months, since the first PMM Self-Assessment in November 2025. The Health Board has strengthened its strategic planning architecture through the implementation of the Integrated Planning Framework, establishment of a Continuous Planning Cycle, development of Strategic Intent Statements, strengthening of governance and assurance arrangements, improved alignment between planning and enabling functions, enhanced stakeholder engagement, and continued development of the Clinical Services Plan and long-term strategy programmes.

3.2. Notwithstanding these improvements, the refresh has deliberately adopted a more rigorous, evidence-based and challenge-focused approach to scoring. Consistent

with feedback received through Welsh Government review processes, the assessment has sought to distinguish between evidence demonstrating the existence of planning processes, governance structures and planning artefacts, and evidence demonstrating that these arrangements are consistently influencing decision-making, prioritisation, resource allocation, service redesign and organisational outcomes.

3.3. The review found that, in many areas, the Health Board has successfully established the foundations associated with higher levels of planning maturity. Notable developments during the reporting period include:

- Introduction of the Integrated Planning Framework;
- Establishment of a Continuous Planning Cycle;
- Development and implementation of Strategic Intent Statements;
- Strengthened planning governance and assurance arrangements;
- Improved alignment of workforce, finance, quality, digital and other key enabling functions;
- Development of the Clinical Services Plan and Long-Term Strategy programmes;
- Enhanced stakeholder and partner engagement arrangements; and
- Strengthened delivery monitoring, risk management and organisational learning processes.

3.4. While these developments demonstrate significant organisational progress, the review found that in several areas the organisation is still transitioning from establishing planning infrastructure and processes towards demonstrating consistent implementation, measurable impact and evidence and evidence of changed organisational decision-making. Consequently, the refresh adopts a more evidence-based assessment methodology, resulting in maturity scores that are considered robust, consistent and defensible.

3.5. Further evidence is required to demonstrate consistent implementation, organisational adoption and measurable impact before progression to the next maturity level can be confidently evidenced. As a result, although the overall domain scores remain unchanged from the previous assessment, the refresh provides a more robust, balanced and defensible assessment of current organisational maturity.

Domain	Self-Assessment 2025	Self-Assessment 2026
A) Strategy Development / Clarity of Purpose, Vision and Strategy • Key Enablers moved from score 2 to 3 but did not impact on overall score.	**2**	**2**
B) Strategy Alignment and Development of an IMTP • IMPT Development moved from score of 2 to 1* • Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan moved from score 2 to 3 • Triangulation of services moved scored from 1 to 2 **unable to meet "approved IMTP" criteria*	**2**	**2**
C) Dynamic & Engaged Planning	**3**	**3**
D) Operational Planning	**2**	**2**
E) Best Practice Approach to Improvement	**3**	**3**
F) Realistic & Deliverable • Risk Identification & Management score moved from 2 to 3 • Development of IMTP and track record score moved from 1 to 2	**2**	**2**

3.6. Importantly, the static headline scores should not be interpreted as an absence of progress. Rather, they reflect a conscious effort to ensure the assessment is realistic, evidence-based and capable of withstanding external scrutiny. The Health Board is demonstrably more mature than at the time of the previous assessment and is now better positioned to evidence progression in future years as current programmes move from development into implementation and delivery.

3.7. Next Steps. Subject to SPSCG support, the PMM Self-Assessment will be presented to:

- ♣ Planning, Population Health and Partnerships Committee for review and recommendation;
- ♣ Board for approval; and
- ♣ Welsh Government in line with required submission timescales (November 2026).

4. KEY RISKS/MATTERS FOR ESCALATION

4.1. No key risks or matters for escalation.

5. RECOMMENDATIONS

5.1. The Group is asked to:

- **NOTE** the findings and proposed maturity ratings within the 2026 Planning Maturity Matrix Self-Assessment; and
- **SUPPORT** onward submission of the assessment to the Planning, Population Health and Partnerships Committee and subsequently the Board for consideration.

ASSESSMENT	
Link to Strategic Priorities	4.Create a Modern, People Centred Healthcare System
	If more than one applies, please list below: 4. Improving quality, outcomes and experience
Design Principles	Consistency with Organisational Values If more than one applies, please list below: All design principles applied through the various key programmes.
Corporate Risks and Board Assurance Framework	Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)
	Not Applicable
	If more than one applies, please list below:

IMPACT ASSESSMENTS		
Equality *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	*Individual programmes will complete as appropriate.*
Socio-Economic Impact Assessment *Have you undertaken a Socio-Economic Impact Assessment*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	*Individual programmes will complete as appropriate.*
Have you undertaken a Quality Impact Assessment Screening?	**Enablers of Quality** All Apply	**Domains of Quality** All Apply
	If more than one applies, please list below:	If more than one applies, please list below:
Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	

Environmental /Sustainability Impact (5Rs)	If more than one applies, please list below:	
	No - Not Applicable	
	If more than one applies, please list:	*Individual programmes will complete as appropriate.*
Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: ☐	No: ☒
	Outcome:	*Individual programmes will complete as appropriate.*
	If no, please include rationale:	
Data Protection Impact Assessment *Have you undertaken a Data Protection Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	*Individual programmes will complete as appropriate.*
Counter Fraud Impact Assessment *Have you considered the counter fraud impacts*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	*Individual programmes will complete as appropriate.*
Legal	There are no specific legal implications related to the activity outlined in this report.	
Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Betsi Cadwaladr University Health Board (BCUHB)

NHS Wales Strategy and Planning Maturity Matrix (PMM)

2026 Organisational Self-Assessment: Evidence Review and Maturity Assessment

Document Control

Prepared by	Corporate Planning Team
Document Status	DRAFT pending Board Approval
Version	V0.16 PPHP
Date	10 August 2026
Intended Approval Route	SPSCG - PPHP - Board

Betsi Cadwaladr University Health Board - Strategy and Planning Maturity Matrix Self-Assessment - August 2026

Domain	Self-Assessment 2025	Self-Assessment 2026
A) **Strategy Development / Clarity of Purpose, Vision and Strategy** Key Enablers moved from score 2 to 3 but did not impact on overall score.	**2**	**2**
B) Strategy Alignment and Development of an IMTP • IMPT Development moved from score of 2 to 1* • Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan moved from score 2 to 3 • Triangulation of services moved scored from 1 to 2 *unable to meet "approved IMTP" criteria	**2**	**2**
C) Dynamic & Engaged Planning	**3**	**3**
D) Operational Planning	**2**	**2**
E) Best Practice Approach to Improvement	**3**	**3**
F) Realistic & Deliverable • Risk Identification & Management score moved from 2 to 3 • Development of IMTP and track record score moved from 1 to 2	**2**	**2**

The Health Board's overall Planning Maturity Matrix scores remain unchanged from the previous assessment; however, this should not be interpreted as a lack of progress. Significant improvements have been made across all domains, including strengthening strategic planning, governance, engagement, integrated planning arrangements, risk management and the development of the Clinical Services Plan and long-term strategy. Many of the foundations associated with higher levels of maturity are now in place and are increasingly being embedded across the organisation.

This refresh has adopted a more rigorous and evidence-based approach to scoring, placing greater emphasis on demonstrating implementation, impact and organisational outcomes rather than the existence of frameworks, processes or governance arrangements alone. As a result, the assessment is considered more consistent, robust and defensible, whilst providing a more accurate reflection of current maturity. Although the headline scores have remained stable, the Health Board is in a significantly stronger position than at the time of the previous assessment and is well placed to demonstrate further progression as current programmes move from development into implementation and delivery.

A) Strategy Development / Clarity of Purpose, Vision and Strategy

A) Strategy Development/Clarity of Purpose, Vision and Strategy - Crieria					
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Strategy & Plan (No Change)	No CSS or delivery plan in place but strategic framework for its development in development.	Draft CSS developed or in development.	Agreed CSS and development of a co-designed clinical services plan underway, with evidence of strong clinical, stakeholder and public engagement throughout. A patient led approach is evident.	Approved CSS and CSP. Implementation underway. Organisation actively identifies risks and opportunities, outcomes are regularly monitored, and planning is informed by data, horizon scanning, and cross-functional collaboration.	The organisation has a fully implemented CSS and CSP that is continuously reviewed and refined using real-time data and predictive insights. Regular strategic reviews (at least twice annually) are in place that enable flexible adjustments in response to emerging trends and priorities, in-year performance, and long-term opportunities. Strategic planning is agile, outcome-focused, and aligned with system-wide priorities, to maximise opportunities driving measurable improvements in performance and population health.

Vision & Purpose (No change)	Organisation is developing its vision and purpose. Clear outcomes are not yet defined.	Vision and purpose, scope and methodology agreed with clear commitment and leadership at a Board and strategy programme level. Clear outcomes are in development.	Organisational vision and purpose with defined outcomes are affirmed in public and internal documents. Organisation demonstrates proactive leadership at Executive and Board level.	Annual Board discussion takes place on organisational vision and purpose ensuring alignment with CSS and enabling plans, intended outcomes and the identification of risks/issues.	Have regular board debate, at least twice annually, on organisational vision and purpose, ensuring alignment with organisational actions, CSS, outcomes and performance and how in-year achievements, issues or opportunities impact on this. Organisation is able to flexibly adjust its CSS to maximise opportunities and remain responsive, outcome-focused, and future-ready.
Alignment of National Policy and All-Level partnership priorities (No change)	National policies and national, regional, local and partnership priorities are understood but are not yet translated into organisational strategies and plans.	National policies and national, regional and local priorities have been translated into strategic intent and agreed with stakeholders. WBFG Act and AHW are apparent and embedded in the agreed approach.	Organisational strategies and plans reflect national policies and national, regional and local health and partnership priorities. WBFG Act and AHW principles and integrated throughout.	Strategies and plans are regularly reviewed. They are aligned and responsive to national policy and legislation, and national/regional/local partnership priorities with clear links to the Regional Partnership Board and Public Service Boards.	Strategies and plans are regularly and proactively reviewed and aligned to emerging national policy and legislation, and local, regional and national partnership priorities. RPB's and PSB's are regularly engaged and involved in process. CSS outcomes demonstrate a contribution to the wider local economy, improved health and well-being and operational effectiveness.

Key Enablers (Increased from 2)	Key enablers—such as quality, safety, workforce, finance, digital technology, and research—are identified but not yet aligned to strategic planning. Their role in enabling delivery is recognised but not actively managed or coordinated.	Key enablers are identified, with plans underway to align them with the organisations overarching CSS. Quality expectations are defined, and initial steps taken to coordinate enabler contributions across programmes.	Key enablers are fully aligned with strategic objectives. Their potential is well understood and actively explored to support delivery. Quality expectations are clearly defined and embedded in planning processes, with enablers contributing to strategic coherence.	Key enablers underpin the development and delivery of the CSS and CSP. Opportunities linked to enablers are translated into actionable deliverables. Quality is integrated throughout the key enabling strategies and plans driving performance and improvement.	Key enablers are embedded across all strategic functions and are delivering measurable improvements and are considered best practice. Their impact is tracked through performance metrics, and they are continuously optimised to support innovation, agility, and system-wide transformation. Quality is not only integrated but drives strategic refinement and outcome achievement.
Engagement in Development (No change)	The duties of the Health and Social Care (Quality and Engagement) (Wales) Act (the Act) are identified as integral to the development and implementation of the CSS.	Engagement plans are in place to support the development of CSS.	Engagement plans are agreed and reflect strong clinical leadership. Plans meet the requirements of the Act	Plans are being implemented effectively with robust processes in place to capture diverse voices (internal and external) with strong clinical leadership, and where appropriate and necessary, offers opportunities for stakeholder involvement in shaping the development of CSS.	Organisation operates best practice and continuous engagement with both internal and external stakeholders, exemplifying the values seen in the quality and engagement act, ensuring voices from all communities are heard and reflected in the annual review of the CSS.

Population Health Needs Assessment (No change)	Plans are in place to undertake a population health needs assessment.	A basic high level population health needs assessment has taken place and is being used to shape the CSS.	CSS and CSP development is informed by population and health needs assessments and incorporates the wider determinants of health.	There is a single, detailed and regularly updated population health needs assessment in place. Strategies are updated regularly to clearly reflect the outcome of the assessment.	Population health needs assessment is recognised as best practice and is recognised and used by partner organisations (such as PSB and RPB) to form a common and shared understanding. CSS/CSP is regularly tested against current, emerging, and future population health needs.
Priorities & Achievability (No change)	The organisation does not have a prioritisation methodology or a recorded list of priorities. Planning is reactive and lacks strategic direction.	The organisation has an approved prioritisation framework related to population health needs assessment and has basic understanding of its priorities but is not yet reflected in plans. health needs.	A prioritisation framework is fully implemented. Priorities are recorded and aligned to population health needs assessments and Cabinet Secretary expectations. Early progress is made to reflect priorities in plans, with initial monitoring arrangements in place.	The organisation has a published, best-practice prioritisation methodology. It is fully aligned to population health needs and Cabinet Secretary expectations. Prioritised services are proactively reviewed and updated, with robust monitoring and governance of decisions embedded in planning cycles.	Prioritisation is embedded across all planning and decision-making processes. The methodology is sector-leading based on the outcome of the population health needs assessment and Cabinet Secretary's expectations. It is co-produced with stakeholders, and continuously refined through evidence, evaluation, and engagement. Priorities are transparently linked to outcomes, resource allocation, and national policy, with real-time

					monitoring and adaptive planning in place.
Horizon Scanning (increased from 1)	Horizon scanning is infrequent and informal, with no structured process or discussion at Executive or Board level. Strategic planning is reactive, lacking foresight into emerging risks, trends, or opportunities.	Annual horizon scanning is conducted to identify key risks and opportunities. Findings begin to inform strategic thinking, but integration into planning and governance remains limited.	Horizon scanning is carried out regularly and used to test and validate strategic plans against future trends and risks. Insights are reviewed annually and inform planning cycles, with growing Board-level engagement.	Horizon scanning is embedded into strategic planning and governance processes. Findings are discussed at Board level annually, and strategies are actively validated and adjusted based on emerging insights. The organisation uses structured methods to anticipate change and mitigate risk.	Horizon scanning is systematic, forward-looking, and published. It informs biannual Board-level strategic discussions and enables flexible, data-driven adjustments to CSS. Insights are used to anticipate future scenarios, align with system-wide priorities, and ensure the organisation remains agile, resilient, and future-ready.

A) Strategy Development/Clarity of Purpose, Vision and Strategy Self-Assessment[i]			
Domain	**Assessed level**	**Evidence Used**	**Any Supporting Narrative**
Strategy & Plan	**2** (No change) "Draft CSS developed or in development."	♣ Long Term Strategy Diagnosis Report Diagnosis Report - July 26.pdf & Companion Document to Diagnosis Report V0.2.docx ♣ Strategic Intent Statements, Strategic Intent Statements.pdf	The Health Board continues to strengthen its strategic planning framework through the coordinated development of the Clinical Services Plan (CSP), 10-Year Strategy, Strategic Intent Statements. The BCU 3 Year Plan 2026-29 has been designed around the emerging strategy and CSP work, and is framed on the four Strategic Intent Statements. Whilst the Clinical Services Plan remains under development, significant progress has been made in establishing the strategic foundations required to support long-term service transformation, organisational recovery and sustainable service delivery. The Foundations for the Future Programme, together with the CSP Programme, provides a structured programme for organisational redesign supported by formal governance, Executive oversight and Board Development. The Diagnosis Report establishes a comprehensive evidence base that is informing future strategic priorities, service models and organisational change. The Diagnosis Report was considered by the Strategic Planning and Service Change Group (SPSCG) (4 and 24 June 2026) and the Planning, Population Health and Partnerships Committee (PPHP) (2 July 2026). The Health Board continues to build on its extant Clinical Services Strategy whilst developing a refreshed strategic framework through the CSP and 10-Year Strategy. Clinical, stakeholder and partner engagement has informed the

			development of these programmes, For example: Strategy Workshop on 8th October 2025 supported by the Bevan Commission, and with the Regional Partnership Board e.g. 19th November 2025. Further co-design, formal approval and implementation is required before progression to the next maturity level. **Maturity Justification** The Health Board remains assessed at **Level 2**. Evidence demonstrates significant progress in developing a coordinated strategic planning framework through the Clinical Services Plan, 10-Year Strategy and Strategic Intent Statements, supported by strengthened governance, and engagement. Whilst the strategic foundations are well established, the Clinical Services Plan remains under development and further co-design, formal approval and implementation are required before progression to **Level 3** can be evidenced.
Vision & Purpose	**2** (No change) Vision and purpose, scope and methodology agreed with clear commitment and leadership	♣ Draft organisational **Vision Statement.** FINAL Health Board Vision and Strategic Intentions paper January 2026_cover sheet ENG.pdf FINAL Health Board Vision and Strategic Intentions Report January 2026 ENG.pdf	Whilst the Health Board does not yet have a formally approved and published Vision Statement Board and Executive led sessions and engagement is informing and shaping strategic planning, organisational priorities and future service transformation. Significant progress has been made in establishing a shared organisational purpose through the co-development of the four Strategic Intent Statements, which now provide the strategic framework for the IMTP 2026-29, organisational priorities, investment decisions and transformation programmes. The development of the 10-

	at a Board and strategy programme level. Clear outcomes are in development.		Year Strategy and Clinical Services Plan is supported by established programme governance, Executive leadership and stakeholder engagement, demonstrating a clear organisational commitment to long-term strategic planning. Board Development Sessions and Executive strategic planning discussions held both prior to and throughout the development of the 3-Year Plan on 11/12/2025 informed and shaped the emerging organisational vision, strategic priorities and long-term ambitions. Activities were planned in advance and scheduled through the Board Development Workplans demonstrating clear and proactive commitment and leadership from the Board level and strategy programme level, strengthening a move towards Level 3. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2**. Evidence demonstrates significant progress in developing a clear organisational vision and purpose through the Strategic Intent Statements, the emerging 10-Year Strategy, Clinical Services Plan and strengthened Executive and Board leadership. Clear strategic outcomes are being developed and increasingly inform organisational planning. However, the organisational vision has not yet been formally approved or embedded within public and organisational documentation. Further implementation, organisational adoption and evidence of impact are required before progression to **Level 3** can be evidenced.

Alignment of National Policy and All-Level partnership priorities	**2** (No change) National policies and national, regional and local priorities have been translated into strategic intent and agreed with stakeholders. WBFG Act and AHW are apparent and embedded in the agreed approach.	♣ BCU 3 Year Plan 2026-29: BCUHB Narrative Plan 2026-29.pdf ♣ Appendix 1 to the BCU 3 Year Plan – Mapping Document: Appendix 1- BCU 3 Year Plan Mapping Document.pdf ♣ Health Board Well-being Statement 2025-2026: FINAL Well-being Statement 300726.docx	National, Regional and Local priorities are reflected within the co-created Strategic Intent Statements and form the basis of the development of the Health Board's 3 Year Plan. Planning Guidance issued to services sets out the strategic framework and assumptions leading to the development of service level plans. The 3-Year Plan, demonstrates clear alignment to A Healthier Wales, the NHS Wales Planning Framework, Technical Planning Guidance, Cabinet Secretary priorities, Special Measures de-escalation criteria and Ministerial Advisory Group recommendations. Strategic planning is increasingly informed through collaboration with the Regional Partnership Board (RPB), Public Services Boards (PSBs) and wider system partners (example in Strategy and Plan domain above). The ongoing refresh of the Regional Population Needs Assessment, together with the development of the Equality Outcomes Framework, strengthens the consideration of population need, health inequalities and partnership priorities within organisational planning. The Health Board continues to strengthen alignment with national policy through implementation of the Well-being Statement 2025–2026, statutory equality commitments and participation in national programmes (e.g. National Clinical Services Plan, National Service Change Framework) as well as participating in national programmes (e.g. Once for Wales programmes, including: Listening to People, Duty of Candour, Duty of Quality. These arrangements support

			increasing alignment between national direction, regional partnership priorities and organisational planning. Further work is being progressed to ensure wider partnership priorities are consistently reflected organisational strategies, service transformation and measurable planning outcomes across all planning programmes. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2**. Evidence demonstrates that national, regional and partnership priorities have been translated into the Strategic Intent Statements, IMTP and wider organisational planning, with the principles of the Well-being of Future Generations (Wales) Act and *A Healthier Wales* clearly reflected in the Health Board's strategic approach. Whilst there is clear evidence of alignment with national policy and statutory priorities, further embedding across organisational strategies and demonstration of measurable impact will be required before progression to **Level 3** can be evidenced.
Key Enablers	3 (Increased from 2) Key enablers are fully aligned with	♣ BCU Integrated Planning Framework 2025-27: FINAL Integrated Planning Framework 2025-27 - Board 27-11-25.pdf ♣ Planning Guidance 2025: FINAL Integrated_Planning_Guidance_2026_27 v3.3.pdf	The Health Board has strengthened the alignment of its key enabling functions with strategic planning through the Integrated Planning Framework and translated, via planning guidance issued, into the BCU 3 Year Plan 2026-29. Further progress has been made to embed enabling functions within organisational planning: The 3-Year Plan integrates enabling functions within the overarching plan, both in Section 4 “Strategic Priorities” and Section 5

	strategic objectives. Their potential is well understood and actively explored to support delivery. Quality expectations are clearly defined and embedded in planning processes, with enablers contributing to strategic coherence.	♣ Board Assurance Framework (BAF), Corporate Risk Register (CRR) and Risk Management Framework Corporate Risk Register and Board Assurance Framework - Betsi Cadwaladr University Health Board & Risk Management Framework.pdf	"Delivering the Plan". Enabling functions are fully aligned with the organisation's strategic objectives (Strategic Intent Statements) within the plan and are clearly visible. A Collaborative Planning Group was established to support the coordination and collaboration of enabling departments (Finance, Workforce, Planning, Performance, DDaT, Quality, Equalities, and Estates) to support alignment of enabling functions within the overarching planning process providing a mechanism to align interdependent areas of working and contribute to delivery of organisational priorities. Quality expectations are more clearly visible and defined both within planning guidance and templates, as well as within the plan. For example, the plan includes references to the Quality Management System, Duty of Quality, Welsh Government Quality Statements and established governance arrangements. The Annual Delivery Plan (Year 1 of the 3 Year Plan) has been fully aligned to the Board Assurance Framework (BAF), aligning governance and strengthening organisational assurance, planning coherence and delivery confidence. **Maturity Justification** The Health Board is appropriately assessed at Level 3. Evidence demonstrates that key enabling functions including workforce, finance, digital, estates, quality, performance, equality and governance are aligned with organisational strategic objectives and are embedded within the IMTP, Integrated Planning Framework and supporting

			enabling strategies. Quality expectations are integrated throughout planning processes, and enabling functions increasingly support organisational coherence, delivery assurance and strategic decision-making. Continued evaluation of organisational impact, service outcomes and delivery benefits will further strengthen planning maturity.
Engagement in Development	**2 (No movement)** Engagement plans are in place to support the development of CSS.	♣ Clinical Services Plan Strategic Engagement Workshop Report (8 October 2025. Strategy Workshop Output Report_8th October 2025.pdf ♣ Community by Design (CbD) Engagement Report (16 December 2025). Community by Design Output Report _V 1.0.pdf ♣ Clinical Services Plan Engagement Summary Report (May-June 2026). CSP event output report v3.pdf ♣ Engagement through the Strategic Planning and Service Change Group (SPSCG), Board Committees and wider governance arrangements supporting strategic planning and organisational development. CSP Progress Report - SPSCG 26-06-04.pdf	Engagement is an important and integral part of the Health Boards approach in the development of the Strategy and Clinical Services Plan as well as other key service changes. The engagement programme reflects the principles of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, with an emphasis on involving patients, staff and partners in the development of strategic plans. A number of events and engagement activities have been undertaken by the Health Board across internal and external partners, including: ♣ A Regional Workshop on 8th October 2025, widely attended by Health Board and key regional partners, led to the co-creation of the 4 Strategic Intent Statements. The outputs were outlined within the Clinical Services Plan Strategic Engagement Workshop Report, capturing stakeholder perspectives to inform the scope, strategic principles and direction of the Clinical Services Plan ♣ Extensive and varied engagement with clinicians, staff, partners, patients and wider stakeholders, supported by strong Executive clinical leadership through the Executive Medical Director has been undertaken to develop the emerging Clinical Services Plan (CSP), including

		♣ Board Development Sessions supporting discussion of the Health Board's future strategic direction, organisational purpose and long-term ambitions. ♣ Regional Partnership Board (RPB) presentation 16 January 2026 DRAFT-RPB - IMTP 2026-01-16 v01.pptx and FINAL RPB - IMTP 2026-01-16 CY.pptx	♣ Engagement through the Strategic Planning and Service Change Group (SPSCG), Board Committees and wider governance arrangements supporting strategic planning and organisational development. Board Development Sessions supporting discussion of the Health Board's future strategic direction, organisational purpose and long-term ambitions. ♣ Engagement approaches adopted through the Tywyn and Penley Community Hospital programmes demonstrate effective collaboration with staff, communities and stakeholders, with the approach recognised by Llais as an example of effective engagement practice. ♣ Community by Design (CbD) Engagement Report (16 December 2025), brought together senior leaders to develop a shared understanding of integrated, community-based models of care and their contribution to the emerging Clinical Services Plan. Engagement and collaboration continue into 2026 for example: ♣ Clinical Services Plan Engagement Summary Report (May-June 2026), summarising outputs from the CSP Engagement Event (5 May 2026) and subsequent Clinical Focus Groups that informed the emerging Case for Change, future service models and service transformation priorities. ♣ Ongoing collaboration on 10th July 2026 with the Regional Partnership Board, wider partners and

			organisational governance groups to continue to align priorities through its planning processes. These activities have established a shared understanding of current challenges, future opportunities and the principles that will inform the development of the Strategy and Clinical Services Plan. The Health Board acknowledges that whilst engagement activity is well established, further evidence is required to demonstrate how stakeholder engagement consistently influences strategic decision-making, service redesign and organisational priorities throughout the development and implementation of the Clinical Services Plan. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2**. Evidence demonstrates that structured engagement arrangements are supporting the development of the Clinical Services Plan and wider strategic planning, underpinned by increasing clinical leadership and broad stakeholder involvement. Engagement activities reflect the principles of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and are informing the development of future organisational priorities. However, further evidence is required to demonstrate that engagement consistently shapes strategic decision-making, service design and implementation before progression to **Level 3** can be evidenced.

Population Health Needs Assessment	**2** (No change) A basic high level population health needs assessment has taken place and is being used to shape the CSS.	Long-Term Strategy Diagnosis Report (evidenced above)	The Long-Term Strategy Diagnosis Report (evidenced above) contains two sections on Population Need and Prevention. This Population health intelligence, including the wider determinants of health, is being used to directly inform strategic planning, priority setting and organisational decision-making. Public Health expertise, demographic analysis and population health evidence have supported the development of the Strategic Intent Statements and the emerging Clinical Services Plan (CSP), strengthening the consideration of population need, prevention and health inequalities within organisational planning. The Health Board is a key partner and contributor to the ongoing refresh of the Regional Population Needs Assessment (RPNA). This, together with development of the Health Equity Framework, provides an important opportunity to strengthen the systematic use of population health intelligence and the wider determinants of health within future strategic planning, service transformation and resource allocation. The Health Board continues to strengthen its evidence-based approach to planning. Development of the Clinical Services Plan methodology includes proposals for a Population Health Needs Checklist, supporting the consistent consideration of population need, prevention, health inequalities and wider determinants of health throughout the planning process. The Health Board's 3 Year Plan has a much stronger and visible narrative for population need. Population health data packs and needs profiles supporting Clinical Services Plan

			workshops, clinical focus groups and strategic planning discussions. In response to Welsh Government feedback, greater emphasis is being placed on demonstrating how population health intelligence informs organisational priorities and planning decisions, rather than simply evidencing the existence of population health assessments. Whilst evidence demonstrates increasing use of population health intelligence, further work is required to consistently demonstrate its influence on strategic decision-making, investment decisions and service redesign. Following the Reflection and Learning exercise within the Health Board, work is in progress to build in a stronger focus on population need led plans and alignment to Health Equity Checklist within its planning guidance and framework. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2**. Evidence demonstrates that population health needs assessments and Public Health intelligence are increasingly informing the development of the IMTP, Strategic Intent Statements and the emerging Clinical Services Plan. The ongoing refresh of the Regional Population Needs Assessment and development of the Health Equity Framework provide a stronger foundation for needs-based planning and consideration of the wider determinants of health. However, further evidence is required to demonstrate the consistent application of population health intelligence across organisational strategies, service

			transformation and resource allocation before progression to **Level 3** can be evidenced.
Priorities & Achievability	**2** (No change) "The organisation has an approved prioritisation framework related to population health needs assessment and has basic understanding of its priorities but is not yet reflected in plans. health needs."	♣ Example of briefing sheets Chief Exec to 121 IMTP priority setting meeting dates: Briefing Sheet for Chief Digital & Information Officer v2.0.docx and Briefing sheet for Executive Director of Public Health v2.0.docx	The Health Board is in the process of establishing an organisational Prioritisation Framework. It has a Prioritisation Framework that it applied to decision making with regards to funding allocation of an investment pot where it was informed by organisational objectives, population health need, financial sustainability, workforce capacity and statutory requirements. The organisation acknowledges that it requires a formal prioritisation framework that is applied across the whole organisation and this is a deliverable within the BCU 3 Year Plan for 2026-27. Notwithstanding the absence of an approved organisation wide framework, the principles are increasingly being applied to support decision-making across planning, investment and service development. Prioritisation discussions have taken place through Executive review sessions (example of briefing sheets provided), Board Development Sessions, Committee scrutiny and programme governance arrangements. This has enabled the Health Board to review competing priorities, consider affordability and capacity constraints, and focus planning on key organisational objectives, including Special Measures improvement and de-escalation priorities. During development of the BCU 3 Year Plan 2026-29, organisational priorities were consolidated under the Strategic Intent Statements, providing a clearer articulation

			of those areas judged to have the greatest strategic importance. The planning process required services and programmes to demonstrate alignment with these priorities, available resources and organisational planning assumptions, strengthening the link between prioritisation and planning decisions. The Health Board is also strengthening transparency by developing a Joint Decision-Making and Prioritisation Framework through the Foundations for the Future programme. Whilst not yet fully embedded, this work will support a more consistent organisational approach to prioritisation, including prioritisation, sequencing and where necessary de-prioritisation of activity. Prioritisation arrangements are increasingly being used to inform organisational planning and decision-making. However, further work is required to demonstrate their consistent application across all services and to evidence how prioritisation decisions directly influence investment choices, resource allocation, service redesign and monitoring arrangements. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2**. Evidence demonstrates the existence of an approved prioritisation approach and a growing organisational understanding of strategic priorities, reflected through the Strategic Intent Statements and the development of the BCU 3 Year Plan 2026-29. Prioritisation considerations are increasingly informing planning discussions, resource decisions and organisational focus. However, evidence of

			consistent organisational application, documented prioritisation and de-prioritisation decisions, and routine integration within planning, investment and performance management arrangements remains at an early stage. Further implementation and demonstrable impact will be required before progression to **Level 3** can be evidenced
Horizon Scanning	**2 (increased from Level 1)** Annual horizon scanning is conducted to identify key risks and opportunities. Findings begin to inform strategic thinking, but integration into planning and governance remains limited.	♣ **Board Development Sessions** FINAL - Informal Board Development - IMTP 2025-12-11.pptx ♣ **Workforce planning**, Strategic-Workforce-Planning-Framework-2026.pdf	The Health Board recognises Horizon Scanning as an important component of mature planning and is strengthening its approach through the development of a Horizon Scanning Discussion Paper alongside the Unified Modelling proposal. This work has established a baseline assessment of current capability, identified organisational strengths and development opportunities, and is informing a more coordinated approach to the identification and interpretation of emerging risks, opportunities and future trends. Evidence demonstrates that Horizon Scanning activities are undertaken across a range of corporate, clinical and operational functions, although these have largely developed independently in response to local planning, professional and statutory requirements rather than through a single organisational methodology. Examples include: ♣ Board Development Sessions that consider long-term strategic direction, emerging risks, future opportunities and organisational sustainability. ♣ Strategic Intent Statements and development of the emerging 10-Year Strategy, supported by population

			health intelligence and evidence-based consideration of future service sustainability. ♣ Workforce planning activities, including nurse staffing reviews and succession planning, which take account of legislative, social, economic and political developments affecting future workforce sustainability. ♣ Demand and capacity modelling within the Integrated Planning Framework, supporting consideration of future service demand, workforce requirements and resource implications. These activities are increasingly informing strategic thinking and future planning priorities. However, the application of horizon scanning intelligence remains variable across the organisation and is not yet consistently embedded within governance, decision-making and planning processes. **Maturity Justification** **Level 2** assessment is appropriate. Evidence demonstrates that Horizon Scanning is undertaken across a range of corporate, clinical and operational functions to identify emerging risks, opportunities and future trends relevant to strategic planning, workforce sustainability and service development. Activities such as Board Development Sessions, Strategic Intent development, workforce planning and demand modelling show that forward-looking intelligence is beginning to influence organisational thinking and planning priorities.

			The Horizon Scanning Discussion Paper has provided a baseline assessment of current organisational capability and identified opportunities to strengthen consistency, coordination and organisational learning. While horizon scanning intelligence is increasingly informing strategic discussions and future planning activity, a formal organisational methodology, systematic application across planning cycles, and stronger integration into governance and decision-making processes are still developing. Consequently, the evidence demonstrates that Horizon Scanning has moved beyond an ad hoc approach and is informing strategic thinking, but has not yet reached the level of organisational integration and maturity required for Level 3.
Overall Judged Score	**2**	The Health Board has made significant progress in strengthening its strategic planning arrangements through development of the Strategic Intent Statements, 10-Year Strategy and Clinical Services Plan. However, much of the evidence demonstrates strategic development activity rather than implementation and impact. Whilst Key Enablers have progressed (2/8 have increased by one level) and we have demonstrated continued development for the remaining 6, the majority of component areas remain at Level 2, making an overall assessment of **Level 2 (Early Progress)** appropriate.	

Strategy Development/Clarity of Purpose, Vision and Strategy Actions						
Domain	**Assessed level 2026**	**Aspired Position**	**Action(s)**	**Timelines / Milestones**	**Evidence to be used**	**Impact Measurement**
Strategy & Plan	2	3	Complete and approve the 10-Year Strategy and Clinical Services Plan	Discovery Phase concludes **Q1** 2026/27; Draft Strategy Summer/Autumn 2026; Final approval by end 2026; CSP Discovery Report Sept 2026	Approved Strategy Approved CSP Board approval Delivery roadmap	CSP priorities reflected in the IMPT and Directorate plans
Vision & Purpose	2	3	Finalise and embed the organisational vision and strategic outcomes within planning, governance and decision-making processes	Final Vision as output of Strategy Discovery Phase during 2026	Approved Vision Statement; Board approval; committee papers; planning guidance; directorate plans.	Strategic outcomes routinely referenced in business cases, plans and Board decision-making.
Alignment of National Policy and All-Level partnership priorities	2	3	Strengthen the translation of national, regional and partnership priorities into organisational planning	Ongoing throughout IMTP period	IMTP mapping documents; planning guidance; policy alignment reviews.	Evidence of organisational priorities and deliverables linked to national and partnership priorities.

			and service redesign activity.			
Key Enablers	3	4	Strengthen alignment between enabling strategies and organisational priorities through the Integrated Planning Framework and planning cycle.	2026-29	Workforce, finance, estates, digital and quality strategies; planning submissions.	Evidence of enabling functions informing prioritisation, planning assumptions and delivery plans.
Engagement in Development	2	3	Continue engagement through Strategy and CSP development and strengthen recording of how feedback informs proposals.	Ongoing	Engagement reports; workshop outputs; consultation summaries.	Evidence of stakeholder feedback influencing strategic priorities or service model development.
Population Health Needs Assessment	2	3	Strengthen the use of population health and health inequalities intelligence within planning and prioritisation processes.	Health intelligence resources Q2 2026/27; PHM roadmap Q3 2026/27; PHM programme established Q4 2026/27	RPNA outputs; population profiles; Health Equity Framework; planning templates.	Increased evidence of population need informing priorities, service reviews and planning decisions.
Priorities & Achievability	2	3	Review and implement the organisational prioritisation framework as part of planning and	Review and Recommendations by Q3	Prioritisation Framework; Executive and Board papers; investment decisions.	Clearer evidence of prioritisation, sequencing and resource allocation decisions.

			investment decision-making.	Approval to implement Q4		
Horizon Scanning	2	2	Develop a consistent approach to horizon scanning to inform future planning assumptions and strategic discussions.	Q4 2026/27	Horizon Scanning papers; Board Development outputs; planning assumptions.	Emerging risks and opportunities reflected within strategic planning activity.

B) Strategy Alignment and Development of an IMTP

B) Strategy Alignment and Development of an IMTP - Criteria					
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
IMTP Development **1** (decreased from 2)	Organisation has an annual plan which responds to some but not all elements of planning framework and cannot provide a financially balanced plan over 3 years.	Organisation has an approved IMTP that aligns with the core elements of the planning framework. The plan demonstrates a structured approach to strategic priorities and is informed by baseline data. It includes initial consideration of risks, outcomes, and resource requirements.	IMTP meets almost all policy expectations and is tailored to deliver clear service transformation aligned with an agreed CSP and reflects a shift from operational delivery to strategic impact. Growing maturity in linking planning to measurable impact, return on investment, and strategic priorities. Risks are clearly identified, with evidence of controls and early mitigation strategies.	The IMTP meets all policy expectations and is consistently delivering against the quadruple aim and is embedded across the organisation and transforming services through the CSP. Risks across quality, access, workforce, and finance are actively managed with evidence of controls and mitigation and demonstrates clear alignment between planning, performance, and transformation.	The IMTP exceeds all national policy expectations. It is recognised as a benchmark for excellence, driving system-wide transformation and delivering sustained impact across the quadruple aim. The plan is co-produced, future-focused, and underpinned by robust evidence, innovation, and adaptive governance. It demonstrates clear and advanced triangulation, delivery timelines and milestones, and integrated risks and mitigation.

Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan **3** (increased from 2)	Some alignment is visible between the annual plan and CSS with the organisation planning on a continuous annual cycle.	Alignment is clear and coherent between the IMTP and CSS with the organisation planning on a continuous annual cycle.	The IMTP is tailored to deliver clear service transformation in line with an agreed Clinical Services Plan. Plans are directly linked to quality, performance and accountability and informed by detailed and future facing modelling.	Coherent aligned plans, including a commissioning plan are performance managed, with staff owning, adapting, acting on and learning from variation.	Planning is owned by all staff and fully integrated and aligned across organisational tiers and system partners. There is a clear golden thread between local, national and regional strategies and partnerships with dynamic alignment to the CSS and Plan, IMTP, commissioning intentions, resulting from horizon scanning results, detailed population health needs assessment and enabling strategies (e.g. workforce, digital, estates).
Triangulation of Services **2** (increased from 1)	Basic high-level triangulation is taking place between services, activity, workforce and finance.	Clear triangulation between services, activity workforce and finance.	Detailed triangulation between services, activity workforce and finance at service level. Triangulation between risk management and development of IMTP	Clear detailed and robust triangulation and analysis of activity, workforce and finance which considers other holistic requirements such as training and working regionally.	Triangulation is system-wide, predictive, and continuously refined through real-time data and advanced analytics. It informs strategic decision-making, resource optimisation, and service redesign across organisational boundaries. The organisation demonstrates a proactive approach to managing interdependencies, future workforce needs, financial sustainability, and service demand, with clear links to population health, regional collaboration, and innovation.
Commissioning	The Board sets out high level commissioning	The organisation has an approved	Commissioning decisions are	The organisation has a clear, transparent	Commissioning is strategically embedded across the organisation

1 (No change)	intentions primarily focused on statutory requirements and broad service categories. Commissioning is reactive, with limited strategic alignment or stakeholder engagement.	and operational commissioning process. Intentions begin to reflect service priorities and are informed by basic population health data and stakeholder input.	prioritised based on service need, population health data, and performance metrics. The impact of commissioned and supporting organisations is actively considered.	commissioning plan that includes a transparent prioritisation framework and actions for both commissioning and decommissioning ensuring risk to patients are minimised. Decisions are evidence-based, responsive to changing needs and communicated effectively to stakeholders.	and system, with clear alignment to the population health needs assessment, clinical priorities, and service transformation goals. The process is co-produced with stakeholders with a clear and transparent prioritisation framework, underpinned by robust evidence, and includes pro-active decommissioning where appropriate with detailed communication strategies. Commissioning decisions are transparent, equitable, and continuously evaluated for impact on quality, access, and outcomes.

Strategy Alignment, and Development of an IMTP – Self Assessment			
Domain	**Assessed level**	**Evidence Used**	**Any Supporting Narrative**
IMTP Development	**1** (decreased from 2) Organisation has an annual plan which responds to some but not all elements of planning framework and cannot provide a financially balanced plan over 3 years.	♣ Board-approved IMTP 2025- FINAL - BCUHB 2025-28 IMTP.pdf ♣ 3 Year Plan 2026-29 (Submitted) BCUHB Narrative Plan 2026-29.pdf and BCUHB Narrative Plan Appendices.pdf	The Health Board submitted its first Board-approved, financially balanced IMTP 2025-28 in March 2025. Whilst approval was subsequently withdrawn following deterioration in the underlying financial position, the process represented a significant step forward in organisational planning maturity and demonstrated the organisation's ability to develop an integrated medium-term plan. The Planning Maturity Matrix criterion for IMTP Development is explicitly linked to the existence of an approved IMTP. As the Health Board was unable to secure approval of its 2026-29 IMTP, it is unable to evidence achievement of the Level 2 descriptor at the point of assessment and therefore remains assessed at Level 1. The assessment reflects compliance with the criterion rather than a deterioration in organisational planning capability. Notwithstanding the assessment outcome, the Health Board has continued to strengthen its planning arrangements during the development of the 2026-29 Plan. Improvements include:

			• strengthened Planning Guidance and supporting tools to improve the quality and consistency of service-level planning; • improved alignment between strategic priorities, deliverables, impacts, milestones and risks; • clearer integration of workforce, finance, quality, performance and operational planning considerations; • enhanced mapping of Planning Framework requirements and Welsh Government priorities within the submitted plan; • clearer alignment between the Strategic Intent Statements and organisational priorities contained within the plan. Planning maturity has also been strengthened through the introduction of the Continuous Planning Cycle, implementation of the Integrated Planning Framework, organisational Reflection and Learning processes, and greater emphasis on year-round planning, monitoring and review rather than an annual planning exercise. Feedback received through Welsh Government review processes and the Rapid Assessment identified areas requiring further improvement but also recognised progress in the structure, format and overall development of the Health Board's planning approach. The organisation

			continues to use this feedback to strengthen future planning cycles and improve the credibility, deliverability and integration of future plans. Further development will focus on improving organisational planning capability, strengthening planning governance, embedding collaborative planning approaches, and ensuring planning assumptions are supported by increasingly robust intelligence, modelling and delivery assurance arrangements. **Maturity Justification** The Health Board is appropriately assessed at **Level 1**. The assessment reflects the absence of an approved IMTP at the point of review and therefore the organisation's inability to fully meet the Level 2 criterion. However, evidence demonstrates continued improvement in the quality and maturity of the planning process through strengthened governance, integrated planning arrangements, enhanced planning guidance, the introduction of a Continuous Planning Cycle and greater alignment between strategic, operational, workforce, quality and financial planning. Whilst these developments provide a stronger foundation for future IMTP submissions, sustained delivery and successful progression to an approvable IMTP will be

			required before advancement to Level 2 can be evidenced.
Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan	**2** (no change) "The IMTP is tailored to deliver clear service transformation in line with an agreed Clinical Services Plan. Plans are directly linked to quality, performance and accountability and informed by detailed and future facing modelling."	♣ BCU 3 Year Plan 2026-29 evidenced above	Noting the comments and starting point for both the Strategy development and the Clinical Services Plan, the Health Board has been able to demonstrate alignment between its strategic planning, service planning and operational delivery. The BCU 3 Year Plan 2026-29 is structured around the Strategic Intent Statements with its organisational priorities aligned to those statements. The Strategic Intent Statements provide the overarching framework for organisational planning, service transformation and strategic decision-making. Through the delivery of the Plan, the emerging CSP and Strategy will inform and shape the next planning cycle. Whilst the Clinical Services Plan remains under development, robust programme governance, mobilisation arrangements and supporting evidence have been established. The Strategic Intent Statements have provided a consistent 'golden thread' throughout the development of the Health Board's planning, aligning strategic priorities, transformation programmes, planning assumptions and service redesign activity.

			The newly introduced ‘continuous planning cycle’ will provide a structure and predictable timeline to ensure alignment between planning and strategy development (including the CSP) remain in step and drives plan development. The IPF provides the governance and planning architecture linking strategic planning, service planning and organisational delivery. In turn the Planning Guidance, informed from the Reflections and Learning work, will continue to strengthen this approach. Board Development Sessions, Executive oversight and Strategic Planning and Service Change Group (SPSCG) governance supporting the development and alignment of the Clinical Services Plan and long-term strategy. **Maturity Justification** The Health Board is appropriately assessed at Level 3. Evidence demonstrates a clear and systematic alignment between the Strategic Intent Statements, the emerging Clinical Services Plan, the 10-Year Strategy and the IMTP. Although the Clinical Services Plan has not yet been finalised, established programme governance, strategic alignment and integrated planning arrangements provide sufficient

			evidence that planning is being undertaken within a coherent and structured strategic framework.
Triangulation of Services	**2** (increased from 1) Clear triangulation between services, activity workforce and finance.	♣ BCU 3 Year Plan (Section 4) BCU 3 Year Plan (Section 4).pdf ♣ Minimum Data Set (MDS) MDS 2026-27_v17.04.26.xlsx ♣ Derived Demand Tool Foundation 2627 (Jan-Dec25) Breast.xlsx	The Health Board has strengthened the triangulation of planning, formalising this expectation within the IPF, and Planning Guidance and Templates. The expectation for services to work closely with enabling departments to triangulate demand, capacity activity, workforce, finance, performance, quality, risk and service planning within the Plan development process. This is supporting improved organisational visibility of interdependencies and more data led decision making. There is clear evidence of triangulation between services, activity, workforce and finance within the plan (Section 4). Further work to progress with a Unified Modelling approach to its demand, activity, finance, digital, estates and workforce is identified within the Plan for delivery in 2026. This will provide the groundwork to support and bolster planning infrastructure, providing stronger foundations for integrated and intelligence-led decision-making and future service planning. These developments demonstrate increasing maturity in the organisation's approach to triangulation. This will support the organisation in demonstrating its

			achievement of Level 3, before the end of the financial year. Weekly Planning Huddles (involving operational, planning and corporate leads from across the organisation) together with the Collaborative Planning Group, provide forums integrated planning, bringing together workforce, finance, performance, quality, risk and service planning to support the development and oversight of plans. Regular demand and capacity meetings to oversee the alignment to and development of the MDS took place throughout Quarter 3 and 4, informing trajectories and performance expectations. Example Trajectories meetings held 19/01/2026, 21/01/2026, 23/01/26, 28/01/26 **Maturity Justification** The Health Board is appropriately assessed at **Level 2**. Evidence demonstrates increasing maturity in the triangulation of workforce, finance, performance, quality, risk and service planning through the IMTP process and supporting planning arrangements. Whilst triangulation is becoming more systematic, further evidence is required to demonstrate its consistent application in strategic decision-making and organisational planning before

			progression to the next maturity level can be evidenced.
Commissioning	**1** (No change) The Board sets out high level commissioning intentions primarily focused on statutory requirements and broad service categories. Commissioning is reactive, with limited strategic alignment or stakeholder engagement.	♣ Commissioning Assurance Framework Commissioning Assurance Framework (CAF).pdf ♣ Refer to CE Briefing Sessions evidenced above. ♣ Refer to BCU Planning Guidance evidenced above	The Health Board establishes high-level commissioning intentions through its annual planning process, informed by Welsh Government priorities, Ministerial expectations, NHS Wales Planning Framework requirements, performance expectations and statutory obligations. As part of the development of the BCUHB Three-Year Plan (2026-29), the Chief Executive facilitated a series of Executive Team discussions to review national policy direction, planning guidance, performance challenges, financial constraints and emerging strategic priorities. These discussions were used to agree organisational priorities and planning assumptions to guide the development of plans across corporate and operational areas. The agreed priorities and commissioning intentions were subsequently reflected within organisational planning guidance issued to services, providing a consistent framework against which plans were developed. This included consideration of:

			• Welsh Government planning and accountability requirements. • Ministerial priorities and NHS Wales strategic expectations. • Performance and quality improvement requirements. • Financial sustainability and affordability challenges. • Population health needs and service transformation ambitions. • Partnership and regional working requirements. The Health Board also undertakes commissioning and contracting activity across a range of services through local, regional and national arrangements, working with organisations including the North Wales Joint Commissioning Committee (NWJCC), Regional Partnership Board (RPB), NHS Wales Shared Services Partnership (NWSSP) and local authority partners. Whilst commissioning activity is well established, organisational arrangements remain primarily focused on delivering statutory requirements, service provision and contractual management. Commissioning intentions are increasingly informing planning discussions and service transformation priorities; however,

			further development is required to establish a systematic strategic commissioning approach that consistently aligns commissioning decisions with population health needs, long-term service transformation and integrated planning objectives. The development of a corporate Commissioning Framework, alongside the Foundations for the Future programme, provides an opportunity to strengthen the alignment between commissioning intentions, planning priorities and resource allocation. **Maturity Justification** **Level 1** is currently appropriate. The Health Board has established arrangements for identifying and communicating high-level commissioning intentions through the annual planning process. Executive-led discussions consider Welsh Government expectations, Ministerial priorities, performance requirements, financial challenges and statutory obligations, with agreed planning assumptions reflected in organisational planning guidance. These arrangements provide a basis for services to develop plans aligned to corporate priorities.

			However, commissioning remains largely focused on responding to statutory requirements, performance pressures and operational service needs. While there is evidence of collaborative commissioning activity and increasing consideration of strategic priorities within planning processes, a fully developed strategic commissioning approach, supported by systematic stakeholder engagement and clear alignment between commissioning decisions, population health need and long-term service transformation, has not yet been consistently implemented. The development of a corporate Commissioning Framework represents a significant step toward strengthening organisational commissioning maturity but further implementation and evidence of impact will be required before progression to Level 2 can be demonstrated.
Overall Judged Score	**2**	The Health Board has continued to strengthen strategic alignment, planning processes and integrated planning arrangements. However, the absence of an approved IMTP, limited evidence of organisation-wide triangulation and the early maturity of commissioning arrangements indicate that the organisation remains within **Level 2 (Early Progress)** overall, albeit with evidence of strong improvement across several elements.	

Strategy Alignment and Development of an IMTP - Actions						
Domain	**Assessed level 2026**	**Aspired Position**	**Action(s)**	**Timelines/Milestones**	**Evidence to be used**	**Impact Measurement**
IMTP Development	**1**	2	Continue implementation of the Integrated Planning Framework and Continuous Planning Cycle to strengthen future IMTP development.	Throughout 2026-29	Planning guidance; Continuous Planning Cycle documentation; Reflection and Learning outputs.	Improved quality, integration and assurance of future IMTP submissions.
Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan	**3**	3	Strengthen alignment between emerging CSP priorities and future planning cycles.	CSP Discovery Report Sept 2026; detailed design late 2026.	CSP outputs; IMTP documentation; transformation programme plans.	Clear line of sight between strategic priorities, service transformation and IMTP deliverables.
Triangulation of Services	**2**	2	Progress Unified Modelling arrangements to strengthen triangulation of workforce, activity, finance and performance information.	Development during 2026/27	Unified Modelling outputs; planning assumptions; trajectories and demand modelling reports.	Increased evidence of planning decisions informed by triangulated information.

Commissioning	**1**	2	Develop organisational commissioning arrangements and strengthen links between commissioning intentions, planning and population need.	GDS contract Q2 2026/27; Social prescribing Q1-Q2 2026/27	Commissioning Framework; commissioning intentions; partnership agreements.	Improved alignment between commissioning activity and strategic priorities.

C) Dynamic and Engaged Planning

C) Dynamic and Engaged Planning - Criteria					
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Stakeholder Engagement **3** (No change)	Staff and partners are aware of CSS/CSP and there is a public commitment in place to undertake stakeholder engagement.	Organisational engagement is evident in practice and reflected in the CSS/CSP. Broad engagement to inform Equality Impact Assessments and Socio-Economic Duty Assessments.	Stakeholders are engaged in and co-design priority setting using the 'engagement cycle' model and a person-centred approach. Staff engagement at an organisation level is increasing.	Full and proactive continuous engagement including diverse communities which informs, owns and tests all impact assessments. Feedback from engagement activities influences and challenges the plan. Planning is also embedded and co-ordinated throughout the organisation.	Internal continuous engagement sees a fully engaged and informed workforce who are able to co-produce. Feedback and learning from continuous engagement activities including protected characteristic groups and socio-economic disadvantaged groups informs local priority setting and the development of the CSS/CSP.
Service Delivery Risk and Issue Management Approach **3** (No change)	Organisation has a service risk management approach in place, but it has not been fully adopted across all areas.	Organisation has service risk management approach embedded across all areas of the organisation and has robust plans in place to address / mitigate risks	A risk management approach is evident and consistent across organisation. The organisations top fragile services are identified.	The risk management approach enables the early identification of fragile or soon to be fragile services allowing for early intervention to ensure service sustainability. Organisation sees	Potential fragile services identified early and robust risk management across organisation pre-emptively responding to emerging service risks and the organisation is able to flexibly adjust plan. The Board are informed and regularly updated on fragile services and organisation rarely sees urgent service changes.

				less urgent service changes.	
Service Model / Regional Design **2** (No change)	Organisation has no route, or route is ineffective to discuss potential opportunities or joint risks. Regional collaboration is minimal, ad hoc, and lacks strategic intent.	Strengthened partnership working arrangements are in place. A methodology for working together is developed, with early efforts to align priorities and build trust.	Opportunities for regional working and shared solutions are identified and developed collaboratively. Planning is increasingly aligned across organisations, with joint priorities and resource sharing.	Agreed proposals for robust regional service models (e.g. consolidation, shared services) are in place and delivery is underway. Governance structures support joint accountability and performance management.	Regional collaboration is fully embedded, strategically led, and continuously evolving. The organisation is a proactive system leader, driving the development, implementation, and optimisation of shared service models and regional solutions. Collaboration is underpinned by co-produced strategies, shared governance, and dynamic intelligence. The organisation anticipates future needs, fosters innovation, and delivers measurable improvements in equity, efficiency, and outcomes across the region.

C) Dynamic and Engaged Planning - Self-Assessment			
Domain	**Assessed level**	**Evidence Used**	**Any Supporting Narrative**
Stakeholder Engagement	**3** (No change) Stakeholders are engaged in and co-design priority setting using the 'engagement cycle' model and a person-centred approach. Staff engagement at an organisation level is increasing.	♣ Stakeholder engagement programme supporting the development of the Clinical Services Board and Committee Report_HB_August 4th 2022_Clinical Strategy V 1.0.pdf ♣ Plan (CSP), including Phase 1 challenged services and Phase 2 programme development 5.1 Clinical Services Phase 1 Learning and Transition Report.docx ♣ Learning and Reflections Report 2026 FINAL - IMTP - Reflection & Learning Report - July 2026.pdf	The Health Board continues to strengthen stakeholder engagement as a core component of strategic planning and decision-making. Engagement increasingly supports the co-development of strategic priorities, service transformation and organisational planning, rather than acting solely as a consultation exercise. Development of the 3 Year Plan, Strategic Intent Statements and Clinical Services Plan has involved clinicians, operational services, corporate functions, partner organisations and wider stakeholders. Established governance arrangements provide structured opportunities to challenge, refine and validate planning assumptions. Examples include: ♣ Learning and Reflections Report on 2026-29 Planning Process ♣ Strategic engagement events and reports informing the development of the Strategic Intent Statements, emerging 10-Year Strategy and IMTP. ♣ Clinical Services Plan engagement involving clinicians, staff, partners and key stakeholders.

			♣ Staff engagement and organisational feedback, including Staff Survey outcomes. ♣ Strategic Equality Plan (2024-2028), Equality Stakeholder Group and Equality Duties Scrutiny Group supporting inclusive engagement. ♣ Regional Partnership Board (RPB) engagement and collaboration with partner organisations through existing committees and forums ♣ Engagement through the Strategic Planning and Service Change Group (SPSCG), Public Health Planning Forum, Local Planning Forum and other planning governance arrangements. ♣ Working with services and operational leads across the organisation to develop the 3-Year Plan (informed by engagement with operational services, corporate functions and partner organisations.) ♣ Board Development Sessions supporting strategic discussion, organisational learning and long-term planning. ♣ Stakeholder feedback informing planning priorities, service redesign and programme development. In response to Welsh Government feedback, greater emphasis has been placed on demonstrating how stakeholder engagement informs planning decisions, organisational priorities and service development. Evidence increasingly demonstrates that engagement

			contributes to organisational learning and the development of strategic programmes. Whilst stakeholder engagement continues to mature, further work is required to consistently evaluate its impact and demonstrate how feedback influences planning decisions and measurable organisational outcomes. **Maturity Justification** The Health Board remains appropriately assessed at **Level 3.** Stakeholder engagement is increasingly embedded within strategic planning and supported by structured governance, partnership working and collaborative programme development. Whilst evidence demonstrates a more integrated and evidence-informed approach, further evaluation is required to consistently demonstrate the impact of engagement on organisational decision-making and planning outcomes before progression to the next maturity level can be evidenced.
Service Delivery Risk and Issue Management Approach	**3** (No change) A risk management approach is evident and consistent across	♣ Gastroenterology Rapid Quality Review ♣ Health Board Risk Management Framework.pdf ♣ Board Assurance Framework (BAF), Corporate Risk Register (CRR) and Directorate risk registers Corporate Risk Register and Board Assurance	The Health Board has mechanisms in place to identify fragile services within the Health board, which applies a risk management approach. In April of this year (2026) using this methodology, the Health Board was able to confirm that Gastroenterology was a fragile service via the Rapid Quality Review. This work has helped inform the development of a framework (currently

	organisation. The organisations top fragile services are identified.	Framework - Betsi Cadwaladr University Health Board	in draft) to support early identification of fragile or soon to be fragile services within the Health Board. The Health Board has established a mature approach to risk and issue management through an organisational Risk Management Framework, supported by comprehensive training, programme governance and portfolio management arrangements. The Board Assurance Framework (BAF) and Corporate Risk Register (CRR) are aligned to the 3-Year Plan and Strategic Intent Statements, demonstrating Executive Team, Board and Committee level oversight of strategic risks and organisational performance through IPEDG, PFIG and SPSCG. This provides a clear oversight of strategic risks and organisational priorities and line of sight through the Plan and BAF. Risk identification, escalation and mitigation are embedded within strategic planning, programme delivery and governance processes. Planning and performance review arrangements provide regular visibility of strategic risks, interdependencies and delivery challenges, enabling informed decision-making and timely management action. Risk management is embedded into the planning process, with risks and mitigations clearly

			identified withing the plan. Major Change and Key Programmes, including the Clinical Services Plan**,** Foundations for the Future and Special Measures improvement programme, are supported by established programme governance and risk management arrangements identifying strategic risks, interdependencies and delivery challenges. The Health Board offers Risk management training, guidance and organisational policies and has received national recognition for its Risk Management Framework and organisational risk management training at the CIR Awards. In response to Welsh Government feedback, greater emphasis is being placed on evidencing how risk information informs planning decisions, resource allocation and organisational learning, rather than solely demonstrating the existence of governance frameworks. **Maturity Justification** The Health Board remains appropriately assessed at **Level 3.** Risk management is embedded within organisational governance, strategic planning and programme delivery, supported by established assurance, escalation and oversight arrangements. Evidence demonstrates that risk information increasingly informs planning decisions and organisational priorities. Continued evaluation of the impact of

			risk management on organisational performance and learning will further strengthen maturity.
Service Model / Regional Design	**2** (No change) Strengthened partnership working arrangements are in place. A methodology for working together is developed, with early efforts to align priorities and build trust.	♣ Strategy Workshop October 2025 referred to above	The Health Board continues to strengthen service model development through collaboration across organisational, geographical and partnership boundaries. Strategic planning increasingly reflects a whole-system approach, supported by the Regional Partnership Board (RPB), Integrated Health Communities (IHCs) and wider partnership arrangements. Integrated Health Community (IHC) planning arrangements supporting place-based service design and delivery and cross-organisational service redesign involving clinical, operational and corporate teams for example the Community By Design Programme, Planned Care and Urgent Emergency Care Programmes. Development of regional clinical pathways and transformation programmes in collaboration with partner organisations for example the Llandudno Orthopaedic Hub, Stroke services etc. The Foundations for the Future Programme and emerging Clinical Services Plan (CSP) provide the strategic framework for future service models, organisational redesign and workforce planning. These programmes support greater consistency across the East, Central and West Integrated

			Health Communities whilst recognising local population needs and service delivery challenges. In response to Welsh Government feedback, greater emphasis has been placed on strengthening collaboration across the Health Board as a single integrated system. Shared planning processes, regional service redesign and cross-organisational programme governance are supporting a more coordinated approach to service planning and transformation. Service model development is increasingly informed by population health intelligence, regional collaboration and partnership working. Whilst further implementation is required, the evidence demonstrates continued progress towards more integrated and sustainable models of care. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2**. Evidence demonstrates increasing maturity in collaborative service model development through strengthened regional planning, Integrated Health Community arrangements and organisational transformation programmes. The implementation of the Clinical Services Plan and continued development of integrated service models will provide further evidence to support progression to the next

			maturity level.
Overall Judged Score	**3**	Stakeholder engagement and risk management have become increasingly embedded within organisational planning and transformation activity. There is growing evidence that engagement, governance and risk processes are informing organisational priorities and service change. Whilst regional service model development remains at an earlier stage, the overall evidence supports an assessment of **Level 3**	

C) Dynamic and Engaged Planning - Actions						
Domain	**Assessed level**	**Aspired Position**	**Action(s)**	**Timelines/Milestones**	**Evidence to be used**	**Impact Measurement**
Stakeholder Engagement	**3**	**4**	Strengthen arrangements for demonstrating how engagement feedback influences planning and service development.	Throughout 2026-29	Engagement reports; consultation summaries; stakeholder feedback logs.	Increased evidence of service, programme or planning changes resulting from engagement activity.
Service Delivery Risk and Issue Management Approach	**3**	**4**	Continue to strengthen fragile service identification and service sustainability planning arrangements.	Ongoing	Risk registers; challenged service reviews; BAF and CRR reports.	Earlier identification of service risks and implementation of mitigating actions.
Service Model / Regional Design	**2**	**3**	Progress priority regional and cross-organisational service redesign programmes through existing partnership arrangements.	Hub milestones Q1-Q3 2026/27; Community by Design programme throughout 2026/27	Programme reports; partnership papers; business cases.	Delivery of agreed service improvements through collaborative working and regional planning.

D) Operational Planning

D) Operational Planning - Criteria					
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Demand & Capacity Modelling **2** (No change)	Basic demand and capacity work is undertaken and contains an appropriate level of detail to support service delivery	Demand and capacity planning undertaken at speciality level to support the design of current and future services. Data is more structured and used to inform service-level decisions	Robust and profiled projections of demand and capacity are used to inform the development of individual service plans, the Clinical Services Plan, and the IMTP. Planning is increasingly data-driven and cross-functional.	The organisation uses detailed and advanced modelling capability to support strategic planning. Demand and capacity modelling is embedded in the IMTP and informs transformation, workforce, and financial planning. Predictive analytics and AI tools support long-term planning.	Demand and capacity modelling including modelling projections is at the core of planning processes across the organisation. Predictive analytics and AI tools support long-term planning. Modelling triangulates resources, staff, finance and activity. It is able to undertake modelling at all levels of prevention and illustrates scenarios for improvement for the IMTP.
Clinical Leadership & Input **2** (No change)	Clinical leads are identified and their roles are defined. Engagement is limited to basic consultation or information sharing	Clinical leads begin to inform service planning and contribute to performance improvement discussions. Their input is considered but not yet central.	Clinical leads are embedded early in the planning cycle to ensure that service design is clinically credible and patient-centred. Clinical leads co-produce plans and provide leadership in	Clinical leadership is embedded in operational planning. Clinical teams actively shape service direction in alignment contributing to future direction services in line with clinical services plan.	Clinical leadership sits at the heart of planning and performance with a strong focus on quality and improvement. Clinical leaders co-produce plans and drive the future direction of plans through developing a culture of quality, innovation, and continuous improvement, fostering deep engagement and ownership across clinical teams.

			development processes. Their involvement is structured and increasingly strategic.		
Planning Process **2** (No change)	Organisation has basic operational plans and planning process in place.	Operational plans are regularly reviewed and remedial action undertaken.	Operational plans have robust triangulation and modelling of plans based on a clear and consistent approach to demand and capacity modelling across the organisation	Coherent aligned and triangulated plans with clear links to CSS and CSP, including, with staff owning, adapting, acting on and learning from variation and inequity.	Operational plans are fully aligned and integrated into the development of IMTP and CSP. Staff own the process and act on opportunities and learning to improve holistic service provision and patient experience.

Operational Planning - Self-Assessment			
Domain	**Assessed level**	**Evidence Used**	**Any Supporting Narrative**
Demand & Capacity Modelling	**2** (No change) Demand and capacity planning undertaken at speciality level to support the design of current and future services. Data is more structured and used to inform service-level decisions	♣ Minimum Data Set evidenced above ♣ Demand and capacity modelling 202627 104 Wk Trajectories - March End Position.xlsx; Derived Demand Tool Foundation 2627 (Jan-Dec25) Breast.xlsx ♣ Example workforce planning, Strategic-Workforce-Planning-Framework-2026.pdf ♣ Specialist service planning 20250507 Skin Cancer Innovation.pdf	In addition to narrative and evidence in support of the Horizon Scanning and Triangulation of Services domains above. Demand and capacity modelling is increasingly informing operational and strategic planning across the Health Board, although the Health Board is cognisant that more work is required in this area to a) increase the consistency and application of demand modelling in its trajectory setting and decision-making processes; and b) spread the methodology more widely to support services outside of the traditional areas of Planned Care, Cancer etc. Pockets of good approaches to, and use of, demand and capacity modelling are predominantly evidenced in operational and clinical (predominantly surgical) based services such as planned care, and cancer services including skin cancer innovation. Demand and capacity analysis is informing planned care recovery, service planning and commissioning decisions. This modelling was used to set the trajectories for performance reflected in both the Plan (Section 4) and the Minimum Data Set.

			Demand analysis and modelling supporting the development of the Clinical Services Plan (CSP) and future service models. Development of a unified modelling approach for the Health Board (referenced above) is a key area of work being progressed in 2026 to strengthen demand and capacity modelling, and the triangulation of intelligence across the whole system to support strategic and operational planning and intelligence led decision making. This includes performance, activity, workforce, financial and productivity data informing planning assumptions and service delivery. Whilst modelling capability continues to mature, further work is required to embed consistent methodologies, strengthen analytical capability and demonstrate the systematic application of modelling across all services. This remains a key area of development within the Continuous Planning Cycle and Clinical Services Plan programme. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2**. Demand and capacity modelling is increasingly supporting operational and strategic planning through improved integration of activity, workforce, finance and performance information. Whilst modelling capability continues to strengthen,

			further evidence is required to demonstrate consistent organisational application and its influence on strategic decision-making before progression to the next maturity level can be evidenced.
Clinical Leadership & Input	**2** (No change) **“**Clinical leads begin to inform service planning and contribute to performance improvement discussions. Their input is considered but not yet central.”	♣ HPF Planning Presentation (Dec) HPF Presentation - IMTP Planning Approach 26-29 FINAL.pptx ♣ HPF Presentation May 2026 FINAL - HPF - IMTP Update 2026-03-06.pptx	Clinical leadership has strengthened over the past year through the appointment of a substantive Executive Medical Director and increased clinical leadership across strategic planning, service transformation and the Clinical Services Plan (CSP) programme. Clinical leadership has been central to the development of the Challenged Services Plans and wider Special Measures improvement programme. Clinical representation within the Strategic Planning and Service Change Group (SPSCG), Executive governance arrangements and Board Development Sessions. There is evidence of improved Clinical expertise reflected within organisational planning through programme governance, Integrated Health Communities, Executive oversight and the Strategic Planning and Service Change Group (SPSCG). For example:

			♣ Clinical leaders are playing a greater role in shaping service models, planning assumptions and organisational priorities. ♣ Whole-organisational Culture, Leadership and Engagement Programme supporting the development of organisational values, behaviours and leadership capability. ♣ Interprofessional Education Group established to strengthen multidisciplinary education, workforce development and organisational capability across BCUHB. Whilst Clinical Lead input is sought, it is not yet a central component in plan development and is not yet consistently represented across all facets of organisational planning. Improvements have been made: ♣ involving clinical leads earlier in the process, seeking Clinical input to inform planning assumptions, service priorities and organisational decision-making throughout the IMTP planning process ♣ working through Executive Director Leads; ♣ promoting clinical engagement at the service level of planning (setting clear expectations and assumptions within the IPF and Planning Guidance and Tools); ♣ Multidisciplinary clinical engagement supporting service redesign, demand and capacity planning, and future service models. ♣ seeking clinical input from relevant committees and groups e.g., Healthcare Professional

			Forum. but not yet central. Further work to consistently embed Clinical leads are early in the planning cycle to ensure that service design is clinically credible and patient-centred is being progressed in 2026 through the Planning cycle and guidance and tools which will strengthen expectations of clinical lead roles in co-producing plans and providing leadership in development processes. Notwithstanding that, the 3-Year Plan contains a much stronger representation of the clinical voice throughout the plan and specifically with sections dealing with Clinical Leadership. ♣ This is particularly reflected in work around the development of the Clinical Services Plan, demonstrating strengthened multidisciplinary clinical engagement through strategic workshops, clinical focus groups and challenged service reviews, providing a stronger clinical evidence base for future service transformation. The Executive Medical Director is the nominated executive lead for the Clinical Services Plan programme, despite the area of work falling under the ED for Strategy and Planning, indicating the important the organisational places on clinical leadership. ♣ This is complemented by organisational initiatives to strengthen leadership, culture and workforce capability, including the Culture, Leadership and Engagement Programme and the Interprofessional Education Group, which

			support collaborative leadership and continuous professional development. Whilst clinical leadership is increasingly embedded within strategic planning and organisational decision-making, further work is required to ensure consistent clinical leadership and multidisciplinary involvement across all planning programmes and services. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2**. Evidence demonstrates significant progress in embedding clinical leadership within strategic planning, governance and service transformation, supported by strengthened Executive clinical leadership, multidisciplinary engagement and organisational leadership development. Whilst clinical leadership is increasingly influencing organisational priorities and decision-making, further evidence of consistent implementation and organisational impact across all planning activities is required before progression to **Level 3** can be evidenced.
Planning Process	**2** (No change) "Operational plans are	♣ ADP Monthly Status Update FINAL ADP month 2 report for SPSCG.docx and 2.1 SPSCG Minutes 26-02-16 v0.3 APPROVED.pdf	There are robust mechanisms in place to ensure that the Health Board Plan is reviewed regularly and remedial action is taken. Monthly Status Updates against the Annual Delivery Plan (Section 4 of the 3-Year Plan) are provided to Executive

	regularly reviewed and remedial action undertaken”	♣ ADP Quarterly Report FINAL - SPSCG - ADP Q1 27.07.26.docx ♣ Forward Governance Plan – Corporate Planning 26.27 Reporting Calendar.docx	Director Leads as an early warning, providing them with a high-level oversight on the status of deliverables within their areas of responsibility. The Status Update specifically calls attention to area’s which are off track or indicating that they will not be achieved in the relevant quarter. This enables them to work with their teams to take appropriate remedial action to bring actions back on track before a formal Quarterly ADP Report is produced. Moving forward, the Health Board, learning from the previous planning and reporting cycles, taking into account wider feedback from across stakeholders and Welsh Government, in addition to it has significantly strengthened its planning and reporting processes: ♣ introducing a Continuous Planning Cycle and development of supporting planning infrastructure. Planning is now embedded as a year-round organisational process rather than a discrete annual exercise. ♣ Formalised a Reflection and Learning stage, to include undertaking the PMM Self-Assessment early in the year to support improving planning maturity and reflect and apply this learning to future planning cycles. ♣ Implemented monthly ADP Status Updates, supplementing the existing Quarterly Reporting. ♣ Established governance and review arrangements, including Directorate Performance Reviews, Corporate Directorate

			Reviews and Service Accountability Reviews, provide regular opportunities to monitor delivery, identify emerging risks, escalate issues and refine planning assumptions. These arrangements strengthen organisational accountability and support continuous improvement. The Health Board is also investing in organisational capability, recognising that effective planning depends upon strong leadership, programme management, analytical capability and organisational change. Work to improve planning literacy, supported by revised guidance, templates and the Planning Portal**,** is helping to strengthen consistency and engagement across the organisation. Whilst further work is required to fully embed continuous planning across all services, the evidence demonstrates a more integrated, coordinated and systematic approach to organisational planning. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2**. Significant progress has been made in strengthening planning processes, governance and organisational capability through the Continuous Planning Cycle, Integrated Planning Framework and supporting review arrangements. However, the organisation is not yet able to fully demonstrate

			plans have robust triangulation and modelling of plans based on a clear and consistent approach to demand and capacity modelling across the organisation (reference sections above for the work which is in progress).
Overall Judged Score	**2**	Operational planning arrangements continue to mature through strengthened governance, demand and capacity work, planning processes and increasing clinical involvement. However, demand modelling, clinical leadership and operational planning processes are not yet consistently embedded across all services. The overall assessment therefore remains **Level 2 (Early Progress)** although there is evidence of good improvement and progress being made across all of the domains.	

Operational Planning - Actions						
Domain	**Assessed level 2026**	**Aspired Position**	**Action(s)**	**Timelines/Milestones**	**Evidence to be used**	**Impact Measurement**
Demand & Capacity Modelling	**2**	3	Roll out a more consistent demand and capacity modelling approach across priority services. – linked to Unified Modelling action	2026/27	Modelling outputs; trajectory reports; service plans; workforce reviews.	Planning assumptions and trajectories increasingly informed by modelling evidence.
Clinical Leadership & Input	**2**	3	Strengthen early clinical involvement in planning, CSP development and challenged service reviews.	Ongoing through 2026-29	Clinical focus group outputs; challenged service reports; CSP documentation.	Increased evidence of clinical input informing planning assumptions and service redesign proposals.
Planning Process	**2**	3	Continue embedding the Continuous Planning Cycle, planning guidance and organisational planning capability development.	Throughout IMTP period	Planning guidance; training records; planning reviews; Directorate plans.	Improved consistency and quality of planning submissions across the organisation.

E) Best Practice Approach to Improvement

E) Best Practice Approach to Improvement - Criteria					
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Engagement **2** (No Change)	Engagement is minimal and reactive. Feedback is collected from patients and staff, but there is no structured approach to measuring the effectiveness of engagement activities or approach. Insights are rarely used to inform decision-making.	The organisation has a visible commitment to best practice, supported by training and an improvement strategy. Engagement with national programmes is active, and structured methods for collecting feedback and measuring impact are in place, though not yet fully embedded.	Organisation is developing an engagement strategy/plan and is proactive in identifying and learning from best practice in engagement to ensure voices are captured from all stakeholders especially clinical, minority and diverse voices.	Engagement is embedded across all organisational activities—planned and unplanned. The engagement strategy ensures robust inclusion of diverse and clinical voices, supported by strong data collection and analysis. Feedback directly informs action, driving continuous improvement.	Stakeholder engagement is transformational—co-designed and co-led by patients, staff, and communities. Real-time feedback tools enable adaptive responses, while inclusive practices ensure diverse voices shape decisions. The organisation is nationally recognised for its leadership in engagement, with a clear link between stakeholder input and measurable improvements
Benchmarking **2** (No Change)	Organisation is beginning to explore value-based healthcare principles, but planning remains reactive and output-focused. Benchmarking is ad hoc,	Value-based planning is gaining traction, and regular benchmarking is conducted with other NHS	Benchmarking processes are formalised, consistently applied, and span across Wales and the UK. The	Benchmarking is fully integrated into planning and performance cycles. Staff across the organisation actively lead benchmarking	Demonstrates full integration of benchmarking and value-based planning across strategic, operational, and clinical areas. Advanced analytics, including predictive and real-time data, drive proactive improvements and

	with limited structure or consistency. There is minimal understanding of how comparative data can drive improvement, and benchmarking is not yet linked to strategic goals.	organisations. The organisation begins to use structured benchmarking methods to identify best practice, though application is inconsistent. Staff awareness is growing, and benchmarking is starting to inform service reviews and improvement discussions.	organisation uses comparative data to identify performance gaps and inform strategic planning. Benchmarking is aligned with value-based healthcare principles, and results are used to prioritise improvement initiatives. Staff are engaged in interpreting data and applying insights to their areas.	and improvement initiatives, using data to drive decisions and measure impact. There is a strong culture of ownership and continuous learning. Benchmarking includes qualitative and quantitative measures, peer comparisons, and outcome-focused metrics aligned with patient value. Insights are shared across teams and used to scale best practice.	innovation. Recognised as a leader in the NHS, the organisation shapes best practice while fostering a culture where staff lead continuous improvement and scalable innovation.
Governance **3** (No Change)	Governance arrangements are informal, fragmented, or unclear. Oversight of IMTP development is minimal, with limited accountability, transparency, or alignment to strategic priorities. There is no structured process for risk management, stakeholder involvement,	A governance structure has been established to provide direction and oversight for IMTP development. Roles and responsibilities are defined, and basic reporting mechanisms are in place. There is	A formal governance and accountability framework is in place for IMTP development and monitoring at programme level. IMTP and CSS/CSP governance is aligned with	Governance is embedded across the organisation, with a mature CSS and oversight mechanisms that are reviewed annually for relevance and effectiveness. IMTP and CSS/CSP governance structures support cross-functional	Governance is fully integrated, agile, and strategically aligned across all levels. Oversight of the IMTP, CSS and CSP is co-produced with clinical leaders and stakeholders, supported by real-time data, predictive analytics, and dynamic risk intelligence. IMTP/CSS/CSP governance structures are benchmarked against national best practice, continuously refined, and used to drive innovation, accountability, and system-wide

	or performance monitoring.	growing awareness of the need for structured governance, but integration with programme-level planning and delivery is still emerging.	strategic objectives, includes defined escalation routes, and supports performance tracking. IMTP Governance is periodically tested for improvements.	collaboration, robust data use, and continuous improvement. Governance is constantly and pro-actively tested for improvements.	impact. Decision-making is transparent, inclusive, and outcome-focused.

Best Practice Approach to Improvement - Self-Assessment			
Domain	**Assessed level**	**Evidence Used**	**Any Supporting Narrative**
Engagement	**2** (No Change) The organisation has a visible commitment to best practice, supported by training and an improvement strategy. Engagement with national programmes is active, and structured methods for collecting feedback and measuring impact are in place, though not yet fully embedded.	♣ Annual programme of public, patient and community engagement Engagement Team Annual Delivery Plan 2026 - Evidence for Maturity Matrix.docx ♣ Example - Board Citizen Experience report Citizen Experience Board Paper_Health Board May 2026.pdf	Engagement is being supported by structured mechanisms that capture, review and apply stakeholder feedback informing strategic direction and priorities. This includes continued implementation of the Values, Behaviours and Culture Change Leaders programme to strengthen staff engagement and organisational culture. In addition to the areas of Engagement reflected in the above Domains, the Health Board continues to strengthen (internal and external to the organisation) stakeholder engagement through a coordinated programme of public, patient, staff and partner engagement that supports strategic planning, service transformation and organisational development. ♣ Recent examples include the Tywyn and Penley service change programmes, ♣ Work on development of the Strategy and CSP E.G. o development of the Strategic Intent Statements, o the Clinical Services Plan and

			o ongoing Board engagement through the Citizen Experience programme. The Health Board encourages full participation in the National Staff Survey, and actively uses those results to engage with and work with its workforce in identifying areas for improvement. The IMTP Reflection and Learning Review, Planning Maturity Matrix (PMM) self-assessment, Directorate Reviews and Board Development Sessions provide regular opportunities to evaluate feedback and ensure it informs future planning, service development and organisational priorities. Learning from Welsh Government feedback, programme reviews, organisational diagnostics and stakeholder engagement is increasingly informing planning, governance and continuous improvement. The Continuous Planning Cycle further strengthens this approach by embedding engagement and feedback throughout the planning process rather than relying on discrete consultation exercises.

			Whilst engagement is well established, further work to strengthen the visibility of how stakeholder feedback influences planning decisions, service redesign and measurable organisational outcomes is underway. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2**. Evidence demonstrates that structured engagement with patients, staff, partners and stakeholders is increasingly embedded within strategic planning and organisational decision-making. Established mechanisms capture and apply stakeholder feedback to inform planning, service development and continuous improvement. Whilst clear progress has been made, further evidence is required to demonstrate the consistent impact of engagement on organisational decisions, service transformation and measurable outcomes before progression to **Level 3** can be evidenced.
Benchmarking	**2** (No Change) Value-based planning is gaining traction,	Benchmarking Tool Screenshot.png Month 3 - Comparison Non-Pay +.xlsx A&E Efficient Benchmarking 24.25.docx	The Health Board continues to strengthen its approach to benchmarking through participation in the NHS Benchmarking Network, national planning forums and comparative analysis across NHS Wales. Benchmarking is increasingly supporting

	and regular benchmarking is conducted with other NHS organisations. The organisation begins to use structured benchmarking methods to identify best practice, though application is inconsistent. Staff awareness is growing, and benchmarking is starting to inform service reviews and improvement discussions.	PFIG Corporate Service Benchmarking June 25 23.05 v7.docx DDAT Benchmarking activity data elements that helps feed the NHSBN submissions.docx NHSBN Emergency Care 2025 Overview Report.pdf	organisational learning, service reviews and value-based planning. The Value and Sustainability Programme has strengthened the use of benchmarking across areas including productivity, costing, expenditure, efficiency and clinical variation. A dedicated Data and Analytics Working Group is supporting the use of comparative intelligence and best practice to identify opportunities for improvement and inform planning discussions. Learning from Welsh Government feedback, external reviews, peer organisations and national benchmarking activity is increasingly informing organisational planning and improvement priorities. Comparative information is beginning to influence planning discussions, challenge existing practice and identify opportunities to improve value and performance. Whilst benchmarking activity is becoming more structured, its application remains variable across the organisation. Further work is required to establish a consistent organisational approach and demonstrate how comparative intelligence routinely informs strategic planning, resource allocation and service transformation. **Maturity Justification**

			The Health Board remains appropriately assessed at **Level 2.** Evidence demonstrates that benchmarking and comparative analysis are becoming more structured and are increasingly supporting service reviews, planning discussions and value-based improvement. Participation in national benchmarking arrangements and the growing use of comparative intelligence provide a stronger foundation for organisational learning. However, benchmarking is not yet consistently embedded across all planning processes, and further evidence is required to demonstrate its systematic application in strategic planning, resource allocation and organisational decision-making before progression to Level 3 can be evidenced.
Governance	**3** (No change) "A formal governance and accountability framework is in place for IMTP development and monitoring at programme level.	Example of Plan tabled: o at PPHP 05 March 2026 PPHP Committee Agenda Bundle 05.03.26 V1.0 (Public).pdf and Minutes from PPHP Committee 05.03.26 V1.0 (Public) Confirmed.pdf o Board on 26 March 2026 (approval to submit) Health Board Agenda Bundle 26.03.26 V5.0 Public_opt.pdf and Minutes from Health Board Meeting 26.03.26 V1.0 (Public) Confirmed.pdf	The Health Board has established a formal governance and accountability framework to support the development, delivery and monitoring of the Plan. The Integrated Planning Framework defines clear governance arrangements, roles, responsibilities and reporting mechanisms, providing a structured approach to organisational planning and assurance.

	IMTP and CSS/CSP governance is aligned with strategic objectives, includes defined escalation routes, and supports performance tracking. IMTP Governance is periodically tested for improvements.”		This is aligned to the organisation’s Boards and Committee Structure providing Executive Team, Board Committees and Board oversight of strategic planning, organisational performance and delivery. The BCU 3 Year Plan was submitted through the following governance routes before Board sign off on 26 March 2026 (SPSCG, PPHP, Board, as well as through non committee forums such as SRG, PFIG, Executive Committee, WG Touchpoint meetings, Board Development sessions) Governance arrangements for the Clinical Services Plan (CSP), Foundations for the Future Programme and the IMTP are increasingly aligned through established programme governance, Executive oversight and Board assurance processes. Defined governance routes provide clear mechanisms for performance monitoring, escalation of risks and organisational decision-making. Routine reporting through the Strategic Planning and Service Change Group (SPSCG), Executive Team, Planning, Population Health and Partnerships Committee (PPHP) and Board provides regular oversight of delivery, organisational

			performance, programme risks and strategic priorities. Governance arrangements increasingly integrate planning, workforce, finance, quality, risk and performance, strengthening organisational alignment and delivery confidence. Governance arrangements continue to evolve through the development of the Organisational Approach to Change, strengthened programme management arrangements and investment in organisational capability. Regular review of governance structures supports continuous improvement and ensures governance remains aligned to organisational priorities and strategic transformation. **Maturity Justification** The Health Board remains appropriately assessed at **Level 3**. A formal governance and accountability framework is established to support the development, delivery and monitoring of the IMTP and associated strategic programmes. Governance arrangements provide clear oversight, defined escalation routes and integrated performance monitoring aligned to organisational priorities. Evidence demonstrates that governance supports

			effective planning, assurance and organisational decision-making. Continued refinement of governance arrangements and evaluation of their effectiveness will further strengthen organisational maturity.
Overall Judged Score	**3**	The Health Board demonstrates a structured approach to governance, continuous improvement and organisational learning. Governance arrangements are well established and support planning, assurance and delivery. Whilst benchmarking and engagement require stronger evidence of impact, sufficient evidence exists to support an overall assessment of **Level 3 (Initial Results)**.	

Best Practice Approach to Improvement - Actions						
Domain	**Assessed level 2026**	**Aspired Position**	**Action(s)**	**Timelines/Milestones**	**Evidence to be used**	**Impact Measurement**
Engagement	2	**3**	Strengthen evaluation of engagement activity and use learning to inform planning and service improvement.	Throughout 2026-29	Citizen Experience reports; engagement evaluations; action plans.	Increased evidence of learning from engagement informing organisational decisions.
Benchmarking	2	**3**	Strengthen the use of benchmarking, comparative intelligence and improvement methodologies to support service improvement.	Throughout 2026-29	NHS Benchmarking Network reports; GIRFT reviews; Value and Sustainability outputs.	Evidence of benchmarking findings informing improvement actions and service reviews.
Governance	3	4	Continue to refine governance and assurance arrangements supporting planning, delivery and organisational improvement.	Throughout 2026-29	Governance reviews; committee reports; BAF and assurance reports.	Improved oversight of delivery, risk and organisational priorities through governance structures.

F) Realistic & Deliverable

F) Realistic & Deliverable - Criteria					
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Risk Identification & Management **3** (Increased from Level 2)	Risk identification and management are inconsistent and reactive. Risks to IMTP delivery are not systematically captured or monitored. There is limited ownership or visibility of delivery risks.	A formal risk management process exists and is applied to IMTP delivery at a high level. Risks are identified at the planning stage and tracked through basic registers and reviewed periodically. Ownership is clearer, but integration with delivery assurance is limited. Escalation processes in place but not always followed.	Risk identification and management are embedded in IMTP development and delivery processes. Risks are identified early and linked to specific objectives, milestones, and outcomes. Controls are monitored, and mitigation actions are tracked. Risk registers are dynamic and inform delivery with clear ownership.	Risk management is proactive, strategic, and forward-looking with an agreed and clear risk appetite. Risks are anticipated and identified through horizon scanning, sensitivity analysis and scenario planning. The organisation adapts delivery plans in response to emerging risks with regular reviews. Lessons learnt informs future IMTP cycles.	Risk management is fully embedded across the organisation and system partners and is triangulated across workforce, finance, digital and clinical lenses. It is predictive, real-time, and continuously informs IMTP delivery through live dashboards and predictive analysis. The organisation leads in using risk intelligence to drive improvement, resilience, and transformation. The organisation operates continuous learning and is recognised for excellence in risk-informed delivery assurance.

Development of IMTP and track record **2** (increased from Level 1)	The organisation has a track record of submitting annual plans that do not meet the requirements of the planning framework, Cabinet Secretary expectations or provide a financially balanced plan over 3 years. Planning is largely operational and short-term, with limited strategic integration and has limited clinical or financial planning alignment and limited stakeholder engagement.	The organisation consistently develops robust annual plans that build assurance as a key step toward an approvable IMTP. Plans begin to reflect medium term priorities, include a finance and delivery framework, and show early signs of strategic alignment including financial forecasts and delivery milestones.	The organisation has developed an approvable, outcomes-focused IMTP that reflects strategic priorities, enabling plans and clinical service plans. A robust 3-year sustainable financial plan is included, with clear links to service transformation (with milestones and timelines) with clearly articulated risks and mitigations.	The organisation has a history of submitting high quality IMTP's that are strategically integrated and includes a comprehensive delivery and assurance framework. It demonstrates alignment across all enabling strategies and is informed by detailed modelling, population health intelligence, and with significant stakeholder input.	The organisation is recognised for excellence in IMTP delivery and assurance and has a long history of developing and submitting high quality IMTP's which surpass policy expectations and is recognised as a system-leading exemplar. It is co-produced and informed by detailed analysis and predictive tools to drive transformation across the health system, delivers the quadruple aim.
Monitoring and Delivery **2** (No change)	Monitoring of annual plan or IMTP delivery is ad hoc and reactive and focused on immediate operational issues. There is limited visibility of progress, and reporting is inconsistent. Accountability is unclear and delivery risks are not systematically managed.	The organisation has a structured approach to monitoring annual plan or IMTP delivery with ownership of delivery emerging across services. Key milestones and actions are tracked, and reporting mechanisms are in	Monitoring of IMTP delivery is consistently seen as business as usual and integrated with performance management reviews and risk assurance processes. Progress is tracked	IMTP delivery is monitored through a robust, outcome-focused framework which includes impact evaluation. The organisation adapts delivery plans based on performance insights, emerging risks, and system pressures. Staff are engaged in owning	IMTP monitoring and delivery are embedded in real-time, system-wide performance and governance structures. The organisation demonstrates strategic leadership in delivery assurance, advanced triangulation, using predictive analytics, scenario planning, and co-produced improvement plans. Delivery is continuously optimised to achieve the quadruple aim. Continuous improvement cycles

		place through basic dashboards and reported to the Board regularly. Accountability is improving, but integration with performance and risk management is limited.	against outcomes, and corrective actions are taken. Delivery is supported by enabling functions and aligned with strategic priorities. Delivery is starting to inform future planning.	and delivering IMTP priorities.	are embedded, with clear evidence of impact and the

Realistic & Deliverable - Self-Assessment			
Domain	**Assessed level**	**Evidence Used**	**Any Supporting Narrative**
Risk Identification & Management	**3** (increased from 2) Risk identification and management are embedded in IMTP development and delivery processes. Risks are identified early and linked to specific objectives, milestones, and outcomes. Controls are monitored, and mitigation actions are tracked. Risk registers are dynamic and inform delivery with clear ownership.	♣ BCU 3 Year Plan evidenced above. ♣ Health Board Risk Management Framework evidenced above ♣ Board Assurance Framework (BAF) and Corporate Risk Register (CRR) evidenced above	The Health Board has embedded risk management within strategic planning, programme delivery and organisational governance. The Risk Management Framework, Board Assurance Framework (BAF) and Corporate Risk Register (CRR) provide a structured and consistent approach to identifying, assessing, escalating and managing strategic risks aligned to the IMTP and organisational priorities. Risk management is integrated throughout the planning process. Risks are identified during the development of the IMTP, Clinical Services Plan (CSP) and major transformation programmes, linked to strategic objectives and delivery priorities, and monitored through established governance arrangements. Controls, mitigating actions and delivery risks are routinely reviewed to support delivery assurance and organisational resilience. Risks associated with the Plan are visible in the BCU 3 Year Plan 2026/29 Routine governance through the Strategic Planning and Service Change Group (SPSCG), Executive Team, Board

			Committees and Board provides clear ownership, oversight and escalation of strategic risks. Risk information increasingly informs planning decisions, prioritisation, programme delivery and resource allocation, supporting a more proactive approach to managing delivery risks. In response to Welsh Government feedback, greater emphasis has been placed on demonstrating how risk management supports delivery rather than simply evidencing the existence of risk frameworks. The Health Board continues to strengthen the visibility of delivery risks, mitigation actions and assurance arrangements within strategic planning processes. **Maturity Justification** The Health Board is appropriately assessed at **Level 3.** Risk identification and management are embedded within IMTP development, programme delivery and organisational governance through established risk management, assurance and escalation arrangements. Risks are increasingly linked to organisational priorities, monitored through routine governance processes and used to inform

			planning, prioritisation and delivery decisions. Continued development of predictive risk management, organisational learning and risk-informed planning will support progression towards the next maturity level.
Development of IMTP and track record	**2** (increased from 1) "The organisation consistently develops robust annual plans that build assurance as a key step toward an approvable IMTP. Plans begin to reflect medium term priorities, include a finance and delivery framework, and show early signs of strategic alignment including financial forecasts and delivery milestones."	♣ BCU IMTP 2025-28 submitted FINAL - BCUHB 2025-28 IMTP.pdf ♣ Welsh Government Feedback on BCU IMTP 25-28 20250902 SE to PT - BCUHB IMTP Feedback.pdf ♣ BCU 3 Year Plan - 2026-29 – submitted BCUHB Narrative Plan 2026-29.pdf ♣ Welsh Government Rapid Assessment Feedback submitted plan 20260413 CEONHSW to CEOBCUHB - Rapid Assessment of BCU Plan 2026-29.pdf	The Health Board has strengthened its approach to IMTP development through implementation of the Integrated Planning Framework, Continuous Planning Cycle and Strategic Intent Statements, improving alignment between strategic priorities, operational delivery and medium-term planning. The Board-approved IMTP 2025-28 represented a significant step forward in planning maturity, providing a financially balanced three-year plan. Welsh Government feedback recognised improvements in the quality, coherence and development of the plan, providing a stronger foundation for future IMTP submissions. The Feedback received was used to further improve and inform the development of the BCU 3 Year Plan for 2026-29. The IMTP is supported by an integrated finance and delivery framework, linking strategic objectives with medium-term

			financial forecasts, workforce and service planning assumptions, and clear delivery expectations. IMTP priorities are structured around deliverables, impacts and performance measures, providing a clear framework for monitoring progress and demonstrating how planned actions contribute to improved outcomes. This approach supports delivery assurance through defined milestones and measurable indicators. Directorate Delivery Plans, supported by the Integrated Performance and Accountability Framework, strengthen organisational oversight of delivery through regular monitoring of progress, performance, risks and corrective actions. Executive Team, Planning, Population Health and Partnerships Committee and Board oversight provide ongoing assurance of plan implementation. Collectively, these arrangements demonstrate increasing planning maturity, with annual plans increasingly aligned to medium-term priorities and supported by strengthened financial planning, delivery assurance and governance.

			Revised Maturity Justification The Health Board is appropriately assessed at **Level 2.** Evidence demonstrates that annual and medium-term plans are developed through a structured and integrated planning process, supported by clear governance, financial planning and delivery assurance arrangements. Plans align strategic priorities with financial forecasts, delivery milestones, performance measures and expected impacts, providing a stronger basis for organisational assurance and future approvable IMTPs. Whilst further evidence of sustained delivery and successive approvable IMTPs would be required at higher maturity levels, the organisation demonstrates the characteristics expected at Level 2.
Monitoring and Delivery	**2** (No change) "The organisation has a structured approach to monitoring annual plan or IMTP delivery with ownership of	♣ Quarterly **Annual Delivery Plan (ADP)** Report evidenced above ♣ Example showing ADP reviewed at SPSCG, PPHP and Board evidenced above PPHP Committee Agenda Bundle 07.05.26 V1.0 (Public).pdf and 2.1 SPSCG Minutes 26-02-16 v0.3 APPROVED.pdf	The Health Board has established a structured approach to monitoring delivery of the IMTP through quarterly Annual Delivery Plan (ADP) reporting, Directorate Performance Reviews, Corporate Directorate Reviews and operational service reviews. These arrangements provide regular oversight of delivery, performance, organisational priorities and emerging risks.

	delivery emerging across services. Key milestones and actions are tracked, and reporting mechanisms are in place through basic dashboards and reported to the Board regularly. Accountability is improving, but integration with performance and risk management is limited”		The Continuous Planning Cycle has strengthened monitoring by introducing regular opportunities to review progress, challenge performance and refine delivery plans throughout the year. Monitoring arrangements increasingly support the identification of delivery issues, enabling timely corrective action and greater organisational accountability. Performance, quality, workforce, finance and risk information is reviewed through established governance arrangements, including the Strategic Planning and Service Change Group (SPSCG), Executive Team, Planning, Population Health and Partnerships Committee (PPHP) and Board. These arrangements provide greater visibility of organisational performance and strengthen oversight of IMTP delivery. Whilst monitoring arrangements are well established, further work is required to strengthen the integration of monitoring with performance management and risk assurance, and to consistently demonstrate how delivery information informs future planning, organisational decision-making and service improvement.

			o Special Measures monitoring and assurance arrangements supporting organisational recovery. o Programme governance supporting delivery of major transformation programmes, including the Clinical Services Plan (CSP) and Foundations for the Future. o Routine monitoring of delivery milestones, actions, performance, risks and mitigating actions using integrated quality, workforce, finance and performance information. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2**. Evidence demonstrates a structured and increasingly coordinated approach to monitoring IMTP delivery through established governance, performance reporting and organisational accountability arrangements. Delivery milestones, actions and performance are routinely monitored, with improving ownership across services. Further integration of monitoring with performance management, risk assurance and future planning will be required before

			progression to **Level 3** can be evidenced.
Overall Judged Score	**2**	There is strong evidence that risk management arrangements have matured and probably justify the move to Level 3 for that individual element. The organisation has also demonstrated improvement in the quality and integration of its planning processes, including implementation of the Integrated Planning Framework, Continuous Planning Cycle and strengthened delivery assurance arrangements. However, the absence of an approved IMTP, a limited track record of sustained delivery against medium-term plans and the continued development of monitoring and delivery arrangements mean the domain overall remains best aligned to **Level 2 (Early Progress)**. The Health Board can demonstrate several characteristics of Level 3 but not yet consistently across the whole domain.	

Realistic & Deliverable - Actions						
Domain	**Assessed level 2026**	**Aspired Position**	**Action(s)**	**Timelines/Milestones**	**Evidence to be used**	**Impact Measurement**
Risk Identification & Management	3	3	Continue to strengthen the use of risk information within planning, prioritisation and delivery decision-making processes.	Throughout 2026-29	Board Assurance Framework (BAF); Corporate Risk Register (CRR); Directorate Risk Registers; SPSCG and Committee reports.	Evidence that risks influence planning assumptions, prioritisation decisions and mitigating actions across programmes and services.
Development of IMTP and track record	2	3	Continue embedding the Integrated Planning Framework and Continuous Planning Cycle to strengthen integrated planning, delivery confidence and future IMTP submissions.	Throughout 2026-29	IMTP submissions; Reflection and Learning reports; Planning Guidance; Welsh Government feedback.	Independent feedback demonstrates improved confidence in the quality, integration and deliverability of organisational plans.
Monitoring and Delivery	2	3	Strengthen integration between delivery monitoring, performance management and risk assurance arrangements.	Throughout 2026-29	Annual Delivery Plan reports; Directorate Reviews; SPSCG, PPHP and Board reports.	Evidence that issues identified through monitoring lead to remedial action, revised delivery plans or escalation through governance processes.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Planning, Population Health & Partnerships Committee

QUARTER 1 REPORT - ANNUAL DELIVERY PLAN (ADP)

Date of Meeting	03 September 2026
Publication Status	Open / Public
	Not Applicable
Report Author name and title	Emma Lea, Assistant Director of Corporate Planning (Interim) Geraint Parry, Assistant Director of Transformation (Interim)
Lead Executive Team Member name and title	Paolo Tardivel, Executive Director of Transformation & Strategic Planning (Interim)

Report Purpose	For Assurance

Executive Summary

Quarter 1 presents a mixed picture. Progress has been made across several priority areas, with important benefits already being realised for the population of North Wales. Planned Care improvement work has resulted in validation of more than 31,000 patient pathways and closure of almost 8,000 pathways no longer requiring treatment, helping improve waiting list accuracy and access to care. Mental Health services have reduced out-of-area placements significantly beyond trajectory, key CAMHS access standards have been maintained, and all waits exceeding 104 weeks for Stage 1 menopause services have been eliminated. In addition, investment in frailty services, falls prevention, discharge improvement and community-based care continues to strengthen the foundations for long-term improvement.

Alongside these achievements, delivery against the 2026/27 Annual Delivery Plan deliverables remains below the level required. Of 48 deliverables due for completion during Quarter 1, 25 (52%) were achieved on time. Across the plan for the full year, 203 of 318 deliverables (64%) are currently assessed as complete or on track, while 115 (36%) are assessed as either at risk or having low delivery confidence. Whilst still relatively early in the year, this highlights the need for focused recovery action and strengthened oversight in a number of areas.

The most significant delivery risks continue to relate to Cancer and Diagnostics, Fragile Services, Dementia and elements of the capital and infrastructure portfolio. Cancer performance remains below the special measures de-escalation criteria and the national standard and diagnostic capacity, whilst improving, continues to constrain wider planned care and cancer recovery. Several fragile services remain dependent on locum, insourced and temporary workforce arrangements, raising concerns regarding long-term sustainability. In Dementia, delivery of the planned emergency care pathway is at risk following the loss of specialist

pathway resource and capital affordability challenges, together with ongoing national dependencies are affecting digital programmes such as LIMS, also continue to affect delivery confidence.

Overall, the organisation continues to make progress in establishing the conditions required for recovery and de-escalation from Special Measures. However, delivery performance and operational outcomes remain inconsistent, and successful recovery of delayed Quarter 1 deliverables during Quarter 2 will be critical to maintaining confidence in delivery of the Annual Delivery Plan by year end. The Quarter 1 position also highlights the importance of clear and effective assurance and governance arrangements to support delivery, recovery and accountability. Work is underway to review the most appropriate approach and governance route for ongoing monitoring of Annual Delivery Plan delivery, performance improvement and associated recovery actions.

The Committee is asked to note both the progress achieved and the risks identified and seek assurance that appropriate recovery actions are in place.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome, Evidence and Data**
N/A		

Acronyms / Glossary of Terms	
BJC	Business Justification Case
COO	Chief Operating Officer
DHCW	Digital Health and Care Wales
IMTP	Integrated Medium-Term Plan
IRCF	Integration and Rebalancing Capital Fund
OBC	Outline Business Case
PPHP	Planning, Population Health and Partnerships
PMO	Portfolio Management Office
SRO	Senior Responsible Officer
SOC	Strategic Outline Case
WG	Welsh Government
UAT	User Acceptance Testing
DHCW	Digital Health and Care Wales

1. Introduction

The 2026/27 Annual Delivery Plan (ADP) sets out the actions that Betsi Cadwaladr University Health Board will undertake to deliver its strategic priorities, respond to national expectations and support continued improvement for the population of North Wales. This report provides the Board with an assessment of progress at the end of Quarter 1, highlighting achievements, areas of concern and the actions being taken to improve delivery confidence during the remainder of the year.

Quarter 1 has seen progress being made across several major transformation programmes including Urgent and Emergency Care, Planned Care, Foundations for the Future, Mental Health, Digital, Data and Intelligence. However, delivery performance across the Annual Delivery Plan has been mixed, with almost half of Quarter 1 milestones not completed within planned timescales and more than one-third of annual deliverables currently assessed as carrying delivery risk. This reflects the continuing operational, workforce, financial and infrastructure challenges facing the organisation.

While many programmes have established important foundations for future improvement, progress has not yet consistently translated into improved operational performance or delivery confidence. Sustained executive focus will therefore be required throughout the remainder of the year to recover delayed milestones, mitigate emerging risks and ensure delivery remains aligned to the organisation's improvement objectives and de-escalation ambitions.

The report therefore seeks to provide assurance on current delivery, identify areas requiring enhanced oversight and support timely intervention where additional action is required.

2. ADP Delivery Overview

This section provides an assessment of delivery against the Annual Delivery Plan at the end of Quarter 1. The position reflects updates submitted by programme and reporting leads following the closure of Quarter 1 and includes both completed deliverables and delivery confidence assessments for the remainder of the year. Full narrative updates are included within Appendix 2.

Table 1 - shows delivery performance against the 48 milestones scheduled for completion by the end of Quarter 1. Of these, 25 (52%) were completed within the planned timeframe. Whilst this represents progress across a substantial and ambitious programme of work, 23 deliverables (48%) were either incomplete, at risk or assessed as having low delivery confidence at the end of June. This position is below the level expected and indicates that delivery will need to accelerate during subsequent quarters if annual objectives are to be achieved in full.

Table 1 – 2026/27 Annual Delivery Plan Q1 Assurance Assessment.

Strategic Priorities	Complete (Q1 only)	On Track to deliver (Q1 only)	At risk of not completing by end of Quarter (Q1 only)	Unlikely to complete by end of Quarter (Q1 only)	Total
1. Focus on Health and Wellbeing	0	0	0	0	0

2. Enhance the co-ordination of care	1 (2%)	0	2 (4%)	1 (2%)	4 (8%)
3. Improve access, outcome and experiences for all	8 (17%)	2 (4%)	3 (6%)	6 (12%)	19 (40%)
4. Create a modern, people-centred healthcare system	16 (33%)	0	1 (2%)	8 (17%)	25 (52%)
Overall	**25 (52%)**	**2 (4%)**	**6 (12%)**	**15 (31%)**	**48**

The greatest concentration of Quarter 1 delivery challenges is within the strategic priorities relating to improving access, outcomes and experiences, and creating a modern, people-centred healthcare system. Several delayed milestones are linked to workforce constraints, programme mobilisation delays, national dependencies, affordability challenges and operational capacity limitations. Recovery plans are being developed through programme governance arrangements and will require ongoing executive oversight through Quarter 2.

Table 2 shows the current overall delivery confidence assessment across all 318 deliverables within the full year 2026/27 Annual Delivery Plan. While 64% of deliverables are currently assessed as complete or on track for delivery by year end, 115 deliverables (36%) are assessed as either at risk or having low delivery confidence. Although this remains an early-year assessment, the position highlights a significant level of delivery risk across the portfolio and reinforces the need for focused management action in a number of key programmes.

Table 2 – 2026/27 Annual Delivery Plan Overall Assurance Assessment

Strategic Priorities	Complete	On Track to deliver *(2026/27)*	At risk of not completing by end of *2026/27*	Unlikely to complete by end of *2026/27*	Total
1. Focus on Health and Wellbeing	0	29 (9%)	4 (1%)	0	33 (10%)
2. Enhance the co-ordination of care	1 (0%)	10 (3%)	14 (4%)	4 (1%)	29 (9%)
3. Improve access, outcome and experiences for all	9 (3%)	66 (21%)	39 (12%)	13 (4%)	127 (40%)
4. Create a modern, people-centred healthcare system	17 (5%)	71 (22%)	27 (8%)	14 (4%)	129 (41%)
Overall	**27 (8%)***	**176 (55%)**	**84 (26%)**	**31 (10%)**	**318**

*Two deliverables scheduled for completion later in the year, were completed ahead of schedule in Q1, therefore 27 deliverables are showing as complete in Table 2, versus the 25 indicated in Table 1 above.

Table 3 below shows the key priority areas within the ADP and the delivery confidence rating for achieving all the deliverables and full priority aims by the end of the year. Full quarter one narrative updates for each key priority can be seen in appendix 2.

Table 3 – Key priority areas end of year Delivery Confidence

Strategic Priorities	Key Priority Area	Executive Lead	Overall Delivery Confidence
1. Focus on Health and Wellbeing	1A Preventative approaches to Health & Wellbeing	Executive Director of Public Health	
	1B Proactive strategies for disease prevention, falls & frailty	Executive Director of Public Health	
	1C Health Inequalities	Executive Director of Public Health	
	1D Health Protection	Executive Director of Public Health	
2. Enhance the co-ordination of care	2A Primary Care	Chief Operating Officer	
	2B Community Care	Chief Operating Officer	
	2C Integrated Health & Well-being Hubs	Chief Operating Officer	
3. Improve access, outcome and experiences for all	3A Urgent and Emergency Care (UEC)	Chief Operating Officer	
	3B Planned Care, Cancer & Diagnostics	Chief Operating Officer	
	3C Fragile Services	Chief Operating Officer	
	3D Mental Health & Learning Disabilities	Executive Director of Allied Health Professionals and Health Science	
	3E Child and Adolescent Mental Health (CAMHs) & Neurodevelopment (ND)	Chief Operating Officer	
	3F Children and Young People Services	Chief Operating Officer	
	3G Women's Health	Chief Operating Officer	
	3H Pharmacy and Medicines Management	Executive Medical Director	
	3I Dementia	Executive Director of Nursing	
4. Create a modern, people-centred healthcare system	4A Foundations for the Future	Chief Executive	
	4B Strategy and Planning	Executive Director of Transformation & Strategic Planning	
	4C Clinical Services Planning, Leadership and Interprofessional Working	Executive Medical Director	
	4D Digital, Data and Intelligence	Director of Digital, Data & Intelligence	
	4E Research, Development and Innovation	Executive Medical Director	
	4F Education Partnership and Projects, Academic Careers and Strategic Alignment of Education	Executive Director of People Services & Organisational Development	
	4G Value & Sustainability	Executive Director of Finance	
	4H Quality	Executive Director of Nursing	
	4I Environment and Estates	Director of Environment & Estates	

	4J Workforce	Executive Director of People Services & Organisational Development	
	4K Finance & Commissioning	Executive Director of Finance	

Key Areas Requiring focus

Current reporting identifies a number of programmes requiring enhanced executive oversight due to delivery risk, low confidence or dependency on factors outside direct programme control. These include:

- Fragile Services, where workforce sustainability remains a significant concern.
- Cancer and Diagnostics, where performance remains below national expectations and workforce constraints continue to affect delivery.
- Dementia, where delivery of key pathway objectives is at significant risk due to the loss of specialist resource.
- Elements of the Health and Wellbeing Hubs programme, where affordability, funding and capital prioritisation challenges continue to affect progress.

The principal themes affecting delivery confidence across the portfolio are workforce fragility, operational capacity constraints, financial pressures, capital affordability, programme mobilisation challenges and national dependencies. These risks will continue to be monitored through programme governance arrangements and escalated where additional intervention is required.

3. Focus on Priority Areas

This section focuses on the organisation's priority areas, providing a quarterly assessment of progress and delivery. It offers an overarching appraisal of where programmes and services currently stand, highlighting areas requiring further attention, support, or intervention.

The detailed monthly service updates underpinning this assessment are provided in Appendix 2.

Major Change Programmes

Across the Health Board, there are four Major Change Programmes. This section outlines the progress during this quarter and delivery confidence against delivery of the full year's Annual Delivery Plan. Full details can be found in the appendix.

Programme	Progress against ADP	Delivery Confidence
Urgent & Emergency Care (3A)	During Q1, the Urgent and Emergency Care (UEC) Programme focused on strategic realignment following the introduction of the NHS Wales Three Pillars Framework, with the UEC Improvement Plan refreshed to prioritise Discharge to Recover and Assess (D2RA), Frailty and Clinical Engagement. Significant progress has been made in establishing the foundations for future improvement, including development of the Single Point of Access model, implementation of community falls services, strengthening Same Day Emergency Care and hospital flow arrangements, progressing WECDS implementation, and enhancing clinical engagement through a UEC Masterclass. Collaboration across partner organisations has also improved, supported by enhanced performance reporting and governance arrangements. Whilst there is positive momentum and stronger alignment to national priorities, the programme remains at an early stage of delivery, with most benefits yet to be fully realised. Sustained demand pressures across health and social care continue to impact key performance indicators, particularly delayed discharges and patient flow. The programme is therefore rated Amber, reflecting good progress in establishing the enablers for change while recognising the need to translate current development activity into measurable improvements in discharge performance, patient flow and UEC outcomes during the remainder of 2026/27.	
Planned Care (3B)	The Planned Care Programme continues to deliver a broad portfolio of transformation initiatives focused on reducing waiting times, improving access and enhancing patient experience across North Wales. During Q1, good progress was made in waiting list validation, electronic referrals, Community Health Pathways, the development of a pan-BCU One Waiting List approach, booking service modernisation, Surgical Hub Accreditation, theatre optimisation and expansion of Patient Initiated Follow-Up (PIFU) models. Notable achievements include validation of over 31,000 patient pathways, closure of almost 8,000 pathways, rollout of electronic referrals across 10 specialties, delivery of 228 Community Health Pathways, and continued success of teledermoscopy services. Whilst the programme is delivering measurable improvements in pathway management and service efficiency, significant challenges remain in translating transformation activity into sustained productivity and performance gains. Workforce constraints, consultant job-planning pressures, variable utilisation of additional capacity, and ongoing financial, digital and leadership dependencies present risks to delivery, including increasing waits for suspected skin cancer patients. The programme is therefore rated Amber, reflecting positive progress against planned milestones and recovery objectives, whilst recognising the need to embed improvements, increase theatre throughput and strengthen delivery confidence during 2026/27.	

Clinical Services Plan (4C)	The Clinical Services Plan (CSP) Programme has focused during Q1 on establishing the strategic foundations for a clinically led, evidence-based approach to shaping future services across North Wales. Progress includes engagement with senior clinical leaders, development of a draft Fragile Services Framework to support service assessment and planning, learning from best practice with Hywel Dda University Health Board, and the preparation of a comprehensive Programme Initiation Document. Work has also highlighted the importance of aligning clinical service planning with enabling strategies, including workforce, digital, estates and value, to support the development of a sustainable and deliverable future clinical services model. Whilst good progress has been made in developing the programme approach and strengthening strategic alignment, delivery has been impacted by organisational capacity constraints, competing corporate priorities, leadership vacancies and the need to consider emerging national policy and strategy developments. As a result, some Annual Delivery Plan milestones have not been achieved within the original timescales. The programme is therefore best assessed as Amber, reflecting positive progress in programme design and stakeholder engagement, whilst recognising the need to agree a revised delivery approach, secure external support and translate strategic development activity into an approved and actionable Clinical Services Plan.	
Community by Design (2B)	The Community by Design (CbD) Programme has made good progress in establishing the foundations for delivering integrated primary and community care services aligned to national priorities. During Q1, strategic funding was secured to support key programme leadership appointments, governance arrangements were developed, and programme mobilisation activities progressed through the development of a Programme Initiation Document and identification of priority delivery areas. Early progress has also been made in advancing key initiatives, including Breathlessness Hubs, community frailty models and the exploration of Community Diagnostics opportunities, while bringing together existing community transformation activity within a single programme framework. Whilst the programme is well aligned to the national Community by Design agenda and has successfully established the structures required to support future delivery, the majority of workstreams remain in the early stages of development and measurable benefits have yet to be realised. The programme is therefore rated Amber, reflecting positive progress in mobilisation, workforce recruitment and governance arrangements, whilst recognising that successful implementation and delivery of community-based models of care will be required to demonstrate improvements in prevention, integrated care and reduced reliance on hospital services during the remainder of 2026/27.	

Key Programmes

Across the Health Board, there are Key Programmes. This section outlines the progress during this quarter and delivery confidence against delivery of the full year's Annual Delivery Plan. Full details can be found in the appendix.

Programme	Progress against ADP	Delivery Confidence
Ablett Mental Health Unit (3D.10)	The Adult and Older People Mental Health Unit Redevelopment Programme made positive progress during Quarter 1, securing Welsh Government approval to proceed with a revised capital budget of £108.1m. This has enabled continued development of the scheme, including preparations for the Supply Chain Partner procurement process and ongoing engagement with Welsh Government stakeholders. Discussions undertaken during the quarter have also provided reassurance that the programme's strategic objectives, including modernising inpatient facilities and improving access to care closer to home, remain aligned with current service needs. While approval to proceed represents an important milestone, the programme's trajectory remains dependent on resolving a number of significant risks. Clarity is required on the scope, timescales and implications of emerging All-Wales mental health bed planning work to confirm alignment with the proposed redevelopment. In parallel, focussed action is needed to manage procurement risks and develop affordable solutions to both capital and ongoing revenue pressures. Addressing these issues at pace, in partnership with Welsh Government, will be critical to maintaining programme momentum and providing confidence in the delivery of the scheme within agreed timescales and financial constraints.	
Electronic Health Record (3D.9) Mental Health (All Ages) Electronic Health Record	The Mental Health Electronic Health Record (MH EHR) Programme has made good progress during Quarter 1, achieving a significant milestone with the successful completion of procurement activity and Welsh Government approval to proceed to contract execution and implementation. Preparatory work has continued across Digital, Estates, Health and Safety, CAMHS and Adult Mental Health Services to support mobilisation and ensure alignment with wider transformational initiatives. These activities have strengthened organisational readiness for the introduction of a single all-age electronic health record, which remains a key enabler of more integrated, consistent and informed care delivery across mental health services. In order to maintain implementation momentum, the immediate priority is securing confirmation of Welsh Government funding through the Digital Priorities Investment Fund process, alongside completing contractual arrangements with the successful supplier. Continued focus is also required on implementation planning, stakeholder engagement and organisational readiness to ensure deployment can commence promptly once funding is confirmed. While overall delivery remains achievable, progress at pace is dependent on resolving the current funding	

	uncertainty and finalising contract execution, which continues to present the principal risk to programme timelines.	
Foundations for the Future (4A)	The Foundations for the Future Programme has delivered all Quarter 1 milestones and continues to make positive progress in strengthening organisational leadership, governance and workforce capability. Key achievements include completion of the Competency Framework and Integrated Leadership Development Framework, progression of the Operational Governance Framework, advancement of organisational design activity, and progression to transition the Quality Management System into business-as-usual arrangements. These developments have strengthened governance and accountability and generated positive staff engagement through culture and leadership improvement initiatives. To improve delivery confidence and return the programme to a green trajectory, priority must be given to progressing organisational consultation activity, accelerating implementation of the revised operating model, and advancing Phase 2 organisational design work, including reviews of structures below Band 8b and the integration of Mental Health and Learning Disabilities services. Continued focus is also required on embedding the Operational Governance Framework, delivering leadership and workforce initiatives, and maintaining effective programme oversight, risk management and stakeholder engagement. While the programme remains on course to deliver its long-term objectives, timely progress in these areas will be critical to sustaining momentum, realising planned benefits and mitigating the impact of delays within the structures workstream.	
Health & Wellbeing Hubs	The Health & Wellbeing Hubs Programme continues to support the Health Board's ambition to strengthen community-based care and deliver more integrated services closer to home. During Quarter 1, progress has been made across several schemes, including advancement of the Strategic Outline Case for Bangor, agreement of Heads of Terms for land acquisition at Waunfawr, and continued partnership development with the Isle of Anglesey County Council for the Holyhead Hub. Further development work has also progressed at Penygroes and Porthmadog, focusing on business case development, site planning and affordability assessments, demonstrating continued momentum across the portfolio despite a challenging financial environment. There are funding, affordability and capital prioritisation challenges that are affecting a number of schemes across the portfolio. This includes progressing decisions on Caledfryn, Denbigh, identifying viable funding solutions, and establishing a formal programme board structure to strengthen oversight, manage interdependencies and accelerate issue resolution across projects. Continued collaboration with Welsh Government and local authority partners, alongside the progression of business cases and partnership agreements, is essential to maintaining momentum and achieving the long-term vision for integrated community services across North Wales.	

Laboratory Information Management System – LIMS (3B.19)	The LIMS Programme has continued to support operational services already deployed, with the Cellular Pathology and Mortuary modules functioning effectively and becoming embedded within routine practice. During Quarter 1, local teams-maintained progress through defect resolution testing, integration testing, end-user training, and participation in national configuration and testing activities for the Aliquots functionality. These activities have helped sustain organisational readiness and ensure that benefits from implemented modules continue to be realised despite wider programme challenges. To return the programme to a more stable trajectory, urgent priority is required at a national level to agree a recovery plan, confirm revised deployment timelines for future tranches, and resolve outstanding system defects. Locally, focus should remain on completing Aliquots configuration and testing, strengthening governance arrangements, addressing leadership capacity through the appointment of a substantive SRO, and mitigating risks associated with ageing legacy systems and ongoing resource pressures. Until there is greater certainty regarding funding, deployment schedules and the national route to delivery, significant risks will remain to programme timescales and benefit realisation.	
Llandudno Orthopaedic Hub (3C.15)	The Llandudno Orthopaedic Hub remains a key element of the Health Board's elective recovery plans and longer-term orthopaedic service sustainability. During Quarter 1, work continued to support mobilisation of the hub and the development of a High-Volume Low Complexity (HVLC) model of care, with preparatory activity progressing to improve theatre utilisation, standardise orthopaedic pathways and reduce unwarranted variation in clinical practice. These developments provide a strong foundation for increasing elective capacity and improving patient access once the hub becomes operational. The immediate priority is the opening and full mobilisation of the Llandudno Orthopaedic Hub, enabling the planned increase in elective orthopaedic activity and delivery of sustainable HVLC services. Focus is also required on achieving target theatre utilisation levels, implementing national orthopaedic pathways, addressing workforce and capacity constraints, and maximising the benefits of the additional capacity to support waiting list reduction. Timely delivery of these actions will be critical to restoring momentum, improving productivity and ensuring the hub delivers its anticipated contribution to elective recovery and service sustainability.	
Value & Sustainability (4G.12)	The Value & Sustainability Programme has made good progress during Quarter 1 in establishing the foundations required to support delivery of both financial and non-financial benefits across the organisation. Key achievements include the development of core workstreams covering Clinical Variation, Non-Pay & Procurement, Medicines Management, Continuing Healthcare and Value-Based Healthcare, alongside the introduction of a comprehensive benefits framework to measure improvements beyond traditional cost improvement metrics. A portfolio of	

	136 schemes has been identified, with £43.7m of opportunities recognised and £24.1m currently rated Green for delivery, while early benefits are being demonstrated through Value-Based Healthcare initiatives including Lymphoedema services, Community Health Pathways and Prehabilitation programmes. Priority now needs to be given to accelerating delivery across the full portfolio of improvement and savings schemes, embedding the benefits framework, and progressing the national thematic workstreams. Continued focus is required on achieving recurrent savings targets, strengthening arrangements for identifying and prioritising value opportunities, and embedding value-based approaches within decision-making and service planning processes. Successful delivery of these actions will be critical to realising the anticipated financial, quality and sustainability benefits, maintaining organisational momentum, and supporting the Health Board's longer-term recovery and transformation ambitions.	

Fragile Services

The Fragile Services work in 2026/2027 comprises of two core elements; existing challenged services and the development of a Fragile Services Framework.

The special measures framework highlighted several clinical services which were fragile because of poor quality and patient experience; staffing levels; and sub-optimal outcomes and performance. The eight services identified included vascular, urology, ophthalmology, orthodontics, orthopaedics, dermatology, plastics and oncology. These services became known as ‘Challenged Services’ and were placed under enhanced scrutiny by Welsh Government (WG).

In the 2026-2029 IMTP, the terminology to describe at-risk services has changed to ‘fragile services’ with both Plastics and Oncology now removed and with Gastroenterology added.

Across Dermatology, Ophthalmology, Orthopaedics, Orthodontics, Urology and Vascular, services remain under sustained pressure, primarily due to workforce shortages, rising demand and constrained capacity. While there has been meaningful progress in reducing long waits and improving access, particularly in Dermatology, Urology and Vascular, this position remains fragile and heavily reliant on interim measures, including insourcing, locum staffing and temporary pathways, rather than sustainable service models.

Workforce fragility is the primary system risk, limiting both recovery and transformation, alongside infrastructure constraints such as delayed capital developments (notably the Orthopaedic hub) and limited estate capacity. Demand and backlog pressures continue to outstrip capacity, with some early gains beginning to reverse in areas such as Vascular, and ongoing patient safety risks evident in high-backlog services like Orthodontics. Although transformation programmes and redesigned pathways are progressing, delivery remains constrained, and performance improvements are not yet stable or sustainable without decisive action on workforce, capacity and infrastructure investment.

As the organisation matures it is evident that the next step is to be in a position to identify fragile and/or at-risk services internally and provide a proportionate organisational response. A Fragile Services Framework is being developed to feed into the next iteration of the Quality Management System through a suite of fragility indicators. This work aims to understand the drivers behind service fragility and includes triangulation of workforce, performance, quality (patient safety, patient experience and clinical effectiveness), finance, staff engagement, as well as information on service standards.

Overall, whilst the work on the Fragile Services Framework is progressing well and on track, the scale of unresolved issues has resulted in an overall rating of Amber. If these issues remain unresolved as the year progresses, then there is a likelihood of this priority turning to Red.

The table below sets out the assurance rating and draws out key headlines that determine the overall rating as at the end of Q1. These may differ from the self-assessed delivery confidence in Appendix 2, which also includes further details from the service.

Programme	Progress against ADP	Delivery Confidence
Dermatology (3C)	Dermatology continues to experience increasing waiting times for suspected skin cancer patients, although Teledermoscopy is helping to improve access by enabling a high discharge rate (66%) and reducing unnecessary outpatient appointments. The service remains fragile due to ongoing difficulties recruiting substantive consultants, resulting in reliance on locum and interim staffing arrangements. Mitigations include a contracted insourcing arrangement with West IHC until September 2026, additional locum capacity, increased clinic capacity at Connah's Quay, and a restructuring of consultant capacity to prioritise urgent suspected cancer patients	
Gastroenterology (3C)	Gastroenterology has implemented an interim regional model for gastrointestinal bleed services, including weekend emergency endoscopy provision, while work continues to standardise referral and treatment pathways across primary and secondary care. However, the service lacks agreed clinical and operational leadership to drive improvement, and overnight endoscopy cover remains unavailable. Current mitigation relies on ongoing medical management of patients until endoscopy services become available the following day.	
Ophthalmology (3C)	Ophthalmology has delivered improvements through enhanced cataract pathways, Teach and Treat initiatives, and data quality improvements, while digital solutions including e-referrals and an electronic health record are being progressed. Despite this, long waiting times persist and workforce and leadership gaps continue to limit service transformation and pathway redesign. Mitigating actions include collaborative working across Integrated Health Communities, recruitment of a West IHC Ophthalmology Lead to strengthen leadership, and ongoing operational workforce planning.	

Programme	Progress against ADP	Delivery Confidence
Orthodontics (3C)	Orthodontics has achieved a significant reduction in Stage 1 waiting times through insourcing activity, and proposals to improve access to Cone Beam CT scanning will strengthen diagnostic capability. However, the resulting increase in patients progressing to treatment has further stretched capacity, with a substantial and growing treatment backlog that exceeds current service capability. Mitigations include exploring additional capacity through external providers and strategic partnerships, undertaking workforce planning, and improving patient communications to better manage expectations regarding treatment delays.	
Orthopaedics (3C)	Orthopaedics has experienced delays in expanding capacity because the planned opening of the Llandudno Orthopaedic Hub did not take place during Q1 due to delays in completing capital works. As a result, anticipated increases in activity have not yet been realised. To mitigate this risk, the service continues to utilise available capacity at Abergele Hospital while awaiting confirmation of the hub opening date.	
Urology (3C)	Urology has made significant progress in reducing long waits for first appointments and diagnostics and has established a partnership with Arrowe Park to provide robotic-assisted prostatectomy procedures, reducing dependency on distant outsourced providers. Despite these improvements, the service remains vulnerable due to an unsustainable on-call model and the absence of a longer-term regional solution. The lack of a robotic platform in North Wales also limits the repatriation of cancer activity. Mitigations include the recruitment of locum staff to stabilise the on-call rota, commissioning arrangements with external providers to maintain access to robotic surgery, and a planned Rapid Quality Review in September 2026.	
Vascular (3C)	Vascular services have sustained improvements in reducing long waits through alternative access models, including nurse-led clinics and hot clinics for higher-acuity patients. Additional progress has been made in developing network governance arrangements and recruiting an Educational Clinical Lead to support the potential return of FY1 doctors. The principal challenge remains securing stronger clinical engagement in service governance to drive and embed improvements. Work is underway with clinical and operational leaders to develop options that increase engagement and strengthen oversight	

3. Change Control Requests

The following summary table categorises a number of change control requests which the Board is asked to give final approval to:

ADP Ref	Summary and Rationale for Change
2627 001 2B.4	Amendment of Executive Lead from Executive Director of Finance to Chief Operating Officer
2627 002 3H.9	Amendment of wording of deliverable and change of Executive Lead from Executive Medical Director to Director of Digital, Data & Intelligence

Further details regarding each of the changes summarised are included in Appendix 1.

4. Next Steps

The Committee is asked to:

- **TAKE ASSURANCE** and **NOTE** the progress made to date including the challenges highlighted within the report.
- **NOTE** the Change Control Requests to be considered by Board.
- **SUPPORT** the onward submission of the Report to Board.

Appendix 1 – Change Control Requests

ADP Ref	Deliverable	Executive Lead	Change Requested
2627 001 2B.4	Develop a proposal for creating an investment fund for community groups and third sector organisations to work with the Health Board on community-based solutions to some of the largest challenges facing the system.	Executive Director of Finance	Amendment of Executive Lead from Executive Director of Finance to Chief Operating Officer
2627 002 3H.9	Deliver the risk prioritised components of Electronic Prescribing Service (EPS) that sustain safe, reliable digital services, covering devices, network/telephony, core infrastructure, and clinical platforms.	Executive Medical Director	Change of Executive Lead from Executive Medical Director to Director of Digital, Data & Intelligence. Amendment of wording of deliverable to the following (change in bold): Deliver the risk prioritised components of **Essential Services Programme (ESP)** that sustain safe, reliable digital services, covering devices, network/telephony, core infrastructure, and clinical platforms.

Appendix 2 – Full Quarter One Report

Annual Delivery Plan Quarter 1 - Overview by Key Priority				
KEY:	**High Delivery Confidence**	**Medium Delivery Confidence**	**Low Delivery Confidence**	**Complete**

1A Preventative approaches to Health & Wellbeing	Executive Director of Public Health	Overall Delivery Confidence
1A.1 Develop a proposal to support referrals to appropriate support following participation in Child Measurement Programme (e.g. to CAMHS, Children's, Dietetics, Weight Management).		Q3
1A.10 Embed Making Every Contact Count (MECC) brief intervention training into organisational processes to increase numbers of trained staff.		Q4
1A.2 Implementation of the recommendations in the Weight Management Review, increasing activity in Level 2 Adult weight services.		Q4
1A.3 Deliver approved Grant funded Programmes of work (Prevention and Early Years, Whole School Approach, Whole System approach to Healthy Weight)		Q4
1A.4 Provide education and targeted approaches to healthy choices through supporting schools, early years environments and families through Dietetics - early years programmes (Come & Cook, Tiny Tums).		Q4
1A.5 Act on the conditions that influence risk factors for ill-health (e.g. environmental, social or economic interventions), including promoting a state of good mental and physical health through assessment of impact including: 1) influence planning applications 2) work with the Alcohol Partnership Board and Public Service Boards (PSBs) to implement their plans 3) contribute to developing the environment through local development plans and Actif North Wales to consider green and blue spaces.		Q4
1A.6 Agree and commence a phased implementation of an enhanced Health Improvement offer within the Health Board and with partners across the health system that increases access to evidence-based opportunities to improve health and wellbeing outcomes.		Q4
1A.7 Produce gap analysis and opportunities from the potential and current state to shape the enhanced Health Improvement offer for services.		Q4

1A.8 Embed Health Improvement into the following areas: 1) delivery planning to support Statement 2 & 4 of the National Mental Health & Wellbeing Strategy (led by Mental Health Services / Public Health Wales), 2) refresh the Preconception Strategic Plan, 3) response plan developed from the weight management review recommendations.	Q4
1A.9 Healthy Travel Charter – increase the number of participating organisations each quarter, supporting Public Service Boards (PSBs) and wider partners to register organisational commitment at a regional and national level.	Q4

Overview

Most care delivery in the NHS now relates to long-term conditions the majority of which have significant preventable factors. Preventable health measures should consider all stages across the life course – from pre-conception and into older age. This can reduce the likelihood and severity of chronic illness, reducing flow towards acute settings. Encouraging healthy behaviours can prevent illness reducing demand across public services, including hospital services, GP appointments, emergency care, and long-term social care. It can also reduce costs of treatment over long periods and free up capacity in the health and care system to focus on more complex or urgent care needs. Population health and wellbeing is crucial for North Wales's socioeconomic resilience and the resilience of its communities. Preventative approaches empower people to take an active role in their own health including improving individual mental wellbeing, maintaining independence which can lead to a better quality of life as people age. Through whole system approaches, conditions can be created for good health through focused approaches which prevent problems arising in the future, build resilience, reduce the incidence of disease and encourage healthy behaviours. Much of this can be delivered outside of the acute setting and by working collaboratively across sectors.

Key Delivery Priority Quarterly Update

There are 10 deliverables within 1A all of which are to be delivered in Q4 except for 1A.1 due in Q3. All are currently reporting high delivery except for 1A.2 which is Amber due to the risk around timelines of a National digital development and the service capability and capacity to deliver. All deliverables have work underway to encourage healthy behaviours which contributes to both preventing ill health and improving the health of our population. The deliverables are grouped into 4 areas; Healthy Weight; Health Improvement; Healthy Travel Charter; MECC as per below:

1a) Healthy Weight (1A.1-1A.4) progressing, responding to the PHW review and 2026/27 ministerial priority on healthy weight and includes the prevention grant funded programmes and Healthy Weight, Whole System Approach. Q1 deliverables include: 1A.1: Strengthening of the Child Measurement Programme approach and development of a plan for the Tier 1 pathway 1A.3: MOUs developed and agreed for 26/27 with Service Leads. Quarterly review meetings held and reports received on delivery progress. 1A.4: Healthy eating programmes continue to be delivered.
1b) Health Improvement (1A.5-1A.8) underway which aims to maintain or improve people's health through a range of interventions. Q1 deliverables include 1A.5: physical activity pathway developed within the iCAN provision, planning applications and alcohol licencing applications continue to be reviewed in accordance with the agreed protocol, 1A.6: Development of a health improvement framework has seen the completion of a set of recommended priorities for all topic areas within the framework with stakeholder engagement. 1A.8: Weight management review recommendations included in the Healthy Weight Ministerial priority action plan for 26/27 with quarter 1 actions delivered.
1c) Healthy travel charter (1A.9) Regional Partnership has been formed. Engagement continues with the first regional meeting taken place in Q1 with clear actions for organisations to take away. Public Service Board summary report created and circulated to support.

1d) Making Every Contact Count (1A.10) developed MECC conversation cards that are to be piloted. Comms plan developed and in place. Two campaigns successfully delivered.

2a) Healthy Weight (1A.1-1A.4) work is designed to maximise the reach of the offer that is provided both through secondary care services and in the community, setting aligned to the WMS review and Ministerial Priorities. Impact on the population will not be evident until further implementation progress is made. A range of performance measures serve as proxy indicators whilst the firming up of outcomes, short, medium and long term are agreed.
2b) Health Improvement (1A.5-1A.8) – During quarter 1 the team responded to eight planning applications of which the impact has public health significance. Recent applications have seen conditions added re: opening hours and application use and applicants actioning public health recommendations.
2c) Healthy Travel Charter (1A.9) Improved collaboration across North Wales through the establishment of the regional partnership group, with positive feedback highlighting the value of the practical guidance and support provided to signatory organisations.
2d) MECC (1A.9) Increased awareness and engagement with MECC through targeted campaigns, co-developed conversation cards and a communications plan. Reach was further extended through promotion by colleagues across the Health Board, including Occupational Health (People Managers Forum) and Health Inequalities (Parkrun Practices), highlighting the value of partnership and matrix working.

3) Delivery oversight is based on a robust programme management approach utilising the portal to manage the plan in terms of milestones and task, risks and issues. Portal programme reports are presented at the Public Health Programme Group with escalations including deviations to plan, risks and issues for information or action and risks managed with mitigation action plans.

1B Proactive strategies for disease prevention, falls & frailty	Executive Director of Public Health	Overall Delivery Confidence
1B.2 Develop and launch a suite of health intelligence resources that support improved, evidence-based decision-making in service planning and help identify and reduce inequalities.		Q2
1B.1 Develop and agree a comprehensive road map that outlines priorities, roles, data requirements and phased delivery actions to support the development of the Population Health Management (PHM) Programme.		Q3
1B.10 Produce local plans to support new National Public Health Wales Human Papillomavirus (HPV) self-sampling programme.		Q3
1B.3 Establish a Population Health Management (PHM) programme with the Digital Team (DDAT) through development of a comprehensive road map, that will facilitate sustainable healthcare transformation in future years by targeting interventions that prevent ill health, improve care and support for people with ongoing health conditions, and reduce inequalities in health outcomes.		Q4
1B.4 Complete implementation of the focused Diabetes High Value High Impact pathway.		Q4
1B.5 Identify place-based approaches within Primary and Community care and develop options which respond to population need and deliver holistic patient centred care for people living with diabetes.		Q4
1B.6 Support improvement and reduce variation in performance and compliance in relation to Diabetes priorities including: 8 Care Processes and reducing variation.		Q4
1B.7 Implement appropriate best practice within the national Quality Statement for Diabetes.		Q4
1B.8 Support the introduction of the National Lung Screening Programme (commence 2027).		Q4
1B.9 Create a plan together with Public Health Wales to support delivery of the National screening uptake targets and improvement against National performance indicators and to reduce variation.		Q4

Overview
Over 60% of NHS activity is linked to chronic long-term conditions which impact significantly on capacity, and demand for services. Most care delivery in the NHS now relates to long-term conditions many of which are preventable or have risks that can be modified. The North Wales population is ageing and falls and frailty are a significant driver of demand across primary and acute NHS Services and is expected to increase. Preventing falls and frailty is crucial to the NHS because it protects people's health, preserves independence, and reduces avoidable pressure on already stretched services. In order to reduce the prevalence and impact of disease, falls and frailty on health services, it is vital to shift focus towards prevention, early intervention and detection, and the prevention of deterioration through greater use of population and clinical intelligence. This includes bringing together available academic evidence, local data and evidence (e.g. patient experience feedback) and stakeholder involvement to improve services and outcomes.

Applying data and evidence through population health management will allow the organisation to target action within identified population groups towards where there is a strong likelihood of a health risk occurring, develop tailored interventions to prevent or reduce the impact of health risks which would contribute to preventing further deterioration, and optimise how the early stages of disease is detected. Intervening in the early stages of disease can prevent the disease from progressing, allows people to self-manage their health, improves health outcomes, prevents the individual developing other health conditions and ensures that people can continue to live their lives fully within their families and communities.
Key Delivery Priority Quarterly Update During Quarter 1 the health board has delivered on key actions and milestones including commencing recruitment to PHM posts which will contribute to developing and strengthening the Health Board understanding of population needs and how best to address these needs. PHM posts will help to develop the population approaches to delivering improvement. High Value High Impact / Diabetes - task and finish group structures and governance structures to support delivery of the programmes of work have been developed. The structures provide the mechanisms and assurance to quality improvement and transformation work linked to Diabetes, prevention and care in North Wales with the aim of improving outcomes and reducing unwarranted variation in access an outcome of care.

1C Health Inequalities	Executive Director of Public Health	Overall Delivery Confidence
1C.2 Regional Vaccine Equity Plan co-developed and launched.		Q2
1C.5 Work with Local Authorities to secure jointly commissioned social prescribing services and expand creative offers with the Third Sector across North Wales.		Q2
1C.7 Based on the work in 2025/26 on the homelessness assessment, to comply with the new Homelessness and Social Housing Allocation (Wales) legislation and needs assessments on other inclusion groups, develop a comprehensive inclusion health offer for people in North Wales.		Q3
1C.1 Implement plans which reduce inequity in the uptake in the most and least deprived areas in preventing ill-health, especially in relation to vaccination, screening and diabetes prevention and care. By utilising population health intelligence and evidence, target approaches to reduce variation and health inequalities within inclusion health groups and areas of deprivation.		Q4
1C.3 Regional Screening Equity Plan co-developed and launched.		Q4
1C.4 Work with primary care partners to reduce variation in vaccine uptake between primary care clusters.		Q4

1C.6 Supporting Marmot principles work towards a whole system shift to prevention and addressing inequalities by increasing the number of organisations/partnerships committing to, and evidencing early delivery against, the missions and Anchor Charter in the Regional Wellbeing, Prevention and Anchor Framework (missions: Environment, Communities, Housing, Food, Employment, Life-Long Learning, Active Lifestyles, Creative Lifestyles)	Q4

Overview

Healthy life expectancy is reducing and the gap in healthy life expectancy and life expectancy is widening. The gap between those in affluent areas and from non-vulnerable groups is widening too, compared to those from the least affluent areas and from inclusion groups (e.g. homeless, Gypsy, Roma, Traveller communities, etc). This could drive demand and increase costs for health services. The Health Board has a key role in reducing health inequalities by delivering equitable access, experience and care, and also to meet the requirements of the Wellbeing of Future Generations (Wales) Act 2015, The Equality Act (2010), the Public Sector Equality Duty and the Socio-economic Duty. Those living in the most deprived areas, and those experiencing extreme disadvantage (e.g. inclusion health groups) need services the most, however these groups experience poorer access which is driving widening inequalities in health outcomes. Inequalities will continue to widen if we do not embed population health approaches in pathways and service plans that can enable the organisation to target resources proportionate to need. Through understanding the needs of communities, the Health Board can better enable provision of care in the right way, in the right place, and at the right time. To drive this change, the organisation must consider the role of health inequalities as a core component of prevention, early intervention and improving population health. The Health Board cannot reduce health inequalities alone. Many factors which impact on health and wellbeing require commitment and coordinated action across public sector organisations, enabled through the organisation's role and opportunity as an Anchor institute. Together, the right social, economic and environmental conditions can be created that allow health and wellbeing to flourish. Working together through developments such as Community by Design and the integrated approach to Social Prescribing, the Health Board will work with local authority colleagues, primary care, the voluntary sector and stakeholders to develop effective offers at place level, improve the economy, provide better opportunities for accessing environments which promote wellbeing, provide fairer procurement, offer employment and improve housing availability and safety. Improving these factors can delay or prevent the onset of ill health and help the population to live well for longer in their communities. One of the way's the Health Board is contributing to this is through supporting Denbighshire County Council as one of the three places in Wales selected to work with the University College London Institute of Health Equity Wales Team to maximise benefits related to the Welsh Government's ambition to become a Marmot Nation.

Key Delivery Priority Quarterly Update

During Q1 a Health Needs Assessment for inclusion health groups has been completed which provides the basis for developing the Health Board offer to those populations that experience poor access to healthcare services. To further support improved access, planning documents supporting the vaccine equity plan and screening inequalities data have also been produced. A draft health equity checklist has been developed with key partners which provides a basis for services to utilise when carrying out planning.

New Social Prescribing contracts with Local Authorities are progressing well. These look to adopt co-commissioning approaches. There has been some delay experienced with a couple of Local Authorities, but detailed plans are in place to ensure the revised timescales are supported to deliver in year. Service specifications which have been co-produced with Local Authorities, BCUHB Public Health and Primary and Community Care are being finalised, having be reviewed by legal teams.

Engagement events have taken place with stakeholders and partners to further develop 'missions' within the Regional Wellbeing, Prevention and Anchor Framework which further supports health board contribution to addressing inequalities and supporting long-term wellbeing in our most vulnerable groups. As part of this, we continue to support Denbighshire County Council with the 'Marmot Nation' Health Equity Wales Local Authority funded project.

1D Health Protection	Executive Director of Public Health	Overall Delivery Confidence
1D.3 Implementation of phase 2 Childhood Immunisation Schedule recognising changes to the immunisation schedule for 2026, protecting children across a range of disease and illness.		Q3
1D.4 Deliver the funded Health Protection plan including establishing a Health Protection partnership with a Service Level Agreement in place with the 6 North Wales Local Authorities.		Q3
1D.1 Through targeted programmes of work for each vaccine / immunisation, implement the vaccine equity plan and work with partners (e.g. schools) to deliver the National Immunisation Framework targets to improve take up rates.		Q4
1D.2 Develop the GP and Identified Validated Sample (IVS) collaborative to improve uptake in the RSV 75 plus cohort.		Q4
1D.5 Enhance the delivery of health board services to protect people in North Wales against existing, new and emerging health protection threats and hazards by supporting screening and vaccination programmes, and disease elimination activities (Hepatitis B and C, and TB).		Q4
1D.6 Deliver evidence-based approaches to protecting and preventing ill health within specific sectors and settings e.g. delivery of infection prevention control interventions in residential Care Homes.		Q4

Overview
Health Protection is an important element of preventing and responding to the threat of communicable disease, environmental and other health risks. Health Protection focuses on preventing harm before it happens and keeps communities safe from communicable and other notifiable illness that could affect large numbers of the population at scale. Risk of infectious diseases include Flu, Measles, and M-Pox, with disease outbreaks having a significant impact on closed settings such as care homes and schools. Health Protection includes the management of vaccine preventable disease risks such as measles, outbreak control planning, and training and education in settings to support Infection Prevention Control (IPC). There is also opportunistic screening and testing for disease such as blood borne viruses and sexually transmitted diseases to contribute to the control of further transmission and support the elimination of diseases like Hepatitis B and C, HIV and TB. Health Protection considers an 'all hazards' approach and includes environmental public health issues arising, zoonotic infection and vector-borne disease. Health protection supports the health and wellbeing of the whole population not just individuals and brings together a range of partners including Local Authorities, Environmental Health, Emergency planning, Public Health Wales and Community services to strengthen resilience across the whole system. It is essential for preventing harm, reducing inequalities, maintaining public confidence, and protecting healthcare capacity.

Key Delivery Priority Quarterly Update
During Quarter 1, significant progress has been made in supporting health board services to protect people in North Wales against communicable diseases, and to protect and prevent ill health within specific sectors and settings.

Between April and June, a number of proactive, preventative Infection Prevention Control (IPC) interventions have been undertaken across Residential Care Homes in North Wales. These have been enhanced with the delivery of monthly IPC Champions education sessions on key topics, and the provision of hand-hygiene training.
Also, the Health Protection Service has continued to support disease elimination agendas through blood borne virus sampling in key workplaces (major employers) and in other settings and services, including in Substance Misuse Services, Probation and Women's Centres. The service has also been deployed to provide TB sampling for Asylum Seekers in the East Area IHC.
In response to two significant High Consequence Infectious Disease threats, the Health Protection Service has led the coordination of preparedness measures within the Health Board whilst also engaging with wider partners. This has included a system briefing for all partners in North Wales, education sessions for medics, additional capacity for HCID PPE training, oversight of HCID plans and pathways, and the provision of information and advice for BCUHB staff. In addition, the Service coordinated and delivered a HCID response simulation exercise for the Health Board.
In quarter 1, the Health Protection Service has taken responsibility for the coordination of Rabies post exposure prophylaxis for individuals exposed to Rabies, e.g. animal bites/scratches in the UK and overseas.

The impact of the above activities include improved preparedness for HCIDs within the Health Board (including a greater number of staff trained in HCID PPE, formalized pathways for the identification, assessment, sampling and management of suspected or confirmed HCID cases), a greater understanding of Health Board areas of weakness for managing a potential HCID case and/or future pandemic, improved resilience within the residential care home sector for the control and management of communicable diseases, progress towards the elimination of Hepatitis B and C, and a reduced number of presentations to EDs for the provision of Rabies post-exposure prophylaxis

With regards the funded partnership between the Health Board and the six Local Authority Environmental Health teams, progress has stalled due to further requests for information from the Director of Finance and the Executive Committee. A further paper has been produced for the Executive Committee (due to be considered on the 15th July). This delay may impact on the achievement of some deliverables in year 1 of the partnership.

Campaigns across all Vaccination and immunisations are being developed or underway. A particular focus this year on reducing inequalities in uptake and this is being supported by the development of the Vaccine Equity Plan. The Health Board is focusing on delivery at scale and utilising the Primary Care partners to enhance delivery.

2A Primary Care	Chief Operating Officer	Overall Delivery Confidence
2A.1 Ensure the new General Dental Service (GDS) contract is in place and embedded, with a clear plan for the procurement of new services including commissioning of tier 2 dental services where appropriate.		Q2
2A.2 Undertake a review of primary care dental services to assess current capacity, patient access, and service utilisation. Work with commissioned providers and system partners to identify opportunities to increase access for patients.		Q2
2A.3 Procure a robust digital system within the Community Dental Service (CDS) to support the management of patient records, and replace the current outdated system.		Q2
2A.6 Develop a costed primary care-led frailty model to enable proactive, coordinated care closer to home, as part of the Community by Design work. Identify the impact that current initiatives are having on maintaining patients at home.		Q3
2A.4 Continue to deliver the Strategic Programme for Primary Care (SPPC) national 'Strategic Workforce Plan for Primary Care in Wales', with the aim of developing a sustainable, skilled workforce to meet the evolving healthcare needs of the population of North Wales over the next five years. Fully utilise the Work Based Learning Funding allocated to Primary Care to support delivery.		Q4
2A.5 The Health Board will strengthen the model of integrated primary and community care across North Wales by designing and delivering strategic priorities that align with the national Community by Design Transformation Programme. The key areas of focus will include urgent and same day care, management of chronic conditions in the community and prevention and population health management.		Q4
2A.7 Finalise a proposal to increase the use of the Audit Plus Frailty Tool in the community to ensure that patients receive proactive care in line with their agreed care plans.		Q4
2A.8 Support the implementation and roll-out of the NHS Wales app in primary and community care services by developing and implementing an action plan to promote the NHS app including patient education, staff training and monitoring of uptake.		Q4

Overview

In the NHS most patient contacts occur in Primary Care, making it the foundation of a sustainable and accessible healthcare system. It encompasses a broad range of community-based services that provide accessible, person-centred care, including general medical services (GP practices), community pharmacies, dental services, and optometry. Primary care also includes multi-disciplinary teams such as nurses, allied health professionals, social prescribers, and community mental health support, working together to deliver proactive, preventative care as well as care for people with longer term conditions. The Health Board recognises the importance of stable, resilient Primary Care services to ensure that the residents of North Wales receive care at the right time and in the right place, medicalised only when necessary. Primary Care plays a critical role in early intervention, prevention, and supporting people to manage their own health and wellbeing, thereby reducing avoidable demand on hospital and specialist services. Strengthening

Primary Care also helps tackle health inequalities by ensuring timely access to local, community-based support, particularly for those with complex needs or living in rural and deprived areas. A well-functioning Primary Care system is therefore essential to improving population health outcomes, supporting the shift towards prevention and early intervention, and delivering a more sustainable, prudent healthcare model for the future. The areas within this objective will all align to and form part of the Community by Design Programme.

Key Delivery Priority Quarterly Update
In quarter one the following has been delivered in Primary Care:
- A review of primary care dental services is in progress. A plan has been agreed for recurrent and non-recurrent funding which will increase access for the population of North Wales. Plans with timelines are in place to ensure delivery of targets in 2026/7.
- An outline business case has been approved to progress the procurement of a new digital system within the Community Dental Service. There is an agreed plan with time frame which supports the delivery of this project in 2026/7.
- The SPPC national plan continues to be delivered across BCU with a focus on the Community by Design major change programme. A proposal for the SPPC has been agreed by BCU exec and is awaiting sign off by Welsh Government.
- Community by Design programme continues to progress. A programme director and programme manager post has been agreed which will shape the leadership of the work, and a CbD programme board has been formed. Once fully established, the programme director and board will drive forward programmes of work which will see both a qualitative and quantitative impact on the population of North Wales. A programme plan will be created which will ensure delivery of the work streams

2B Community Care	Chief Operating Officer	Overall Delivery Confidence
2B.4 Develop a proposal for creating an investment fund for community groups and third sector organisations to work with the Health Board on community-based solutions to some of the largest challenges facing the system.		Q1
2B.12 Diagnostic Provision in the Community will be reviewed including undertaking a needs assessment for diagnostics and working with current providers to review and agree the most efficient delivery mechanism.		Q2
2B.2 Undertake a demand and capacity review to understand the levels of community nursing that are required across the Health Board, including weekend working.		Q2
2B.8 Undertake a review of urgent care services available in the community including general practice, optometry, dental and pharmacy. Identify how services may be optimised and expanded.		Q2
2B.11 Develop a proposal to establish local breathlessness hubs to provide specialised support and care for people experiencing chronic breathlessness.		Q3

2B.1 Develop Community by Design as a Major Change programme, working with partners to ensure it reflects national priorities and local needs.	Q4
2B.10 Implement appropriate best practice within the national Quality Statement for Older people and people living with frailty.	Q4
2B.3 Map current Enhanced Community Care services across North Wales, identifying where services are located and the differences. Develop a proposal that offers recommendations as to how to further reduce unnecessary hospital conveyance and admissions.	Q4
2B.5 Develop a strategic delivery plan for Palliative, End of Life and Bereavement Care (PEoLBC) in line with the All-Wales Service Specification for the delivery of Palliative and End of Life care in Wales and All Wales Competency Framework. This will include consideration of how to increase weekend capacity for specialist palliative care nursing.	Q4
2B.6 Agree an approved Quality Improvement Plan for End-of-Life Care Decision Making	Q4
2B.7 Implement appropriate best practice within the national Quality Statement for Palliative and End of Life Care.	Q4
2B.9 The Health Board will enhance the coordination of care for people with long term conditions and improve access to a broader range of community-based services, investing in integrated primary and community care.	Q4

Overview

The Health Board will continue to prioritise the delivery of care closer to home, recognising that community-based services are essential to improving outcomes through prevention, early intervention, and supported self-management. Providing care within local communities makes services more accessible, improves user experience, and helps reduce inequity by removing practical, geographical, and socioeconomic barriers to care-based services which is essential to improving outcomes through prevention, early intervention, and supported self-management. The Primary Care Model for Wales emphasises local delivery through integrated cluster working, enabling multidisciplinary teams to meet needs proactively within community settings and as this shifts toward a Community by Design approach this will be built upon. In parallel, the NHS Wales Decarbonisation Strategic Delivery Plan highlights the need for a shift toward nonacute, community delivered healthcare supported by expanded use of digital technology, including remote monitoring, virtual support, and enhanced homebased care. Increased use of community hubs and outreach models will support seamless health and social care closer to people's homes. By strengthening community services, the Health Board can ensure that hospital-based care is reserved for cases requiring more complex or escalating clinical intervention. This approach not only supports prudent healthcare principles but also improves service sustainability, reduces pressures on acute settings, and enables people across North Wales to receive timely, person-centred care within their own communities.

Key Delivery Priority Quarterly Update

The Community by Design Major Change Programme is being established and the existing workstreams are being aligned to the Programme. SPPC funding grant will support the appointment of the Programme Director and support. Workstreams aligned to the CbD programme include frailty, Enhanced Care and the establishment of Breathlessness Hubs. A proposal has been developed for an overarching group to coordinate the development of community frailty services. A decision on leadership of the group and to confirm its mandate is awaited. A group has also been established to deliver breathlessness hubs and a reference group is proposed to support the broader agenda of increasing access to diagnostics in community settings.

The proposals are in development phase, so limited impact to date.

The Associate Directors of Primary Care are working closely with colleagues in the Transformation team to establish the governance and groups to deliver the key objectives for 2026/27. Heads of Nursing for Community Nursing and for Palliative Care are continuing to progress service developments with their teams.

2C Integrated Health & Well-being Hubs	Chief Operating Officer	Overall Delivery Confidence
2C.2 Waunfawr Integrated Health & Well-being Centre – sign heads of terms to secure purchase of a site, progress the parallel elements of the programme plan.		Q1
2C.7 Holyhead Integrated Health & Well-being Centre – agree memorandum of understanding with Local Authority, thereafter progress the programme plan.		Q1
2C.8 Rhyl (Royal Alexandra Hospital - Phase 1) Integrated Health & Well-being Centre – commence construction, and progress the programme plan for delivery. Develop the case for Phase 2 later in the financial year.		Q1
2C.1 Bangor Integrated Health & Well-being Centre – work with partners on a strategic outline case		Q2
2C.4 Porthmadog Integrated Health & Well-being Centre – revise options appraisal for location, progress the parallel elements of the programme plan.		Q2
2C.5 Conwy West Integrated Health & Well-being Centre – finalise site location, progress the parallel elements of the programme plan.		Q2
2C.6 Denbigh (Caledfryn) Integrated Health & Well-being Centre – finalise funding strategy, thereafter progress the programme plan.		Q2
2C.3 Penygroes Integrated Health & Well-being Centre – develop an outline business case, progress the parallel elements of the programme plan.		Q3
2C.9 Finalise Integrated Rebalancing Capital Fund (IRCF) prioritisation.		Q3

Overview
Health and Wellbeing Hubs are essential to transforming how care is delivered across North Wales. With an ageing population, falling healthy life expectancy and widening inequalities, particularly in deprived and rural communities, a new model of care is required to ensure people receive timely, coordinated support closer to home. Hubs bring together physical health, mental health, social care and community wellbeing services in one accessible location, creating a “no wrong door” approach that enables earlier intervention, smoother referrals and more holistic care. By embedding prevention and public health activity within local communities, they help address the wider determinants of

health, promote independence and reduce avoidable demand on acute services. This integrated model directly supports Welsh Government's A Healthier Wales vision and BCUHB's Strategic Intents to strengthen primary and community care and shift the balance towards prevention and early intervention. Several hub schemes are already underway across the region, such as Bangor, Holyhead, Caledfryn in Denbigh and the Royal Alexandra Wellbeing Hub in Rhyl, and each is being developed in partnership with Local Authorities, housing associations and third sector organisations, reflecting the multi-agency model required to deliver integrated, community-based care. The Health Board's IMTP prioritises a coordinated programme approach to ensure these developments are aligned to population need, strategically governed, and deliver maximum impact for the communities they serve.

Key Delivery Priority Quarterly Update

The Health and Wellbeing Hubs Programme remains a key component of BCUHB's strategy to transform community-based care across North Wales, supporting the shift towards prevention, early intervention and integrated service delivery closer to home. Progress has continued across a number of hub developments, with significant advancement in business case development, land acquisition, partnership arrangements and strategic planning with local authority and Welsh Government partners.

The Bangor Integrated Health and Wellbeing Centre has reached an important milestone, with the Strategic Outline Case nearing completion and expected to enter Health Board governance processes shortly. Engagement with Welsh Government and local partners has continued to address previous concerns regarding the Menai Centre lease arrangements and to strengthen the wider wellbeing, leisure and community offer within the hub, ensuring alignment with the vision for integrated community facilities.

Good progress has also been made at Waunfawr, where Heads of Terms for land acquisition have been agreed and are ready for signature. Development of procurement documentation and refinement of the Business Justification Case are advancing well, providing a solid foundation for progression to the next stage of the programme. Holyhead has similarly seen positive momentum, with the Memorandum of Understanding between the Health Board and Isle of Anglesey County Council approaching completion, strengthening the partnership arrangements required to progress delivery.

Development activity continues at Penygroes and Porthmadog. At Penygroes, discussions with Welsh Government have clarified the requirements for progressing the business case, while initial construction cost information has been obtained to inform future planning. In Porthmadog, work is ongoing to secure funding for business case development and design activity, alongside continued engagement with stakeholders to determine the preferred site location.

A number of schemes continue to experience challenges linked to funding availability, affordability and programme prioritisation. At Caledfryn, Denbigh, progression has been paused while funding options and the long-term revenue implications of the proposed service model are reviewed. The launch of public consultation activity has also been delayed pending resolution of these issues. Conwy West remains deferred until 2028 following previous capital prioritisation decisions, while Phase 2 of the Royal Alexandra Health and Wellbeing Hub in Rhyl have been placed on hold following direction from Welsh Government, although Phase 1 has been successfully completed.

3A Urgent and Emergency Care (UEC)	Chief Operating Officer	Overall Delivery Confidence
3A.1 Reduce avoidable ambulance conveyances and ED admissions from Care Homes through providing falls lifting equipment and level one falls prevention training to be delivered to 30 Care Homes across North Wales.		Q1
3A.12 Implement appropriate best practice within the Getting it Right First Time (GIRFT) Corridor care improvement guide.		Q1
3A.3 Reduce avoidable ambulance conveyances and ED admissions from the community by developing a proposal to use Six Goals Programme funding to increase Community Resource Teams (CRT) capacity, focused on mobilising Band 3 therapy support staff as a dedicated pan BCU community falls response resource.		Q1
3A.6 Provide more suitable pathways for frail patients that ensure they have shorter lengths of stay within acute hospitals in line with the national Acute Frailty Service (AFS) model. Undertake baseline assessment and gap analysis for current Acute Front Door Frailty Services across all acute sites, identifying current service provision, workforce utilisation, SDEC alignment and opportunities to strengthen early frailty assessment and intervention.		Q1
3A.13 Implement appropriate best practice within the national Quality Statement for Care in Emergency Departments.		Q2
3A.2 Reduce avoidable ambulance conveyances and ED admissions from the community through producing an options appraisal for the National Six Goals Team to support funding for St John's Level 1 falls training and lifting equipment for Community Resource Teams (CRTs), ensuring a consistent pan North Wales approach to community-based falls response.		Q2
3A.7 Adopt national best practice in relation to implementation of safe, fast, and consistent ambulance handover processes at the ED front door.		Q2
3A.8 Reduce ambulance hours lost, improve hospital-wide flow and ambulance handover times by standardising triage and streaming processes across all sites (majors, minors, SDEC, frailty).		Q2
3A.9 Reduce ambulance hours lost, improve hospital-wide flow and ambulance handover times by strengthening senior clinical decision-maker presence at the front door, especially during periods of high demand.		Q2
3A.10 Reduce the number of people delayed in hospital and their length of stay, thereby reducing the potential for deconditioning, by strengthening application of community Discharge to Recover and Assess (D2RA) pathways, ensuring faster discharge options for frail patients.		Q3
3A.5 Improve pathways of care delays out of the hospital through working more closely with the Local Authority Social Care Information Advice and Assistance (IAAs) team to improve referral pathways out of hospital.		Q3

3A.11 Reduce the number of people delayed in hospital and their length of stay, thereby reducing the potential for deconditioning, through implementation of Optimal Hospital Flow facilitators, utilisation of the Transport Coordination hub and enabling a 7-day discharge model across all acute sites.	Q4
3A.4 Reduce avoidable ambulance conveyances and ED admissions by transitioning from the current Single Integrated Clinical Assessment and Triage (SICAT) model to the Single Point of Access model (SPOA) with a broader Multi-Disciplinary Team (MDT) that is able to better sign post the most appropriate alternate to hospital treatment routes. This will ensure there is sufficient resource to operate the SPOA 7 days a week, 12 hours a day.	Q4

Overview
Urgent and Emergency Care (UEC) is vital to keeping people in North Wales safe, healthy and supported when they need help most. But growing demand and pressure across the system are creating delays throughout the whole pathway, with an impact of reducing hospital flow, and affecting patient experience and safety. These challenges also disrupt planned care, widen health inequalities, and contribute to the Health Board's ongoing Special Measures status. Improving UEC requires action across the whole pathway, including prevention and community support, efficient hospital processes, and safe and timely discharge. The potential of preventative actions in areas such as falls, frailty and inclusion health is important to reduce the growing demand for UEC services. No single part of the system can resolve this alone. Strong partnership working with the Welsh Ambulance Service (WAST), Local Authorities, primary and community care, and the voluntary sector is essential. At the same time, there are key improvements within the Health Board's direct control that must progress at pace, including better discharge coordination, strengthened clinical pathways, and more effective use of workforce and capacity. As one of the Health Board's Major Change Programmes, UEC underpins delivery of the national Six Goals for Urgent and Emergency Care. The aim is to build an integrated, responsive system where people receive the right care, in the right place, at the right time, supporting better outcomes, restoring confidence, and contributing to sustainable improvement across the whole Health Board. This area is being supported by the Intensive Support Team (sponsored by the partnership of the Health Board, Welsh Government and NHS Performance and Improvement). In addition to the workstreams and deliverables set out below there will be the development of detailed Operational Improvement Plans at both service level (currently Integrated Health Communities) and a pan BCU level. These Operational Improvement Plans are being informed by the work of the external experts

following the 6As assessment and the use of other diagnostic tools. The Operational Improvement Plans will have rapid cycle actions (90-day cycles) and will focus on the implementation of standards/protocols of practice (clinical and operational) across the system, improving safety and building sustainability. The use of best practice such as GIRFT Corridor Care Guidance (and other best practice standards) will drive the Operational Improvement Plan approach. Outputs from the Major Change Programme will also inform the rapid cycle actions to enable transfer and implementation from the Programme into practice.

Key Delivery Priority Quarterly Update

During Quarter 1, the programme focused on establishing the foundations required to deliver the Six Goals for Urgent and Emergency Care. Key achievements include:

• Progressing the transition to a Single Point of Access (SPoA) model, including governance, workforce planning and alignment with the national framework.
• Securing funding and commencing implementation of the Community-Based Falls Response Framework, including falls equipment procurement, CRT pilot activity and workforce modelling.
• Delivering falls management training and equipment programmes for care homes.
• Completing Acute Frailty baseline assessments and options appraisals across all acute sites.
• Re-establishing and strengthening SDEC governance, completing baseline reviews and developing improvement plans.
• Undertaking baseline work to improve ambulance handovers and strengthen collaboration with WAST.
• Establishing Optimal Hospital Flow Task and Finish Groups, recruiting Hospital Flow Facilitators and implementing delayed discharge dashboard pilots.
• Progressing discharge improvement initiatives, including development of the North Wales Trusted Assessor Memorandum of Understanding.
• Advancing WECDS implementation, with the programme approaching go-live.

As expected in the first quarter, activity has primarily focused on creating the infrastructure needed to deliver long-term improvements. Early impacts include:

Qualitative

• Improved collaboration between Health Board teams, Local Authorities, WAST and regional partners.
• Better visibility and management of delayed discharges through new dashboard reporting.
• Enhanced support for care homes through falls training, equipment provision and follow-up arrangements.
• Improved readiness to implement national UEC frameworks through strengthened governance, workforce planning and pathway development.

Quantitative

• Falls training programmes delivered across targeted care homes, with KPI monitoring established.
• An additional Optimal Hospital Flow Facilitator posts recruited.
• Delayed discharge dashboards implemented in pilot areas.
• WECDS implementation progressed to the final stages ahead of deployment.

Whilst there have been local improvements, system-wide performance measures such as Pathway of Care Delays have yet to demonstrate sustained improvement due to

continued demand pressures across health and social care.

To ensure delivery of the overarching aims, the programme will:
• Complete implementation of the SPoA model and associated referral pathways.
• Roll out the Community-Based Falls Response Service and care home falls initiatives across North Wales.
• Implement Acute Frailty Services supported by agreed workforce models and performance measures.
• Develop and embed a consistent BCU-wide SDEC model.
• Continue improvements to ambulance handover processes and H45 performance.
• Expand dashboard reporting and standardised operational processes across all Integrated Health Communities.
• Embed Optimal Hospital Flow initiatives, including Board Rounds, Red-to-Green and discharge planning improvements.
• Complete WECDS implementation and strengthen performance reporting arrangements.
• Develop sustainable workforce and financial plans to support long-term delivery.

Overall, the programme remains on track, with Quarter 1 focused on establishing the systems, governance and workforce foundations needed to deliver measurable improvements in urgent and emergency care outcomes by March 2027.

3B Planned Care, Cancer & Diagnostics	Chief Operating Officer	Overall Delivery Confidence
3B.15 WS6b – Diagnostics: Complete replacement of both Linear Accelerators at Ysbyty Glan Clwyd.		Q1
3B.20 Finalise delivery strategy and financial model for the Nuclear Medicine consolidation project, including PET-CT scanner for North Wales.		Q1
3B.7 Secure continuation of additional external capacity within dermatology, endoscopy, radiology and urology to meet existing demand into 2026/27. (Investment from Planned Care fund).		Q1
3B.10 Finalise the oncology clinical strategic plan for north Wales.		Q2
3B.13 Review outstanding requirements not yet met within the Cancer Quality Statement and produce proposals for implementations.		Q2
3B.14 Introduce a 'breast pain only' pathway to ensure women receive the most appropriate care in a timely manner. (Dependent on national funding).		Q2
3B.16 WS6b – Diagnostics: With the support of the NHS Wales Performance and Improvement (NHS Wales Performance & Improvement) develop diagnostics plans which are safe, sustainable and fit for the future. This includes the full implementation of digital technology as a key service enabler to address workforce shortages.		Q2
3B.8 Agree the strategic model for the delivery of dermatology services in north Wales.		Q2
3B.9 Agree the strategic model for the development of robotic assisted surgery in north Wales.		Q2
3B.19 Continue to work with Digital Healthcare Wales (DHCW) and partners to implement the national Laboratory Information Management System (LIMS)		Q3
3B.5 WS5 – Follow-up Pathways: Modernise outpatient services management of follow-up care through ensuring consistent and best practice application of See on Symptom (SOS) and Patient Initiated Follow-up (PIFU) across all specialties and undertaking pathway validation and data quality cleanse of the follow-up waiting lists in line with the National Clinical Information Network (CIN) pathways and discharge protocols.		Q3
3B.1 WS1 – RTT Pathway Validation: Consistent clerical and clinical validation will be in place incorporating national guidance and a suite of initiatives included expanding the reach of the EBO Virtual 'chat bot' for patient validation.		Q4
3B.11 WS6a – Cancer: Increase compliance with national optimal pathways with particular focus on increasing straight to test rates.		Q4
3B.12 Deliver opportunities for streamlined follow-up to improve patient care (e.g. Patient Initiated Follow-up – PIFU or See on Symptoms – SOS).		Q4

3B.17 Progress national business justification case for digital cellular pathology, enabling the service to fully realise clinical and operational benefits, including overall increased reporting performance for routine cases in addition to those of higher clinical priority.	Q4
3B.18 Effective commissioning of additional diagnostic capacity in key specialties where core capacity and Waiting List Initiatives (WLIs) are insufficient to meet forecast demand.	Q4
3B.2 WS2 – Referral Pathway Refinement: A range of initiatives to support a reduction in referrals to outpatients in high volume specialities, adopting best practice in waiting list management including the continuing roll out of the community health pathways, to ensure better prioritisation of available capacity for the longest waiting patients with a particular focus on unwarranted variation and associated referral threshold management.	Q4
3B.3 WS3 – Booking Services: Reduce variation in outpatient waiting times and improve communication with patients on the waiting lists by adopting best practice including modernisation and standardisation of centralised booking services.	Q4
3B.4 WS4 – Pre-operative & Operative Effectiveness: Adopt best practice in theatre management through standardising pre-operative assessment process, and driving theatre productivity across North Wales. Undertake the national Surgical Hub Accreditation to support improved efficiencies and High-Volume Low Complexity listings.	Q4
3B.6 Effective commissioning of planned care services in key specialties where core capacity and Waiting List Initiatives (WLIs) are insufficient to meet forecast demand.	Q4

Overview
Timely access to planned care, cancer services and diagnostics is central to improving outcomes, experience and confidence in health services across North Wales. Feedback from patients and communities highlights the consistently high quality of care delivered by staff, and our continued focus is on ensuring that people are able to access this care as

quickly and seamlessly as possible. Across planned care, cancer pathways and diagnostics, the past year has demonstrated that targeted action, strong leadership and collaborative working can deliver meaningful improvement, creating a strong foundation for the next phase of transformation. Work has also demonstrated many ways to improve efficiency and thus patient access. Demand continues to grow across all three areas, driven by demographic change, advances in treatment and increasing complexity of care. Cancer services exemplify this: the Health Board diagnoses nearly 5,000 new cases every year, with numbers rising, and earlier diagnosis supported by timely diagnostics offers the greatest opportunity to improve survival and reduce inequalities. Approximately 4,000 people each month following assessment including diagnostics are told they do not have cancer; an increasing trend. This volume of patients is putting pressure on capacity and hence mobilising new ways of working will continue to be a major part of how services adapt to this increase with little additional available resource. Planned care recovery likewise depends on efficient diagnostic pathways, with imaging, endoscopy and pathology capacity underpinning every stage of treatment planning and delivery. Diagnostics therefore sit at the heart of system improvement. Despite record levels of activity, demand has continued to outpace capacity, but the introduction of the new Radiology Information System (RISP) and the progression of major business cases create significant opportunities for service modernisation. Moving from short-term recovery solutions toward sustainable, year-round capacity will support more consistent performance and ensure diagnostics can meet future needs, including the growing role of genomics and AI-enabled technologies. A specific focus on diagnostics medium-term clinical and service plan will help identify key pathway efficiencies and modernisation opportunities from initial referral through to follow-up and surveillance. The Planned Care Major Change Programme provides the framework to integrate pathway redesign, national best practice, GIRFT recommendations and value-based healthcare principles. Strengthened clinical leadership, robust demand and capacity planning, and modernised diagnostic infrastructure will together enable more responsive pathways, improved patient experience and better outcomes for the population of North Wales, reflecting the organisation's commitment to continuous improvement and high-quality, sustainable services. This area is being supported by the Intensive Support Team (sponsored by the partnership of the Health Board, Welsh Government and NHS Performance and Improvement). In addition to the workstreams and deliverables set out below there will be the development of detailed Operational Improvement Plans at both service level (currently Integrated Health Communities, Womens, Diagnostics and Cancer Service Divisions) and a pan BCU level. These Operational Improvement Plans are being informed by the work of the external experts. The Operational Improvement Plans will have rapid cycle actions (90-day cycles) and will focus on the implementation of standards/protocols of practice (clinical and operational) across the system, improving effective deployment of resources and building sustainability. The use of best practice such as GIRFT Guidance (and other best practice standards) will drive the Operational Improvement Plan approach. Outputs from the Major Change Programme will also inform the rapid cycle actions to enable transfer and implementation from the Programme into practice.

Key Delivery Priority Quarterly Update
PLANNED CARE
1. What have we delivered so far this year towards the aim?

The Planned Care Programme is continuing to implement a coordinated portfolio of transformation initiatives focused on reducing waiting times, improving patient access and experience, and delivering more sustainable planned care services across North Wales. Following lessons learned from the 2025/26 programme, 15 priority projects were initially approved, with 1 additional project pilot approved to start in the July meeting, with further opportunities being developed and aligned to the emerging Planned Care Recovery Plan.

Key actions underway include:

- Expanding patient validation through the EBO chatbot and strengthening clerical and clinical validation processes to improve waiting list accuracy and identify patients who no longer require treatment.

- Increasing referral optimisation through the rollout of electronic referrals and Community Health Pathways, with work commenced to embed CHP clinical thresholds within secondary care triage, helping ensure patients are referred appropriately and capacity is prioritised for those with greatest clinical need.

- Increasing compliance with national optimal pathways through improving compliance with the gynaecology post-menopausal bleeding pathway, adopting the nationally and locally approved breast pain only pathway and increasing use of Teledermoscopy.

- Developing a pan-BCU "One Waiting List" approach to support more equitable access to care regardless of locality.

- Modernising booking processes through standardised services and a service level agreement, quality accreditation for administrative staff, and testing a return to partial booking to improve attendance rates and reduce wasted capacity.

- Preparing for Surgical Hub Accreditation and using specialty optimisation reviews to identify opportunities to improve theatre productivity and increase high-volume, low-complexity activity.

- Expanding Patient Initiated Follow-Up (PIFU) and See on Symptom (SOS) models to reduce unnecessary follow-up appointments and improve patient self-management in line with the adopted CIN self-management protocols

- Commenced with a programme of work to reduce the follow-up backlog and redress the balance between the follow-up to new ratio.

- Developing a single integrated planned care recovery and transformation framework, supported by specialty-level recovery planning and strengthened governance arrangements.

While workforce, funding and digital capacity constraints remain significant risks, mitigating actions are in place and the programme remains broadly on track to deliver the planned transformation objectives.

2. What impact (both qualitative and quantitative) has the work had on the population of North Wales compared to what it set out to achieve?

The programme has delivered measurable improvements in waiting list management, referral optimisation, access to care and patient experience during Q1.

Quantitative impacts include:

- Validation of 31,815 patient pathways during Q4 2025/26, resulting in: 7,978 pathway closures (25%) for patients waiting over 36 weeks. Closure of 2,823 pathways for patients waiting over 104 weeks. A 49% reduction in Stage 3 pathways. A 51% reduction in duplicate pathways.

- Expansion of electronic referral management to 10 priority specialties across BCUHB.

- Delivery of 228 Community Health Pathways, exceeding the Q1 target of 210.

- Teledermoscopy maintained a 66% discharge rate, reducing unnecessary outpatient appointments and improving access to specialist dermatology assessment.

- Validation of follow-up waiting lists resulted in 25% of an initial cohort of 805 gynaecology patients being appropriately discharged within the first two weeks of review activity.

Qualitative impacts include:

- Improved confidence in waiting list data and more accurate prioritisation of patients requiring treatment.

- Increased consistency in referral management and clinical thresholds across North Wales.

- Improved patient experience through digital validation tools, enhanced communication, and more flexible follow-up models such as PIFU and SOS.

- Greater equity of access through development of the One Waiting List approach and standardised pathways.

- Improved clinical decision-making and pathway efficiency through specialty optimisation reviews and cancer pathway redesign work.

Overall, the programme is demonstrating tangible benefits and is contributing to improved access, reduced unnecessary activity, and more effective use of available planned care capacity across North Wales.

3. What actions are we undertaking to ensure we are on track to deliver the full overarching aim and associated impact by the end of March 2027?

To maintain delivery momentum through to March 2027, the programme is focusing on a number of critical enabling actions:

- Recruiting additional validation staff to increase capacity and maintain waiting list quality.

- Accelerating rollout of the patient validation chatbot to long-waiting cohorts across multiple specialties.

- Implementing recommendations arising from national specialty optimisation reviews and GIRFT principles.

- Finalising and implementing the One Waiting List model and Booking Service Level Agreement.

- Progressing Surgical Hub Accreditation and strengthening theatre optimisation work.

- Expanding PIFU, SOS and follow-up validation activity to reduce avoidable outpatient demand.

- Developing options to sustain Community Health Pathways after national funding ends in 2027.

- Aligning programme governance with the emerging Planned Care Recovery Plan and confirming future senior leadership arrangements to maintain oversight and accountability.

Collectively, these actions are intended to ensure the programme delivers its overarching objective of improving access, outcomes and patient experience while establishing a more sustainable and equitable planned care model across North Wales by March 2027.

CANCER

A programme of service-level actions is being undertaken to improve cancer performance in north Wales, although progress continues to be constrained by significant structural pressures.

At a strategic level, the Foundations for the Future programme is reshaping the Health Board's operating model, with direct implications for how cancer services are governed and delivered. In parallel, a draft oncology clinical strategy and an emerging robotic-assisted surgery strategy are being developed as part of the wider Clinical Services Plan. These will be critical in modernising care delivery, maintaining service quality, and supporting workforce recruitment and retention, recognising that advanced technologies such as robotic surgery will become standard practice in the coming years.

Pathway improvements are being taken forward through close working with primary care, supported by targeted education and the Community Health Pathways software to enable more appropriate routing of patients into the system. Alongside this, a range of innovative services are being embedded, including nurse-led triage in colorectal services, teledermoscopy in dermatology and the expansion of self-management and patient-initiated follow-up pathways in gynaecology and skin which launched in Q1. Collectively, these approaches will improve pathway efficiency, reduce unnecessary activity, and support more timely access to care.

However, cancer waiting time performance remains significantly under target, with 53% achieved against the 75% standard, primarily due to constraints in diagnostic capacity and workforce availability. Diagnostic services, particularly endoscopy, continue to represent the most significant system bottleneck, with demand exceeding capacity despite mitigation measures such as additional modular facilities. Workforce fragility remains the most significant risk to sustainability. A number of key services, including dermatology and gastroenterology, are heavily reliant on insourced provision and locum staff. While this has enabled the maintenance of services in the short term, it is not financially or

operationally sustainable. In parallel, vacancies in clinical leadership roles, including Cancer Clinical Advisory Group chairs, are limiting the ability to drive consistent improvement and maintain strong strategic oversight.

There are also ongoing challenges in equity of access and patient experience. While services such as prehabilitation are delivering strong outcomes, access is currently limited geographically. Similarly, gaps in psychological support, are impacting patient experience and outcomes, with variation across the region. Communication between primary and secondary care remains a significant systemic issue, with continued reliance on paper-based processes leading to delays and fragmented care, although local improvement initiatives are underway.

Overall, while there is clear evidence of meaningful progress and innovation for the population of north Wales, the system is not yet operating within a stable or sustainable model. Delivery of the full overarching aim by March 2027 will depend on continued targeted investment in diagnostic capacity, workforce stabilisation through agreed models of sustainable service delivery across north Wales, and equitable access to supportive care services.

DIAGNOSTICS

Diagnostics remains a critical enabler of improvements across planned care and cancer services, with work continuing at pace to ensure the Health Board is on track to deliver its overarching objectives by March 2027. Building on the strategic action plan developed with NHS Wales Performance and Improvement, a comprehensive operational implementation plan is being developed to translate recommendations into measurable service improvements. This work is being aligned with the Intensive Support Team programme and the broader Planned Care Major Change Programme to ensure a coordinated approach to pathway redesign, capacity optimisation and performance improvement.

Alongside operational planning, a number of medium- and long-term sustainability initiatives are progressing. Key business cases are being developed to strengthen diagnostic infrastructure, modernise equipment and digital capability, and support the establishment of sustainable capacity models that reduce reliance on short-term recovery measures. These developments, together with the implementation of standardised operational and clinical practices, will support more efficient deployment of resources and improve resilience across diagnostic services.

The primary anticipated benefit for the population of North Wales is a reduction in diagnostic waiting times, supporting earlier diagnosis, faster access to treatment and improved patient experience. As diagnostic services underpin both cancer and planned care pathways, improvements in diagnostic timeliness are expected to have a wider system impact, contributing to reduced pathway delays and supporting delivery of national performance standards.

Qualitatively, the work has strengthened collaboration across services and established a clearer framework for operational improvement, informed by external expertise and best practice guidance. Quantitatively, the focus remains on reducing waits and improving flow through diagnostic pathways, with delivery plans and associated performance measures being developed through the operational implementation planning process to track progress towards the March 2027 objectives.

Over the coming year, priority actions will focus on implementing the operational improvement plan, progressing strategic business cases, embedding best practice standards and identifying further opportunities for productivity and pathway efficiencies. Collectively, these actions will support the transition from recovery-based approaches to sustainable service models, ensuring diagnostic services are equipped to meet growing demand while improving access, experience and outcomes for the population of North Wales.

3C Fragile Services	Chief Operating Officer	Overall Delivery Confidence

3C.1 Finalise and implement a network-wide plan to facilitate improvements in vascular theatre utilisation, ensuring GIRFT principles are maintained.	Q1
3C.15 Open Llandudno Orthopaedic hub	Q1
3C.33 Agree immediate model for out of hours Gastro-Intestinal (GI) bleed provision, in order to provide safe and high-quality care.	Q1
3C.36 Further development of QMS to provide structured view and understanding of the drivers behind fragile services, through the triangulation of broad range of key data points.	Q1
3C.39 Review and implement improvements to the governance surrounding services of concern, including establishment of both risks and separate issues logs.	Q1
3C.41 Build upon work already completed to create a central monitoring, oversight and reporting to ensure effective responses to recommendations from the Royal Colleges, HIW and other reviews, ensuring they are discharged and either verified or delivered or scheduled for delivery within the health board's longer-term improvement plan.	Q1
3C.7 Engagement and implementation of interim pan North Wales networked Dermatology service model, to better utilise resources (staff and funding) across North Wales. This is ahead of the full Clinical Services Plan work due to urgency around service sustainability especially in the West.	Q1
3C.2 Commence implementation of vascular service review as part of the first tranche of Clinical Services Plan reviews, to: -Help strengthen integrated working across hub and spoke sites, -Support development of a skilled, happy and sustainable workforce, -Improve patient outcomes across key pathways-Ensure greater alignment with national guidance and best practice.	Q2
3C.20 Complete outsourcing review to identify repatriation opportunities as well as long-term strategic partnerships.	Q2
3C.23 Full workforce review, succession planning, skills mix, expansion of roles such as Optometrists, Orthoptists, Advanced Clinical Practitioners, to support more sustainable services.	Q2
3C.24 Ensure sufficient nursing and Healthcare Support Workers to enable High Volume Low Complexity Theatre lists - Cataract 90% of lists to have 7 Cataracts per list.	Q2
3C.28 Develop plan and seek approval to support a sustainable model for flexible cystoscopies, to contribute to improvements in the Urology 8-week diagnostics.	Q2
3C.32 Standardisation of Gastroenterology referral and treatment pathways, supported by triage, across primary and secondary care, to ensure appropriate use of Health resources. Including access to Endoscopy.	Q2
3C.37 Use the new QMS capability to map the highest priority services of concern as part of the Clinical Services Plan work, capturing the main KPIs for each that will be tracked to measure improvement.	Q2

3C.40 Design and implement a support package for services of concern in order to support their improvement, incorporating learning from the Clinical Services Plan Phase 1 work on Challenged Services.	Q2
3C.9 Balancing Dermatology work between primary and community and secondary care – Further development of the Community Health Pathways and Teledermoscopy in order to reduce avoidable referrals into secondary care.	Q2
3C.11 Building upon the progress in improving this service to date, closing key vacancies and forming stronger multi-professional working, renewed recruitment efforts to appoint substantive consultants.	Q3
3C.14 Develop proposals to increase access to Cone Beam capable CT scanners, improving capacity and patient experience and travel.	Q3
3C.18 Rationalisation of hip and knee implants, reducing variation to those referenced in GIRFT reports, improving value for money. Starting in Llandudno and then rolling out across all sites.	Q3
3C.19 Implement national standard pathways for Orthopaedics across all sites, reducing pathway variation.	Q3
3C.21 Develop proposals for pan North Wales models of care for Ophthalmology, working within the Clinical Services Plan framework, including potential strategic partnerships.	Q3
3C.22 Improve data quality and completeness through standardised regional coding for all sub-specialties, clinical and non-clinical validation, to support improved reporting and service planning.	Q3
3C.26 Continue to work with DHCW and CAVHB to implement the national Eye Care referral and patient record systems.	Q3
3C.27 Present the final on call options appraisal to Operational Leadership Team (OLT) and Executive Committee and secure a preferred option decision, in order to address unsustainable use of locum consultants due to recruitment and retention issues related to an unattractive on-call rota.	Q3
3C.3 Review elective and emergency open AAA outcomes from November 2024 for patients treated at University Hospital North Midlands (UHNM). With support from the Vascular Society, Royal College of Surgeons and National Leads, make clear recommendations to the Health Board for the ongoing delivery of open Aortic Aneurysm surgery together and implement a clinical plan that will ensure delivery of best possible outcomes for the people of North Wales.	Q3
3C.30 Award of Vasectomy contract within North Wales via appropriate procurement routes and mobilisation of referrals to successful provider, in order to improve patient experience and care closer to home. Patients currently have to travel into England for this service.	Q3
3C.31 Develop sustainable Health Board processes for multi-professional delivery of Local Anaesthetic Transperineal Prostate (LATP) biopsies for diagnosis of prostate cancer.	Q3

3C.38 Ensure that services of concern monitoring, escalation and de-escalation processes, governance and reporting are adequately covered within the latest Performance and Accountability framework, covering both Executive and Board Member visibility. Including capturing how people's care and treatment outcomes are monitored and how they compare to similar services.	Q3
3C.10 Balancing Dermatology work between primary and community and secondary care – Directed enhanced service in place to allow low risk cancers to be managed in the community.	Q4
3C.12 Design of a clear service delivery model based on equity, sustainability, and estate capacity.	Q4
3C.13 Full workforce review, succession planning, skills mix, expansion of roles such as Dentists with special interests, Orthodontic Therapists, to support more sustainable services.	Q4
3C.16 Mobilise and deliver HVLC Orthopaedic activity in Llandudno - Deliver a sustained HVLC programme targeting 85% theatre utilisation.	Q4
3C.17 90% of elective arthroplasty lists to have 4 primary joints, supporting improvements in theatre utilisation.	Q4
3C.25 Deliver the next tranche of Teach and Treat course delivery to support hospital service demand reduction and care closer to home: with graduates providing extended "community first" workforce (Independent Prescribing, Glaucoma and Medical Retina capacity) within community optician practices.	Q4
3C.29 Develop proposal for strategic partnership as close to North Wales as possible, on major urology cancer service, including timelines for full Robotic Assisted Surgery (RAS) transition which will improve Urgent Suspected Cancer (USC) performance and patient experience through care closer to home. Patients are currently traveling to London for RAS prostatectomy and nephrectomy.	Q4
3C.34 Develop a regional Integrated Digestive Disease Service (IDDS) with strong multi-professional working, in order to provide a safe and effective care for patients with gastro-intestinal disease.	Q4
3C.35 Establish sustainable model for Endoscopy service provision across North Wales including Joint Advisory Group (JAG) accreditation (national accreditation). Including considering proposals for a new endoscopy unit and reducing reliance on insourcing and outsourcing.	Q4
3C.4 Reduce waiting times for new and review out-patient appointments by increasing the number of clinics delivered by our non-consultant workforce, in-line with vascular society guidance and professional standards.	Q4
3C.5 Embedding a culture of safe learning through adopting the 'Safe Learning Charter' across the network, both self-assessment via the associated maturity matrix as well as incorporating learning from HEIW's report on training and education and the PPA service review into culture and behaviour.	Q4
3C.6 Implement appropriate best practice within the national Quality Statement for Vascular Disease	Q4
3C.8 Involvement in the full Clinical Services Plan work to design the long-term sustainable Dermatology model.	Q4

Overview

The Health Board currently has a number of clinical services where maintaining a reliable and consistent service is challenging. The initial set of services were identified as part of the Special Measures escalation process, namely Urology, Vascular, Ophthalmology, Dermatology, Plastic Surgery, Oncology, Orthopaedics and Orthodontics. Since then, the Health Board has been both making improvements in those services and continuing to develop its approach to identifying and supporting other fragile services. The entry in this year's IMTP is a mixture of both services identified under Special Measures as well as one self-identified by the Health Board. Two of the services identified under Special Measures, Oncology and Plastics, have not been drawn out in the IMTP as they have addressed the identified issues sufficiently to be considered for de-escalation. Whilst at the time of writing that decision had not been made, the Health Board are satisfied that their service level plans are sufficient to monitor their progress, making space for those services identified by the Health Board. Work in this area has formed part of the first phase of the Clinical Services Plan (CSP), addressing issues that could not wait until the full CSP was underway. The CSP priority area will cover the longer-term transformational changes for these services, with this section continuing to focus on the short-term actions necessary to address the most urgent issues.

Key Delivery Priority Quarterly Update

Challenged Services: Across Dermatology, Ophthalmology, Orthopaedics, Orthodontics, Urology and Vascular, services remain under sustained pressure, primarily due to workforce shortages, rising demand and constrained capacity. While there has been meaningful progress in reducing long waits and improving access—particularly in Dermatology, Urology and Vascular—this position remains fragile and heavily reliant on interim measures, including insourcing, locum staffing and temporary pathways, rather than sustainable service models.

Workforce fragility is the primary system risk, limiting both recovery and transformation, alongside infrastructure constraints such as delayed capital developments (notably the Orthopaedic hub) and limited estate capacity. Demand and backlog pressures continue to outstrip capacity, with some early gains beginning to reverse in areas such as Vascular, and ongoing patient safety risks evident in high-backlog services like Orthodontics. Although transformation programmes and redesigned pathways are progressing, delivery remains constrained, and performance improvements are not yet stable or sustainable without decisive action on workforce, capacity and infrastructure investment.

Fragile Services Framework - A draft fragile services framework has been developed to feed into the next iteration of the QMS through a suite of Quality Planning metrics. This has been developed to understand the drivers behind fragile services and includes triangulation of workforce, performance, quality (patient safety, patient experience and clinical effectiveness), finance, staff engagement, as well as information on service standards.

Dermatology – ongoing inability to recruit substantive consultants, resulting in continued reliance on interim staffing.

Ophthalmology – workforce and leadership gaps are constraining delivery of transformation programmes, creating medium confidence in achieving regional model and pathway improvements.

Orthopaedics – delay to Llandudno Orthopaedic Hub opening preventing planned capacity and impacting elective recovery trajectory.

Orthodontics – significant and growing backlog (treatment) exceeding capacity, posing a sustained patient safety risk without fundamental service model and workforce solutions. Proposals to increase access to Cone Beam capable CT scanners are reported as complete, thus improving capacity and patient experience.

Urology – unsustainable reliance on locum workforce and fragile on-call model, creating financial pressure and long term service instability.

Vascular – unsustainable workforce model combined with long waiting lists, risking reversal of performance gains and impacting timely access to care.

Gastroenterology - An interim regional model for GI bleed provision has been established, with emergency endoscopy services coordinated through Ysbyty Glan Clwyd for patients across all three acute hospital sites. Patients from Ysbyty Gwynedd and Wrexham Maelor are transferred on a treat-and-return basis following early clinical assessment and stabilisation. The model provides a clear and consistent pathway for urgent GI bleed management, improving service resilience and patient safety. However, overnight endoscopy cover is not currently available, meaning some patients may require ongoing medical management until the service is available the following day.

3D Mental Health & Learning Disabilities	Executive Director of Allied Health Professionals and Health Science	Overall Delivery Confidence
3D.2 Train inpatient staff on the use of ReQol 10 Patient Reported Outcome Measures (PROMS) alongside the National Programme Safety team.		Q1
3D.3 Agree and develop with partners a phased Open Access Mental Health Service model with a view to implementing the demonstrator site by Q4 based on the international evidence base.		Q1
3D.8 Establish a digitally delivered specialist All-Wales gambling harm and treatment service.		Q2
3D.1 Engage with National Patient Safety Programme to improve quality and safety across services with the implementation Safe Discharge and 72-hour follow-up standards.		Q4
3D.10 Strengthen the strategic case for the development of the purpose-built, future-proof Adult and Older People Mental Health Unit at the Ysbyty Glan Clwyd site with the aim of presenting a full business case to Health Board for the approval by the end of Q4.		Q4
3D.11 Progress the 13 key areas supported by the Board in the Scope of Mental Health Oversight and Development Group, including but not exhaustively; strategic plan and models of care, outcomes framework, performance, service user engagement, standards of clinical practice, workforce planning, estate and physical environment, culture and organisational development, leadership and management, legacy reviews, finance, dementia care and psychological therapies.		Q4

3D.4 Engage with the National workstream to Improve Physical Health of People with Severe and enduring Mental Illness including review and alignment of the BCU MHLD physical health policy in line with national developments.	Q4
3D.5 Deliver a material reduction in the number of out of area placements through robust clinical and patient safety management (inclusive of community and acute staff) aligned to the implementation of the Crisis Care Model.	Q4
3D.6 Reduce Health Inequalities for people with learning disabilities by increasing the uptake of the annual health checks and public health screening initiatives across services.	Q4
3D.7 Define and formally adopt a tiered crisis response framework for LD services with clear pathways for prevention, early intervention, urgent response, intermediate care provision in partnership with the Local authorities and post-crisis stabilisation.	Q4
3D.9 Continue to progress the Electronic Healthcare Record (EHR) Transformation Programme which will reduce paper records and be a key enabler for service transformation, through commencing the implementation of the All Ages MHLD and continued engagement with WG regarding a wider EHR.	Q4

Overview
Adult Mental Health and Learning Disabilities (MH&LD) services are redesigning, expanding and improving services aligned to the national strategies for both Mental Health and Wellbeing and Learning Disability with support and direction from NHS Wales Performance and Improvement to deliver on the emerging Strategic Programme for Mental Health. This will enable the Health Board to deliver stepped care models across MH&LD services, ensuring service users receive the appropriate level of care based on their specific needs and circumstances including crisis and long-term needs. The development of an open access model with a focus on recovery along with the introduction of an electronic health record will be the most significant step in the redesign of our services since the implementation of the Mental Health Measure. Mental Health and Learning Disabilities will focus on improving the quality and safety of the care delivered within, community, inpatient and specialist services. Engagement with the distinct national quality and safety programmes will support training, embed learning and tools and introduce safety and outcome measures across services that will ensure we are delivering bilingual care that meets service user needs, addresses physical health care needs and reduces risk. It is important to reduce the gap in health outcomes for people with mental health and learning disabilities, supported by a focus on prevention, early intervention and reducing health inequalities. We continue to invest in long term capital plans to improve mental health and learning disabilities environments, making them safer through, for example, ligature reduction measures and more therapeutic settings to support our engagement approaches with service users, visitors and staff. The Board has identified the continued improvement of mental health services as a key priority, with open and transparent public Board reporting of progress and challenges at least twice per year. The Royal College of Psychiatrists 'Review of Reviews' has featured strongly during 2024 and 2025. The Board in January 2026 approved the establishment of a Mental Health Oversight and Development Group, chaired by the Chief Executive with a 'whole-organisation' emphasis on improving sustainable, modern, high-quality services.

Key Delivery Priority Quarterly Update
Work to deliver the Strategic Programme for Mental Health continues, with the establishment of a working group to take forward the multi workstream elements of the Patient Safety Programme, this work is being aligned to the introduction of the Nursing and Midwifery Quality Standards dashboard that MHLD are piloting. Home Treatment teams are progressing the enhanced service provision as agreed within Phase 1 of the crisis care model. The enhanced service has supported the reduction in the use of OOA beds, as part of a number of measures taken to ensure daily oversight and management of bed utilisation, internally and externally. Development of the OAM model, is now being considered in terms of ambition and viability, this is being done alongside the wider development of the community mental health teams with phase 2 of the crisis care model at the heart of the work. The gambling harm service was successfully launched on 1st April 2026 with a minimum viable product. Staff have been recruited and are in post, supporting initial delivery with recruitment progressing for full-service complement planned in Qtr. 2.

Actions to reduce OOA bed usage has resulted in an end of June position of 2, which is an improvement on the agreed trajectory of 10 for Qtr. 1.
Gambling harms service is operational and actively delivering direct support to service users 24/7. @ 3rd June 2026 172 helpline contacts were recorded and the service supporting 46 individuals with active treatment.

All key workstreams are supported by a robust project management approach with clear performance management, reporting and escalation that feeds into and through our divisional governance process. Key project deliverables and risks are monitored with opportunities to escalate challenges built into the process along with seeking to accelerate any milestones where possible.
For shared deliverables such as the implementation of the all-ages Mental Health EHR and ligature reduction works, we continue to work with colleagues across Estates, Health and Safety, CAMHS and DDaT to progress.
The establishment of the MHODG is a critical oversight structure to ensuring delivery and progress at an organisational level advocating that mental health is everyone's business and that the division is enabled to connect more broadly for greater impact for North Wales citizens.

3E Child and Adolescent Mental Health (CAMHs) & Neurodevelopment (ND)	Chief Operating Officer	Overall Delivery Confidence
3E.5 Improved Access to Information, Guidance, and Assessment - Establish Clear, consistent access pathways in line with NEST/NYTH principles. Including streamline ND assessment prudent pathways to improve efficiency – introducing standard audit mechanisms and use of same day assessments for clear cases, enhance joint working across services and sectors - building links with education, CAMHS and third sector and piloting multi-agency ND input in schools.		Q2
3E.2 Improve access to CAMHS services by reducing and sustaining waiting times under the Mental Health Measure (MHM) and improving patient pathways to deliver better outcomes and experiences for Children and Young People (CYP). Including: exploring options for embedding Open Access principles, map and standardise pathways across the region using clinical guidelines and WG Community CAMHS service specification.		Q3

3E.1 Early Help - Strengthen Early Intervention and Prevention. Develop and embed CAMHS Early Help systems and processes within the new model with partners across IHCs and regionally, to align with Flexible Open Access Mental Health Support and NYTH/NEST. Including: integration of schools in-reach, establishing reliable data reporting and measurement of impact, and establishing plans for secondary prevention that targets those at greatest risk of developing mental health problems.	Q4
3E.3 Deliver a transformed and sustainable crisis model through full implementation and embedding of the crisis enhanced service model. Including working with adult mental health and partners on plans for an Open Access North Wales demonstrator project, develop and initiate plans for further Alternative to Admission, operationalisation of the 24/7 regional crisis consultation and advice line.	Q4
3E.4 Early Identification & Family Centred Support - Co-design new needs led model of care across children's neurodevelopmental (ND) services collaboratively with Children's Regional Partnership Board. Including: referral process review and improvement, roll out of standardised profile of need tool to be used prior to specialist ND referral is considered, ensure clear pathways and local points of access into ND services across all age groups, development of neuro affirmative communities.	Q4
3E.6 Improved post assessment/diagnostic support - Co-designed post-assessment support to ensure continuity, tailored interventions. Including: Map support offers regionally, align services to provide targeted post diagnostic support, ensure consistent signposting and referral pathways for support following diagnosis, develop ND transfer & transition protocols to provide seamless transition between child and adult services across agencies.	Q4

Overview

CAMHS provides specialist assessment, care and treatment for children and young people experiencing significant mental health difficulties. Delivered by multidisciplinary teams, including psychiatrists, psychologists, nurses, allied health professionals and therapeutic practitioners, CAMHS also supports the wider children's workforce to respond effectively to mental health needs. Rising complexity, increasing demand and pressure across pathways make CAMHS a key priority for service improvement. All service development is aligned with the National Strategic Mental Health Programme, ensuring more equitable access, improved safety, and high value pathways from early intervention through to inpatient care. A whole system approach is essential, with close collaboration through the Children's Regional Partnership Board (RPB) to reduce duplication, build shared learning and ensure responses wrap around children and young people's needs. Plans focus on enabling timely access to the right level of support, embedding trauma informed and rights-based practice, and delivering the Welsh Government's "no wrong door" approach. CAMHS will help children and young people achieve better outcomes, build resilience, and experience improved mental health and wellbeing across North Wales. ND services deliver multidisciplinary assessments for children and young people presenting with Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD) and other neurodevelopmental differences. Demand for assessments has grown significantly, with waiting lists now exceeding 6,500 and some families waiting more than three years. These delays can negatively impact wellbeing and increase pressure on other services, including CAMHS. Improving ND services is therefore a critical priority. It is important to reduce the gap in health outcomes for young people with mental health and learning disabilities, supported by a focus on prevention, early intervention and reducing health inequalities. The ND Improvement Programme works in partnership with education and social services, supported by the Children's Regional Partnership Board (RPB), to meet the expectations of the National Neurodivergence Improvement Programme and the Code of Practice for the Delivery of Autism Services. A key focus is shifting from a diagnosis driven model to a needs led approach, ensuring timely early help, reasonable adjustments and consistent support for families. Priorities include reducing waiting times, redesigning pathways, strengthening workforce capability and improving post assessment support.

Delivering these improvements relies on strong cross sector collaboration and sustained whole system commitment to meeting the needs of neurodivergent children and young people in North Wales.

Key Delivery Priority Quarterly Update

3E.1

The implementation of the Early Help model and the national Schools in Reach specification is underway across the region governed via the Early Help sub-programme group.

The collation of data has been standardised across teams and an Early Help dashboard developed; this will support ongoing business planning and equity of service offer.

Planning is underway for the Body Project pilot to provide early support to young people with emerging concerns and/or at greater risk of developing an eating disorder, the pilot is supported nationally via the Mental Health Strategic Programme.

The embedding of the Schools in Reach service into local Early Help teams continues supported by the national specification and the regional Steering Group. Following a tender process, a contract has been awarded to Friends Resilience for licences to continue to deliver the Friends Resilience programme across education settings for the next three years, building resilience in children and young people to prevent escalation.

3E.2

The Mental Health Measure (MHM) Part 1A assessment target has been sustained over the last 12 months. The target for therapy (Part 1B) is more challenging to deliver and sustain however following a slight dip in April to 78%, the 1B target has been met regionally in May and June. The expansion of the group offer across teams has supported the delivery of the target and enhanced the service offer to children, young people and their families. A standard operating procedure has been finalised and is out for review to ensure that group provision is defined and equitable across the region.

Services leads are fully engaged with partners via the Regional Supporting Mental Wellbeing Group led by the Children's RPB, this will be the conduit to developing and exploring options to embed the Open Access principles going forward.

3E.3

The agreed enhanced service model is being embedded across the Unscheduled Care teams with key leadership roles in place; implementation of the regional hub team continues to support local teams as required which will allow for further extension of hours of operation. Funding for the Alternative to Admission scheme in the Central IHC has been extended for 2026-27, positive feedback received from children and young people and their families on the provision. Discussions are ongoing with Service and Estates leads in the West IHC on provision and locations for an Alternatives to Admissions hub in the area.

A standard operating procedure is being developed to ensure equity of provision across the region. Liaison with partners and stakeholders to take place regarding the consultation with plans to live to be developed. Engagement with AMH on the Open Access North Wales demonstrator project continues.

3.E4

A review of the current referral process has taken place with ND teams, referrers and families, findings are being reviewed and recommendations drafted with new referral from out for consultation.

ND Service Leads are fully engagement with the Children's RPB and partners to co-design a new needs led model of care via the Strategic Regional ND group and regular meetings with CRPB leads. Training for the profile of need tool continues with partners across the region led by the RPB, additional local trainers to be identified, following current round of training it will be paused to allow for evaluation to date and development of the guidance frameworks. Draft national ND standards have been received and are out for

review across the service and wider Children's Services, these will support the move towards a needs led model and a prudent assessment approach.

3.E5
The prudent assessment process was launched in Q3 of 2025-26, a review has taken place with findings and recommendations being produced. Job planning is underway in the teams with a standard job plan agreed across the region. NHS Performance and Improvement undertook a week-long visit to the teams, report and recommendations awaited, action plan to be developed. WG ND Improvement funding is being utilised to purchase additional assessments via the contract in place, additional funding streams to be explored for additional assessments to address all-over three-year waits.
Local Children's Area Group (CAG) meetings held with partners in each IHC Area to develop initiatives for new ways of working, utilising the agreed Information Sharing Protocol (ISP), overseen by Regional Strategic ND group led by CRPB.

3.E6
A review has been completed to map all third sector provision for ND support and shared with teams; this will inform teams with of signposting for support opportunities within their local area. A transition/transfer task and finish group has been established with colleagues from MHLD and IAS led by the CRPB; data is being collated and reviewed with a view to agreeing the transfer and transition of young people over and approaching 18 years of age and developing a policy. This will ensure that young people are assessed and signposted for support within the appropriate service.

3F Children and Young People Services	Chief Operating Officer	Overall Delivery Confidence
3F.3 Undertake a review of specialist nursing team roles and delivery of care for children with complex needs.		Q1
3F.8 Work with the Partnership Transformation Programme to commence the development of a strategic plan for children with a learning disability, and reduce inequalities for consultation.		Q1
3F.5 Ensure that children with diabetes have timely provision of insulin pumps and CGM		Q2
3F.2 Working with partners, undertake a gap analysis of the requirements to fully implement the Healthy Child Wales 2 Programme and submit proposals to the Health Board for implementation.		Q3
3F.4 Commence developing a service specification for delivery of community nursing care for children with complex care needs		Q3
3F.6 Assess compliance with Diabetes NICE Guidance in readiness for the launch of the Type 1 diabetes screening programme for children		Q3

3F.7 Set out the proposal to the Health Board based on the service specification gap analysis related to the submitted Paediatric Palliative Care in Wales self-assessment, including specialist palliative care nursing.	Q3
3F.9 Finalise and implement the Transition Pathways for children into adult services across all long-term conditions (respiratory, endocrine, cardiac and neurological conditions, cancer, CAMHS and Learning Disabilities).	Q3
3F.1 Delivery of school age immunisation programme by immunisation team with targeted work in low uptake areas.	Q4

Overview

Improving access, outcomes and experience for children and young people is fundamental to delivering high quality, high value and sustainable care across North Wales. As part of Strategic Intent 3, Children and Young People Services are prioritised because early life health is one of the strongest predictors of lifelong wellbeing, and timely, well-coordinated pathways can prevent escalation, reduce inequalities and improve long-term outcomes. Health inequalities have a significant and lasting influence on children's health. When children grow up in circumstances that limit access to healthy environments, stable housing, nutritious food, safe play, high quality early years provision, and timely healthcare, their health outcomes are measurably poorer. These inequalities increase the likelihood of low birth weight, delayed development, poorer mental health, chronic illness, and reduced educational attainment. Without targeted action, particularly prevention and early intervention, the gap in outcomes widens between the least and most deprived, as children grow, shaping long term health and wellbeing and contributing to preventable illness in adulthood. The Health Board's integrated model, spanning community care, hospital care and specialist care, supports children and their families up to age 18, and beyond where additional needs exist, ensuring continuity across critical developmental stages and transitions. By strengthening pathways, reducing unwarranted variation, enhancing multidisciplinary working, and delivering care as close to home as possible, the aim is to provide safe, compassionate and seamless services that respond to what matters to children and young people. This section sets out how the Health Board will align with national priorities, improve flow and access, embed evidence based clinical models, and modernise services so that every child and young person in North Wales can benefit from improved experiences, better outcomes and equitable, sustainable care.

Key Delivery Priority Quarterly Update

Children's Services continue to prioritise focus on early intervention within core services, with timely care throughout the pathways. During q1 the service has made progress on the following:

Targeted immunisation delivery in communities and schools where there is low uptake, with good uptake. Planned catch up sessions over the summer are fully booked some localities. Planning for delivery of Meningitis B programme completed with letters to eligible cohort sent.

Submission of the workforce gap analysis required related to implementation of the Healthy Child Wales Programme 2 has resulted in a national review of the timeline for implementation.

The Review of the Children's Community Nursing Team has commenced, further work is required to validate the workforce and financial data, and the review of the service offer is

being collated. This will assist in defining Levels of Care and the service offer, to ensure that there is equity across North Wales.

Children with diabetes are supported with their care in accordance with NICE guidance. Children are supported with insulin pumps and continuous glucose monitoring in a timely manner

Palliative care for children is provided by the community nursing teams and Consultant in palliative care, a business case is required to fund the gap in funding for this post and for a lead nurse as required by the national standards and evidenced within the self-assessment submitted by the Health Board.

Developing the strategy for children with learning disabilities has not progressed this quarter at the pace hoped for, the timeline for this is partially dependent on the Partnership Transformation Programme

Pathways supporting children to transition to adult services be that disease and treatment focussed or lifelong support is due to commence with leadership from the office of eth medical director.

3G Women's Health	Chief Operating Officer	Overall Delivery Confidence
3G.4 Develop an implementation plan to deliver the outstanding commitments in the National Perinatal Engagement Framework (2025), including a paid Chair for Maternity and Neonatal Voices Partnership.		Q2
3G.10 Participation in national digital and data development initiatives such as Women's Health Dashboard.		Q3
3G.2 Receive and analyse the findings of the Perinatal National Assurance Assessment Report (expected in Q4 2025/26), together with the key priorities outlined in the 2025 Quality Statement for Maternity and Neonatal Services, and develop a comprehensive proposal for local implementation inclusive of detailed costing.		Q3
3G.1 Progress the rollout of Phase 2 of the Digital Maternity Cymru System, with a focus on implementing maternity electronic health records to enhance the quality of care and improve communication for pregnant individuals.		Q4
3G.3 As part of the Clinical Services Plan, undertake a comprehensive review of the configuration of Pan–North Wales Perinatal Services to ensure the delivery of safe, high-quality and sustainable care.		Q4
3G.5 Collaborate with Health Education and Improvement Wales (HEIW) to prioritise year two service actions to ensure the Perinatal Strategic Workforce Plan is delivered within the Health Board.		Q4
3G.6 Support the local delivery of the NHS Wales Women's Health Plan across North Wales, to include work on Menstrual Health, Endometriosis and Adenomyosis, Contraception – Postnatal Contraception and Abortion Care, Preconception Health, Pelvic Health and Incontinence, Menopause, Violence Against Women – Domestic Abuse and Sexual Violence, Ageing Well and Long-Term Conditions and strengthening community pathways.		Q4
3G.7 Address variation in services such as Contraception, Menopause support and Pelvic Health.		Q4
3G.8 Deliver improvements to Women's Health prevention and early intervention, including preconception health and earlier identification of women's health conditions.		Q4
3G.9 Expand Women's Health service offering, currently focused via the Llandudno Womens Health Hub.		Q4

Overview
Women's Services within the Health Board are delivered through a comprehensive network which includes all three District General Hospitals, and Community and Primary Care settings. This integrated pathway approach ensures accessibility, continuity, and high-quality care for women and families across North Wales. The Service provides regional oversight and governance, working in close collaboration with Third Sector partners to deliver person-centred, safe, and effective services. The Health Board's commitment is to maintain and enhance standards of care, reduce health inequalities, and respond to the evolving needs of the population through innovation, workforce development, and

strategic planning. Health outcomes for women are worsening especially for women from the most deprived and disadvantaged communities, a focus on prevention and reducing the differences in women's access to health care and interventions is required to reverse this. The NHS Wales Women's Health Plan for Wales represents a significant commitment to improving health services for women, ensuring that their voices are heard and their health needs are prioritised. By addressing systematic inequalities and enhancing research and education the plan aims to create a more equitable health care system to enhance health outcomes for women locally and nationally. This plan details 64 measurable actions across 8 priorities to improve outcomes for women and girls across their lifetime. Specific key actions for the Service will continue to inform its priorities. The Maternity and Neonatal Quality Statement in Wales outlines the expected standards for maternity and neonatal services, emphasising the importance of high-quality care for women and their families. The statement aims to address the complexities of pregnancy, including the increasing prevalence of conditions such as diabetes and mental health issues and to improve outcomes for women ensuring that every child receives the best start in life. It also focusses on the need for inclusive policy making and the involvement of service users in shaping the services they need.

Key Delivery Priority Quarterly Update

1. What have we delivered so far this year towards the aim?

Significant progress has been made across the maternity, neonatal and women's health agenda during 2026/27, including:

• Completion of benchmarking exercise against the Perinatal National Assurance Assessment Report
• The findings of which were presented to the Executive Team and Quality, Safety and Experience (QSE) Committee in May and July.
• Incorporation of benchmarking findings into the Health Boards Annual Plan and Women's Services priorities for 26/27.
• Participation in the first Clinical Services Plan (CSP) workshop, ensuring maternity services are recognised as an essential service within future Health Board planning.
• Benchmarking against the National Perinatal Engagement Framework, including implementation of three of the five national maternity surveys, and the remaining two to be implemented in line with national discussion.
• Development of a proposal for a paid Maternity and Neonatal Voices Partnership (MNVP) Chair through the Women's Health Hub programme.
• Submission of detailed stakeholder feedback to HEIW on the draft Perinatal Strategic Workforce Plan Service Specification.
• Preparation and submission of a Women's Health Plan funding proposal to Welsh Government in May (expected outcome awaited in June).
• Completion of the Pathfinder Women's Health Hub phase and commencement of a formal evaluation to inform future service design.
• Improvement in menopause waiting times.

2. What impact (both qualitative and quantitative) has the work had on the population of North Wales compared to what it set out to achieve?

Qualitative Impact

• The benchmarking of national assurance recommendations has informed local services priorities for improvement, ensuring local services are aligned to national expectations for maternity and neonatal care.
• Service governance and assurance arrangements have been strengthened through presentation of findings to Executive and Board-level committees, promoting ward to Board reporting.
• Women's Health Hub development work has increased understanding of local need and informed future models of care that are intended to improve access, prevention, early intervention and integrated community-based services.

• Engagement with national programmes, including the Perinatal Engagement Framework and workforce planning initiatives, has ensured North Wales is actively contributing to and aligning with national policy developments.
• The menopause/ planned care improvement programme is delivering a better patient experience through reduced waits and improved access to specialist support.
Quantitative Impact
• 5 local benchmarking exercises completed against national reports pertaining to services and reported through Health Board governance structures.
• 3 of 5 national maternity surveys implemented, providing enhanced opportunities to capture women's experiences and inform service improvements.
• 100% elimination of waits exceeding 104 weeks for Stage 1 menopause services, achieving Welsh Government expectations in Q1.
• 2 regional funding proposal submitted to Welsh Government to support delivery of Women's Health Plan priorities and Phase 2 of the Digital Maternity Cymru.
• Multiple stakeholder responses submitted to influence the future Perinatal Strategic Workforce Specification.
• 1 Pathfinder Women's Health Hub evaluation commenced, providing evidence to support future service expansion across North Wales.

Whilst many programmes remain in the planning and implementation phase, the work undertaken has established the foundations required to deliver longer-term improvements in accessibility, quality, patient experience and health outcomes for women, babies and families.

3. What actions are we undertaking to ensure we are on track to deliver the full overarching aim and associated impact by the end of March 2027?
To ensure delivery remains on track, the following actions are being progressed:
• Implement and monitor actions arising from the Perinatal National Assurance Assessment Report through established committee structures.
• Develop detailed implementation plans and costed proposals linked to national maternity, neonatal and Health Board perinatal priorities identified through the assurance and benchmarking processes.
• Continue participation in the Clinical Services Plan workstreams to support future configuration and sustainability of perinatal services across North Wales.
• Complete implementation of the remaining national maternity surveys and progress delivery of the National Perinatal Engagement Framework, including development of arrangements for a paid MNVP Chair, subject to funding approval.
• Work with HEIW/ MatNeo Network and national partners to implement the agreed Perinatal Strategic Workforce Plan once the final specification is published.
• Complete evaluation of the Pathfinder Women's Health Hub and develop a revised business case aligned to Primary Care Clusters and the Health and Wellbeing Hub model.
• Progress Women's Health Plan priorities for the Service through the Welsh Government funding proposal (if approved), including workforce development, contraception services, pelvic health, menstrual health and postnatal care improvements.
• Continue delivery of the menopause recovery programme to further reduce waiting times and address variation in women's health services.
• Maintain oversight of funding availability and resource requirements and any risks if not secured to service sustainability.

As a minimum the above actions will support the maintenance of safe essential services.

3H Pharmacy and Medicines Management	Executive Medical Director	Overall Delivery Confidence
3H.1 Commission and publish a Pharmaceutical Needs Assessment (PNA) and agree an action plan from this to ensure pharmaceutical services are aligned to population need, address gaps in provision, and support equitable, sustainable care delivery.		Q3
3H.2 Support General Pharmaceutical Council (GPhC) Step 4 accreditation for the Bangor University MPharm programme (confirming regulatory provisional accreditation to deliver the programme) and enrol Cohort 2 to strengthen the local pharmacy workforce pipeline and support sustainable service provision.		Q3
3H.6 Following completion of implementation, fully embed Electronic Prescribing and Medicines Administration (ePMA) by establishing clear pharmacy clinical ownership to lead safe prescribing configuration, formulary oversight, system optimisation and structured change control.		Q3
3H.3 Launch and develop the North Wales Transforming Access to Medicines (TrAMs) programme, as one of three national transformation hubs, to modernise pharmacy technical services and strengthen regional collaboration, including scoping pharmacy provision to support advanced therapies within a national hub model.		Q4
3H.4 Continue to work with Community Pharmacy Wales (CPW) and Health Education and Improvement Wales (HEIW) to support community pharmacy contractors to expand the number of Pharmacies offering the Pharmacist Independent Prescribers Service (PIPS), strengthening prescribing capacity and improving access to care.		Q4
3H.5 Ensure full implementation of the High Value Medicines Value & Sustainability Board programme by supporting clinicians to adopt best-value prescribing practices, optimising procurement and product selection, reducing low-value prescribing, and strengthening performance oversight to deliver sustainable financial and quality benefits.		Q4
3H.7 Work with primary care and community services, via the Local Enhanced Clinical Effectiveness Service, to support evidence-based patient reviews that reduce inappropriate gabapentinoid prescribing in line with NICE guidance, extend periods of treatment, and increase the use of low Global Warming Potential inhalers in line with the All-Wales respiratory treatment pathway.		Q4
3H.8 Engage with national genomics leads and clinical networks to scope the potential role of pharmacogenomics in clinical pathways, explore opportunities to develop local champions, and raise awareness through shared learning and engagement.		Q4
3H.9 Deliver the risk prioritised components of Electronic Prescribing Service (EPS) that sustain safe, reliable digital services, covering devices, network/telephony, core infrastructure, and clinical platforms.		Q4

Overview

Pharmacy and medicines management are central to delivering high-quality, safe and sustainable healthcare. As demand rises and treatments become more complex and costly, we must maximise the clinical value of medicines, reduce unwarranted variation and ensure best use of resources while improving patient outcomes. A coordinated regional approach to technical services is needed to support specialised and emerging therapies, alongside clear oversight of population need and equitable access to pharmaceutical services. Continued digital development in prescribing and medicines intelligence will improve oversight, provide clearer information to support decision-making, and strengthen the safe and effective use of medicines across the system.

Key Delivery Priority Quarterly Update

1. What have we delivered so far this year towards the aim?

- Progressed implementation of the Pharmacy and Medicines Management Annual Delivery Plan, with clear workstreams in place to support delivery of key priorities.
- Transitioned ePMA into a sustainable business-as-usual model with strengthened governance, clinical safety, reporting and digital oversight. The programme is now moving towards formal closure in September.
- Progressed development of the North Wales Pharmacy Technical and Aseptic Hub (TrAMs), including agreement to advertise the Deputy Hub Lead post and continued development of the regional hub model.
- Progressed medicines value and sustainability work, including enhanced oversight of high-cost medicines, expansion of Blueteq implementation, and publication of Local Enhanced Clinical
- Effectiveness Service (LECES) notices on Sell2Wales. This enables work with primary care and community services to support evidence-based prescribing reviews, reduce inappropriate gabapentinoid prescribing and increase use of low Global Warming Potential inhalers in line with national guidance.
- Completed the first draft of the Pharmaceutical Needs Assessment and commenced the consultation phase.
- Continued collaboration with Bangor University to support development of the North Wales pharmacy workforce, with the first cohort successfully completing Year 1 of the MPharm programme.
- Strengthened regional and national collaboration on genomics and pharmacogenomics, with BCUHB now represented on national programmes. Planning is also underway for the National Genomics Showcase to be hosted in Llandudno on 19 November 2026.

2. What impact (both qualitative and quantitative) has the work had on the population of North Wales compared to what it set out to achieve?

- Moving ePMA into a business-as-usual setting has provided a more robust platform for prescribing and medicines administration across the Health Board, supporting safer care, reducing reliance on paper processes and strengthening oversight of medicines use.
- Expansion of Blueteq and strengthened oversight of high-cost medicines has improved our ability to ensure patients have equitable access to approved treatments whilst supporting effective use of NHS resources.
- Publication of the Local Enhanced Clinical Effectiveness Service (LECES) notices has enabled progressing commissioning of prescribing improvement work across primary care, supporting safer use of medicines, reducing inappropriate prescribing and promoting environmentally sustainable treatment choices.
- Completion of the draft Pharmaceutical Needs Assessment has provided a clearer understanding of the pharmaceutical needs of local communities, helping ensure future services are planned around population need and reduce inequalities in access.

- Progression of the North Wales TrAMs Hub programme is supporting long-term sustainability of specialist pharmacy technical services, helping ensure patients can continue to access complex and specialised medicines in North Wales.
- The first Bangor University MPharm cohort completing Year 1 represents an important step in developing a sustainable local pharmacist workforce, helping address future workforce challenges across North Wales.
- Increased participation in national genomics and pharmacogenomics programmes is helping position North Wales to benefit from advances in personalised medicine, enabling treatments to be better tailored to individual patients in the future.

Overall, Quarter 1 has focused on strengthening the systems, services and workforce needed to support safer use of medicines, more equitable access to pharmaceutical care, and better long-term outcomes for the population of North Wales.

3. What actions are we undertaking to ensure we are on track to deliver the full overarching aim and associated impact by the end of March 2027?
- Continue delivery of the Pharmacy and Medicines Management Annual Delivery Plan, with progress, risks and benefits monitored through established governance arrangements.
- Complete consultation and publication of the Pharmaceutical Needs Assessment and use the findings to inform future service and workforce planning across North Wales.
- Continue embedding and optimising ePMA within the business-as-usual environment, using system data and user feedback to drive improvement and support safer prescribing.
- Progress the North Wales TrAMs Hub through the North Wales Project Board, including recruitment to key posts, while continuing to work alongside South East and South West hub leads to develop an aligned all-Wales approach.
- Implement the Local Enhanced Clinical Effectiveness Services (LECES), supporting evidence-based prescribing reviews, medicines optimisation and delivery of agreed value and sustainability priorities.
- Continue expansion of Blueteq and strengthen oversight of high-cost medicines to support equitable access, reduce unwarranted variation and improve use of NHS resources.
- Track and monitor delivery of medicines value and sustainability programmes to ensure planned benefits are realised and sustained.
- Continue working with Bangor University and national partners to support development of the future pharmacy workforce in North Wales.
- Maintain active involvement in national genomics and pharmacogenomics programmes to ensure North Wales is well placed to adopt future innovations in patient care.

3I Dementia	Executive Director of Nursing	Overall Delivery Confidence

3I.1 Complete a review of existing dementia care provision within Emergency Departments to include benchmarking against areas of best practice.	Q1
3I.4 Undertake a review and training needs analysis of existing dementia training approaches and align national guidance and best practice standards, informing the development of a training programme for the workforce, building on the work completed for the bitesize training.	Q2
3I.6 Undertake environmental assessments to review the Health Board's current assessment of appropriate and suitable dementia friendly environments for all care settings and make proposals as appropriate.	Q2
3I.2 Review analyse and make recommendations to the Health Board on the requirements to implement a Dementia Care Pathway for Emergency Departments.	Q3
3I.3 Design and deliver bespoke dementia patient and carer experience review for ED.	Q3
3I.5 Design and implement a programme tailored to the needs of the workforce to enable a consistent service delivery through agreement of a core minimum standard of dementia education across the Health Board.	Q3
3I.7 Recommendations and proposals collated and presented to the Health Board, working with Estates, to align any recommended improvements to Estates strategy and available budget.	Q4
3I.8 Design and implement a staff campaign to raise awareness of prevention as it affects dementia.	Q4

Overview
Dementia is a major and growing priority for the Health Board due to the rapidly ageing population of North Wales and the significant impact the condition has on individuals, families, communities and the wider health and care system. Forecasts show substantial increases in both the 65+ and 85+ population, alongside rising multimorbidity and frailty, meaning many more people will live with dementia and increasingly complex needs in the years ahead. Dementia is identified nationally as one of the major neurological conditions driving demand across the NHS, and locally it already contributes to high levels of unplanned care, prolonged hospital stays and pressure on carers and community services. At the same time, inequalities across North Wales, particularly in areas of high deprivation, are associated with poorer dementia outcomes, later diagnosis and reduced access to support. Addressing dementia is therefore essential to improving population health, delivering person-centred, bilingual, compassionate care, strengthening community-based pathways, and ensuring the Health Board can meet future demand sustainably while supporting people to live well for longer. Dementia Care will be one of the areas that becomes a focus on the newly established Mental Health Oversight and Development Group, chaired by the Chief Executive, and will report to Board at least twice per year.

Key Delivery Priority Quarterly Update

1. Underpinning ground work has laid foundations for future improvement work. An ED Task group to coordinate ED improvement is in operation and meeting monthly; ED teams have undertaken their own scoping and ED tours have taken place with the Consultant Nurse for Dementia (Corporate Nursing) and Regional Dementia Improvement Manager. Furthermore, to monitor existing dementia practices, a bespoke template has been developed for use by all 3 EDs; Reps from each ED Team have planned visits to exemplar ED departments in the UK to identify best practice; good practices identified plus a plan to adopt/embed.

2. It is too early for impact and any impact from this kind of intervention/s cannot be expected to have discernible impact on population outcomes. Instead, they can be expected to impact in the longer term on such things as patient/family experience, reduction in complaints and concerns, safety, staff satisfaction, retention etc but again some of these are hard / impossible to measure with any rigour.

3. Extensive strategies are in place and working well to prepare and support teams for delivery, underpinned by strong governance. There is strong confidence that some aspects of the aim will be achieved but this only relates to those actions that are in the direct control of the Consultant Nurse for Dementia and key clinical staff in the ED settings e.g. review of literature, exemplar ED visits, patient experience review etc. Steps being taken include development of a bespoke data gathering tool to capture progress against deliverables from each IHC/Division which is being used to create the single combined IMTP Portal quarterly reports; regular Consultant Nurse Dementia meetings with each IHC/Division People's Experience Group and PSGQ groups to make clear what is needed; meetings with the dementia representatives in each IHC/Division; supporting teams with reporting and improvement planning, calendar reminders until April 2027, reminder emails, keeping relevant seniors sighted in IHCs/Divisions, a video of requirements created, monthly Emergency Department Task Group meetings set to April 2027.

However, the majority of the aim - development of a pathway for emergency care for people with dementia - is at significant risk of not being achieved by March 2027. The specialised Pathways Practitioner resource (0.6 WTE) has unexpectedly been reallocated to other BCU priorities This impact (failure of the aim) will occur in Q3 if no solution is found. The pathways resource is too specialised and large to be picked up by existing resources in Emergency Departments and the Consultant Nurse Dementia. This is being looked at through a Triple A alert through dementia governance processes, including the BCU strategic Dementia Delivery & Transformation group on 9.7.26 which reports to (QEDG) and if needed Safeguarding Governance & Performance group on 28.7.26.

A clinical pathway is a structured, evidence-based plan that outlines the step-by-step care for patients with a specific condition, detailing what happens, when, and by whom. Clinical pathways are designed to standardize care for a defined patient population over a specific period, translating clinical guidelines into actionable steps for healthcare teams. They cover diagnosis, treatment, and follow-up, and allow for deviations when patient-specific factors require alternative approaches. Pathways improve efficiency, reduce hospital stays, and enhance patient outcomes by providing a shared plan for all care providers.

4A Foundations for the Future	Chief Executive	Overall Delivery Confidence
4A.3 Complete the revised Integrated Leadership Development Framework.		Q1
4A.4 Complete Competency Frameworks, which includes the competencies and skills required for particular roles by banding, equipping staff with the skills to deliver their roles.		Q1
4A.9 Implement a new governance model as part of the revised operating model, ensuring sharper accountability, fewer/streamlined meetings, focusing on delivery and transparency.		Q2
4A.10 Publish to BCUHB Board the collated lessons learned from Phase 1, including outcomes from the consultation process, evaluation of performance and benefits measurement and how FFTF supports de-escalation by improving governance and accountability.		Q3
4A.11 Publish the Operating Framework, including how business partnering will operate with the Service Groups, and the directory of services reflecting the new organisational model.		Q3
4A.13 Co-produce with staff and partners an organisational approach to change framework that supports teams to successfully design, deliver and sustain change.		Q3
4A.5 Review and improve the Establishment Control Review (ECR) process, to ensure it is more streamlined and fully supported.		Q3
4A.6 Review and improve the process for creating, reviewing, and approving business cases.		Q3
4A.7 Implement the Foundations for the Future design and thereby establish a clear organisational structure led by an effective and complete executive team with the leadership capacity and capability to deliver high quality, sustainable care.		Q3
4A.1 Implement and deliver the year 1 actions from the Culture, Leadership and Engagement 3-year Improvement plan 2026-29. The delivery plan is structured into five areas. 1. Vision and Values, 2 Goals and Performance, 3. Learning and Innovation, 4. Support and Compassion, 5. Teamwork. Year one focusses on embedding systems and processes in these areas to improve leadership quality, employee engagement, psychological safety and practically embedding the agreed values and behaviours.		Q4
4A.12 Engage with partners (JCC, NWAS, Local Government, Third Sector) to review the operating model and identify changes to the ways we operate and define operating policies and/or updated MOUs where applicable.		Q4
4A.2 Complete the transition to new senior posts and establish new service groups and corporate directorates, supported by cross-functional operating agreements and ongoing team and leadership development.		Q4

4A.8 Complete the design of Phase 2. This will include reviewing the structures of the organisation at bands 8b and below, a plan for the effective integration of Mental Health and Learning Disabilities, and a rapid review of phase 1 implementation across all 5 pillars of the Programme.	Q4

Overview

Delivering high quality, equitable and sustainable services for the people of North Wales depends on BCUHB operating as a coherent, effective and agile organisation. A highly effective organisation aligns strategy, culture, people, processes and structures into a unified operating model that enables good governance, timely decision making and clear accountability. Strengthening these foundations is essential not only to improve services today, but to ensure the Health Board can adapt and respond to the complex demands of the future. Work undertaken to evaluate the Operating Model agreed in 2022 highlighted significant gaps as detailed in the Discovery Report developed in November 2024. While it examined structural arrangements, other critical elements of an effective operating model, including organisational culture, strategic alignment, people capability and process design, were not sufficiently addressed. Over time, it has become increasingly clear that aspects of the current model do not provide the flexibility expected of a large integrated Health Board. Challenges remain in achieving consistency across divisions, reducing duplication, ensuring equitable service provision, and enabling decisions to be taken at the right level and at the right time. These issues are not unique to this health board; across the UK, large healthcare organisations are seeking operating models that support system wide working, improve integration and better leverage scale. The Foundations for the Future Programme directly responds to this need. It applies a recognised organisational change methodology (Tushman and O'Reilly's 'Leading Organisational Change and Renewal') to create an operating model that strengthens ways of working as one Health Board. The programme provides greater clarity of purpose, enable more agile and accountable decision making, and embed the conditions required for sustainable improvement. By establishing clear foundations, strategically, culturally, structurally and operationally, the Health Board will be better equipped to deliver its strategic objectives and, most importantly, improve outcomes and experiences for the population of North Wales. This is a significant programme of change for the organisation and as such will continue to require refinement moving forward. The first phase of the Delivery will be implemented and next phase of the Programme will therefore get underway during 2026/27. It is envisaged that the programme will be complete by the final quarters of 2027/28.

Key Delivery Priority Quarterly Update

1. What have we delivered so far this year towards the aim?

The Competency Framework and the Integrated Leadership Development Framework have been completed (historically), delivering the Q1 Annual Delivery Plan milestones. Progress has also been made in:

- developing the Operational Governance Framework,
- embedding culture and leadership improvement activity,
- strengthening programme governance and risk management arrangements,
- progressing organisational design work,
- transitioning the Quality Management System into business-as-usual arrangements.

2. What impact (both qualitative and quantitative) has the work had on the population of North Wales compared to what it set out to achieve?

As an organisational transformation programme, benefits are expected to be realised over the medium and long term. During Q1, the programme has strengthened the foundations required to deliver sustainable improvement through:

- enhanced leadership capability,
- clearer governance arrangements,
- improved workforce planning,
- increased organisational readiness for change.

Early qualitative feedback from the culture change activity has demonstrated strong engagement and positive staff experience.

3. What actions are we undertaking to ensure we are on track to deliver the full overarching aim and associated impact by the end of March 2027?

During Q2, the programme will continue implementation of the Foundations for the Future programme through:

- progression of organisational consultation activity,
- further development of the Operational Governance Framework,
- continued delivery of culture, leadership and workforce initiatives,
- completion of operating model products,
- ongoing strengthening of programme governance, risk management and stakeholder engagement arrangements.

4B Strategy and Planning	Executive Director of Transformation & Strategic Planning	Overall Delivery Confidence
4B.1 Complete the Discovery Phase of the new 10-year Health Board Strategy by finalising evidence gathering, synthesising insights from key stakeholders, and undertaking structured engagement across the organisation and wider partners. This will culminate in an agreed Discovery Report, to inform the subsequent Design Phase of the Strategy. This work will also cover some specific requirements within the NHS Wales Planning Guidance:□A review of the organisation's Well-being objectives and how they fit within the Health Board's overarching strategic objectives. Provide clarity on the full suite of underpinning strategic plans (such as the Clinical Services Plan, Estates Strategic Plan and Digital Strategic Plan) and timelines for their development. Incorporate the Health Board's ambitions relating to Advanced Therapies and Genomics.		Q1
4B.4 Co-create a Third Sector Partnership Working Framework with Third Sector Partners to move to more proactive and strategic collaborative approach.		Q1
4B.5 Draw on support from NHS Performance and Improvement (NHS P&I) colleagues to develop proposals on an improved approach to a unified modelling across demand, capacity, skills mix, activity, performance, finance and workforce, incorporating benchmarking against other Health Boards – to be utilised in the 2027-30 IMTP planning cycle.		Q1
4B.6 Undertake an annual reflection and learning exercise in relation to the annual planning cycle, incorporating the planning maturity matrix self-assessment tool and involving internal and external stakeholders.		Q1
4B.8 Update the BCUHB Integrated Planning Framework and associated more detailed planning guidance in light of annual reflection and learning exercise, emphasising the importance of clinical leadership, Community by Design principles and patient feedback in service planning.		Q2
4B.9 Contribute to the broader organisational capability development work, specifically in relation to development of skills in planning.		Q2
4B.10 Develop an organisational approach to de-prioritisation and de-commissioning for teams to utilise in reaching and implementing decisions of this nature, ensuring the full range of clinical and operational perspectives are central to the approach.		Q3
4B.2 Complete the full strategy design phase by translating the insights from the discovery phase into a validated strategic framework, including defined goals, strategic priorities, delivery roadmaps, and governance model, culminating in a final Strategy ready for Board approval. This will include structured engagement with key stakeholders throughout the design process to test assumptions, refine options, and build organisational alignment, ensuring aspects such as the Marmot principles (relating to early childhood, education, employment, preventing ill-health, housing and community well-being) are covered within the scope.		Q3
4B.11 Support delivery of commitments set out in the IMTP through monthly monitoring and timely escalation of any risks to delivery as well as quarterly reporting of delivery against the IMTP and Special Measures de-escalation framework.		Q4

4B.3 Implementation of the strategy will be via key underpinning quality impact assessed strategic plans (e.g. Clinical Services Plan) and their key deliverables falling within the 2027-30 IMTP.	Q4
4B.7 Deliver improvements in the organisation's approach to planning through delivery of the planning capability action plan that is informed by feedback from key stakeholders, annual learning cycles and contains actions from the planning maturity matrix self-assessment. Aiming to progress to level 3 and above across all areas.	Q4

Overview

Developing a refreshed 10-Year Strategy and strengthening organisational planning are interdependent priorities that will shape how the Health Board responds to changing population needs, rising demand, workforce pressures and a challenging financial environment. Together, they provide the clarity, coherence and discipline needed to move from short-term reactive approaches to sustained, proactive transformation. The renewed strategy will build on the co-created strategic intents developed with partners in 2025/26 and will articulate a clear long-term direction that reflects the scale of challenge, the need for new models of care, and the importance of prevention, early intervention and reducing health inequalities. It will place population health and regional collaboration at its core, ensuring that future service design is informed by evidence, demographic trends and meaningful engagement with communities, clinicians and partners. Effective planning is the mechanism through which this strategic intent becomes deliverable action. Good planning translates ambition into clear decisions about resources, service change, workforce and financial trajectories, supported by robust risk and performance frameworks. By triangulating workforce, financial and activity modelling, planning ensures that long-term goals are realistic, affordable and operationally grounded. It also strengthens accountability, enabling the organisation to track progress, intervene early when delivery risks arise and maintain alignment with national policy and statutory obligations. Strong partnership working across North Wales, including with local authorities, the Third Sector and regional bodies, is essential to both the strategy and the planning process, ensuring shared priorities and coordinated solutions. A credible 10-Year Strategy, underpinned by mature, integrated planning, will provide the foundation for stability, consistent decision-making and sustainable improvement. This combined approach will support the Health Board to prioritise effectively, deploy limited resources where they have greatest impact, and communicate transparently with the public about the case for change. Ultimately, it will equip the organisation to deliver high-quality, resilient services that meet the needs of the population now and over the longer-term.

Key Delivery Priority Quarterly Update

1. What have we delivered so far this year towards the aim?

Progress has been made across all key workstreams supporting development of the refreshed 10-Year Strategy and strengthening organisational planning. A draft Strategic Discovery (Diagnosis) Report has been produced and discussed through governance forums, providing an emerging evidence base and stakeholder insight to inform the next phase of strategy development. Work has also commenced on developing a unified organisational modelling approach, including baseline mapping of data, analytical capability and existing modelling activity across workforce, finance, performance and operational functions. In addition, engagement has taken place with NHS Performance and Improvement colleagues to support future benchmarking and model development.

Partnership working has advanced through engagement with all North Wales County Voluntary Councils (CVCs), with arrangements in place to commence co-production of a

Third Sector Partnership Working Framework during Quarter 2.
The annual reflection and learning exercise for the 2026–29 planning cycle has been completed, including extensive stakeholder engagement, a Reflection and Learning Workshop, production of a draft learning report and a comprehensive refresh of the Planning Maturity Matrix self-assessment. This deliverable was achieved within Quarter 1 and provides important evidence base for future planning improvements.

2. What impact (both qualitative and quantitative) has the work had on the population of North Wales compared to what it set out to achieve?

The work is primarily focused on strengthening the organisation's planning, partnership and governance arrangements and therefore the impact to date has been largely indirect. Improvements have been made in stakeholder engagement, organisational learning, planning maturity and oversight of delivery, helping ensure future service plans are better aligned to population needs, clinical priorities and partner perspectives. Engagement has been undertaken across a range of internal and external forums, including Third Sector partners, providing a stronger foundation for collaborative, evidence-based planning and improved outcomes for the population of North Wales.

3. What actions are we undertaking to ensure we are on track to deliver the full overarching aim and associated impact by the end of March 2027?

Work is well underway on all areas that didn't quite complete within Q1, with all completing during Q2 and still supporting delivery of the overarching aim by March 2027. As the 10-year strategy work transitions into a formal programme approach, the work programme for the remainder of the year will be re-assessed to ensure it is deliverable in the timeframes that remain.

4C Clinical Services Planning, Leadership and Interprofessional Working	Executive Medical Director	Overall Delivery Confidence
4C.1 Agree the CSP methodology and first tranche of areas to be prioritised and establish the CSP Programme by developing the programme structure, governance, and delivery approach, supported by targeted internal engagement and awareness raising activities to build understanding and organisational buy in. Success will be demonstrated through formal approval of the methodology, confirmation of programme governance, and evidence of staff awareness and engagement across key teams including the first major engagement event held.		Q1
4C.5 Job descriptions with roles with responsibilities and appropriate remuneration in place for all clinical leadership posts with Foundations for the Future organisation structure, across primary, community and secondary care.		Q1
4C.9 Provide clarity over best practice clinical and operational multi-professional working, in line with the new operating model structures roll out, both roles and responsibilities and effective team working. Across primary, community and secondary care.		Q1
4C.2 Operationalise the CSP Programme by finalising detailed delivery plans for the process (pertaining to the first tranche of areas), establishing programme reporting and risk management processes, and initiating structured engagement with leads to prepare for CSP assessments. Success will be demonstrated through approved delivery plans, active reporting cycles, and evidence of areas' readiness to enter the CSP process in Q3.		Q2
4C.10 Provide organisation development support to ensure newly formed teams are working effectively together across clinical and operational inter-professional disciplines. Across primary, community and secondary care.		Q3
4C.3 Deliver the full CSP assessment process for the first tranche of priority services, including evidence gathering (including use of key population level intelligence, assessment workshops, option development and prioritisation. This will be supported by structured engagement with leads and clinical and operational teams from the full set of professional groups to ensure clarity, collaboration and high-quality outputs. Success will be demonstrated through completed CSP assessment documentation and agreed prioritisation outcomes for all first tranche areas that demonstrates Community by Design principles, maximise pathway redesign and strengthened joint working between primary and secondary care and partners.		Q3
4C.6 Commence implementation of a menu of formal training programmes informed by training and development needs analysis for all within clinical leadership positions, across primary, community and secondary care.		Q3
4C.4 Finalise and submit the first tranche of CSP service change proposals for formal approval by the CSP Programme Board. This will include refining proposals based on feedback, completing required documentation, and ensuring alignment with strategic, operational and financial considerations. Success will be demonstrated through Programme Board approval of all first tranche service change proposals and confirmation of readiness for wider Health Board governance approvals and implementation planning.		Q4
4C.7 Generalised upskilling related to modern NHS needs via Clinical Services Plan programme to include strategic planning, value-based health care, population health management etc, across primary, community and secondary care.		Q4

4C.8 Develop a clear and attractive career path and development package for those in or aspiring to Clinical Leadership position, drawing on internal and external expertise and support including NHS P&I and CMO. Across primary, community and secondary care.	Q4

Overview

Delivering sustainable, high-quality services for the people of North Wales requires a clear, forward-looking Clinical Services Plan (CSP) supported by strong, skilled and collaborative clinical leadership. Together, these elements provide the foundations for moving from reactive service management to a proactive, coherent approach that aligns strategic ambition with the realities of clinical practice, workforce capability and population need. The CSP sets out how services will evolve to provide person-centred, preventative and evidence-based care, reducing unwarranted variation and ensuring that models of care reflect the principles of Community by Design and the priorities of the Health Board's long-term strategy. Central to achieving this vision is empowered, multi-professional clinical leadership. Modern healthcare demands leaders who can balance quality, performance and sustainability, work across traditional boundaries, use data intelligently and make value-driven decisions. These skills are essential for guiding the redesign work underway through the first phase of the CSP work, where clinically led assessments of challenged or fragile services are informing options for consolidation, redesign or new models of care. This is being built upon in the 'Fragile Services' section of the IMTP, which will identify and address clinical services that meet the principles for fragility in the National Clinical Framework (AR-13). As the CSP progresses, effective leaders will be needed across all sectors; primary, community and secondary care, to drive change at pace, support colleagues through transition and ensure that service improvements translate into better outcomes for patients. To enable this, clearer role definitions, strengthened leadership development offers and more robust job planning and remuneration models will be required. Creating attractive, well-supported clinical leadership roles is essential to engaging clinicians in shaping the future of services and ensuring that redesign is grounded in practical experience and professional insight. By integrating structured clinical service planning with strong inter-professional leadership, the Health Board will be better equipped to make consistent, transparent decisions, strengthen regional working, improve workforce resilience and deliver sustainable, high-value care. This combined approach is critical to realising the ambitions of the 10-year strategy and creating a modern, resilient and equitable healthcare system for North Wales.

Key Delivery Priority Quarterly Update

The Clinical Services Planning (CSP) Programme remains a key strategic enabler for delivering the Health Board's long-term ambition to provide sustainable, high-quality and person-centred services across North Wales. During Q1, significant effort was invested in establishing the foundations required for a clinically led and evidence-based approach to service planning, with a particular focus on building a shared understanding of the organisation's history, current service challenges, future opportunities and lessons learned from previous transformation activity.

A major engagement event, supported by a series of follow-up focus groups, was successfully delivered and provided an important platform for increasing organisational awareness, engagement and understanding of the proposed approach to clinical service planning. This early engagement has strengthened relationships across professional groups and reinforced the importance of multi-professional leadership and collaboration as critical enablers of future service redesign.

Whilst initial engagement activity has been successfully completed, formal agreement of the CSP methodology, confirmation of the first tranche of priority service areas, and establishment of the full programme governance and delivery framework were not achieved within Q1. This reflected a deliberate decision to prioritise programme quality and organisational alignment over pace, ensuring that future CSP activity is built upon a robust understanding of current challenges, strategic priorities and workforce considerations.

As a consequence, the original Q1 milestone is not recoverable within the planned timescale and the establishment phase of the programme has extended into Q2.

The delay in finalising the programme foundations has impacted the critical path for subsequent deliverables, including operationalisation of the programme, commencement of formal service assessments and development of service change proposals. Consequently, there is a significant risk that the original scope and timescales for delivery during 2026/27 will require reprofiling. The extent of this impact is currently being assessed through development of the CSP Programme Initiation Document (PID), which will establish the programme methodology, governance arrangements, delivery model, prioritised scope, sequencing and milestones for the remainder of the year.

Work is progressing to develop a realistic and deliverable programme roadmap that reflects organisational capacity, competing priorities and the lead-in time required to mobilise clinical and operational colleagues. Importantly, the programme recognises that successful clinical service planning will require strong and credible clinical leadership, supported by experienced operational leadership, to drive change across organisational and professional boundaries. Future delivery will therefore be dependent upon securing sufficient programme capacity and identifying senior clinical leaders with the authority, influence and capability to support complex service redesign and decision-making.

Despite the challenges to timescales, the approach being taken remains closely aligned with the principles underpinning the Clinical Services Plan, Community by Design and the wider IMTP. The programme continues to strengthen the foundations for clinically led assessments of fragile and challenged services, ensuring that future decisions are informed by population need, service sustainability, workforce considerations, quality outcomes and opportunities for greater integration across primary, community and secondary care.

Overall, progress during Q1 has focused on establishing the conditions necessary for successful long-term delivery rather than progressing rapidly into formal assessment activity. Whilst this has created short-term delays and increased the likelihood that milestones will require reprofiling, it is expected to provide a stronger platform for sustainable clinical service planning and interprofessional leadership in future phases. Executive Team agreement of the CSP PID, governance arrangements and revised delivery plan during Q2 will be critical to enabling programme mobilisation, clarifying priorities and ensuring delivery remains aligned to the Health Board's strategic transformation objectives.

4D Digital, Data and Intelligence	Director of Digital, Data & Intelligence	Overall Delivery Confidence
4D.13 Implement a comprehensive Digital Skills Assessment and publish Training Needs Analysis and Academy plan on LMS landing page.		Q1
4D.14 Programme of training and development of resources around the principles of Making Data Count to enhance competency in use and presentation of data across the organisation.		Q1
4D.3 Develop and commence implementation a programme of data governance audits to provide assurance on data processing and reporting accuracy.		Q1
4D.6 Develop and implement a Clinical Coding quality dashboard to facilitate improved clinical coding error detection and correction.		Q1
4D.1 Identify and commence implementation of best practice and tools available to support improved organisation wide demand and capacity planning.		Q2
4D.16 To develop a Strategic Outline Case for the digitalisation of paper-based patient records that clearly defines the strategic need, benefits, risks, and options for the project.		Q2
4D.17 Completion of a gap analysis against the requirements of the newly released Cyber Assessment Framework (CAF) version 4 – this will be the tool used by our regulators to measure compliance.		Q2
4D.18 Create and establish a robust AI framework to ensure the appropriate processes, people and governance arrangements are in place. This will provide assurance that the approval/review process in place provides structure for the appropriate and safe use of AI tools which considers all 7 AI principles, covering safety, confidentiality, research, evaluation, partnership, ethics, transparency, and data quality.		Q2
4D.7 Undertake review around opportunity for AI and automation of clinical coding.		Q2
4D.11 Further enhance existing information products to introduce elements of Population Health Management (PHM) e.g. deprivation analysis, further identification of patient cohorts for targeted interventions. (Shared objectives with Public Health Team on PHM).		Q3
4D.4 Develop a data quality framework that makes clear the responsibilities and accountability associated with the collection and management of data across the health board.		Q3
4D.5 Develop proposals for a Robotic Process Automation (RPA) approach and associated implementation plan.		Q3
4D.10 Develop proposals for move from on premises to on cloud analytics, to improve processing speeds, reliability and enabling a broader suite of tools.		Q4
4D.12 Create a suite of population health measures based on existing approaches that will facilitate sustainable healthcare transformation by targeting interventions that prevent ill health, improve care & support for people with ongoing health conditions, and reduce inequalities in health outcomes.		Q4

4D.15 Progressively and systematically decommission and archive unsupported systems and devices in line with available resources, while maximising the efficient use of current supported systems to reduce technical debt, support costs, and safety risk.	Q4
4D.19 To review the organisational wide Digital Roadmap to take into account the 10-year strategy and Clinical Service Plan.	Q4
4D.2 Further development and roll out throughout the year of the data quality kite mark to provide assurance on data quality and accuracy.	Q4
4D.20 Ensure that digital clinical safety, cyber security and information governance risks in relation to digital are considered by the board, and undertake regular board development sessions to develop digital and data competence.	Q4
4D.8 Move to an internal specialty focused training plan for clinical coding trainees, that improves recruitment and retention as well as efficiency.	Q4
4D.9 Work with the Universities on potential applications of advanced analytics and mathematical modelling for use in service planning.	Q4

Overview
Strengthening the Health Board's Digital, data and intelligence capability is fundamental to delivering safer, more efficient and more personalised care across North Wales. Digital systems, high-quality data and robust analytical capability are mutually reinforcing; together, they enable clinicians and operational teams to access reliable information, support timely decision-making and create the foundations for modern, technology-enabled care pathways. As the organisation moves away from fragmented systems and paper-based processes, establishing interoperable, stable and user-centred digital platforms will provide the confidence and consistency needed to support day-to-day care while enabling future transformation. A core part of this shift is improving the quality, governance and usability of data. When data is accurate, standardised and linked across services and organisations, it becomes a powerful asset for population health management, pathway redesign and proactive care. Enhanced analytical tools and improved clinical coding will help unlock insight into patient journeys, variation in care, resource use and opportunities for prevention. This intelligence-led approach allows the Health Board to plan more effectively, reduce duplication, minimise administrative burden and better target interventions to meet the future needs of communities. Digital reliability and data integrity must sit alongside strong cyber security. With the increasing frequency and sophistication of cyber threats to healthcare, integration of resilient infrastructure, clear organisational response plans and strong staff awareness is essential to protect patient information and maintain public trust. A secure environment is also a prerequisite for harnessing innovation, whether through advanced analytics, AI-supported decision-making or more integrated digital pathways. Together, these developments form a coherent, interdependent programme of modernisation. By aligning digital improvement with strengthened data governance, intelligence capabilities and robust cyber security, the Health Board will create a more connected, insight-driven and resilient system landscape, supporting better clinical decisions, a more seamless patient experience and sustainable service improvement across North Wales.

Key Delivery Priority Quarterly Update
1. What have we delivered so far this year towards the aim?

• Developed and implemented a Clinical Coding Quality Dashboard covering approximately 75% of common coding errors.
• Expanded the Data Quality Kite Mark to key datasets, including Referral to Treatment and referrals.
• Established a programme of data governance audits and identified priority areas for review.
• Developed demand and capacity modelling, including a bed modelling pilot now being rolled out Health Board-wide.
• Completed an Robotic Process Automation proof of concept and developed draft proposals for future automation opportunities.
• Established collaboration with Bangor University to support advanced analytics and demand forecasting.
• Developed draft options appraisals for Artificial Intelligence in clinical coding and future clinical coder training models.

2. What impact has the work had on the population of North Wales?

• Improved confidence in the quality and accuracy of data used for operational and strategic decision-making.
• Enhanced clinical coding oversight, supporting more accurate reporting, planning and resource allocation.
• Improved understanding of demand and capacity pressures to support service planning and patient flow.
• Strengthened assurance around data quality, governance and reporting.

• Created foundations for future efficiencies through automation, advanced analytics and improved workforce capability.
While much of the work is foundational, it is helping to build the digital, data and intelligence capability required to improve patient care, service planning and organisational efficiency.

3. What actions are we undertaking to ensure we are on track to deliver by March 2027?

• Continue rollout of demand and capacity modelling across the Health Board.
• Extend the Data Quality Kite Mark and implement the data governance audit programme.
• Finalise and implement the Data Quality Framework.
• Complete RPA and Artificial Intelligence options appraisals and progress priority automation opportunities.
• Expand the Clinical Coding Quality Dashboard to cover all key error indicators.
• Develop and implement a sustainable clinical coding training model.
• Continue partnership working with Bangor University on advanced analytics, forecasting and research opportunities.
Overall, delivery remains on track, with governance arrangements in place and milestone plans supporting achievement of the March 2027 objectives.

4E Research, Development and Innovation	Executive Medical Director	Overall Delivery Confidence
4E.1 RD&I strategic plan and delivery plan approved, aligned to health board strategic intentions and national performance metric.		Q1
4E.2 Develop a proposal for a self-sustaining innovation centre, working with industry and academia, prioritising digital innovations and medical technology, aligned with the NHS Wales Technical Planning Guidance 2026-29 Digital and Innovation enabling plan, and Welsh Government's Innovation Strategy delivery plan.		Q3
4E.3 Work with People Services colleagues to develop and implement a plan to normalise research as a core part of clinical practice by embedding research expectations within job descriptions, appraisal objectives, and job plans for identified priority staff groups, supported by guidance and manager training.		Q4
4E.4 Increase the number of non-commercial and commercial research studies opened by the Health Board and recruitment to those studies, through proactive engagement with sponsors and streamlined feasibility and approval processes.		Q4
4E.5 Work with local academic partners to identify and implement to increase joint appointments and/or honorary contracts, closely working with the Academic Careers Community of Interest, ensuring that posts add value to research and innovation activity and support the above actions.		Q4

Overview Research, Development and Innovation (RD&I) is essential to the Health Board's ability to deliver high quality, modern and sustainable healthcare for the population of North Wales. It provides the evidence base for transforming services, improving outcomes and ensuring that clinical decisions and organisational priorities are grounded in what works. RD&I enables the Health Board to test new technologies, redesign pathways and adopt innovations that improve productivity, enhance safety and reduce unwarranted variation, which are key requirements for recovery, transformation and long-term sustainability. Research active organisations consistently achieve better patient outcomes, attract and retain skilled staff, and foster a culture of continual learning and improvement, all of which are critical for BCUHB as a University Health Board and as an organisation in Special Measures. RD&I also plays a vital role in addressing major system pressures by supporting new models of care, improving diagnostic and treatment options, and generating solutions that help meet rising demand within constrained resources. Strong RD&I capability supports national priorities such as A Healthier Wales and value-based healthcare, while expanding opportunities for citizens to access cutting edge treatments and innovative approaches. Embedding RD&I into everyday practice therefore strengthens organisational resilience, accelerates transformation and directly contributes to better outcomes and experiences for the people of North Wales.
Key Delivery Priority Quarterly Update Research and innovation continue to make an important contribution to service improvement, transformation and patient outcomes across the Health Board. Through research activity, innovation adoption and partnership working, we are supporting the development of new models of care, improving access to evidence-based interventions and helping to embed a culture of continuous improvement. Whilst challenges remain around research support service capacity, actions are underway through an agreed recovery plan to strengthen infrastructure and ensure sustainable delivery. We are also actively contributing to national and local initiatives to embed research and innovation within routine NHS practice, recognising their role in improving quality, supporting workforce development, driving transformation and delivering better outcomes for the population of North Wales.

4F Education Partnership and Projects, Academic Careers and Strategic Alignment of Education	Executive Director of People Services & Organisational Development	Overall Delivery Confidence

4F.1 Work with Further and Higher Education Partners to capture their contribution to the development of the Health Board's clinical services plan so that education provision across the region can reflect the future development of healthcare.	Q1
4F.6 Commence full business case for the North Wales Medical school in partnership with Bangor University.	Q1
4F.7 Conduct an analysis as to the key barriers in establishing academic careers and update the pathway framework accordingly.	Q2
4F.8 Having established an Academic Careers Community of Practice to bring together academics across BCUHB, develop a delivery plan which will outline how we should enhance their work and maximise its impact within BCUHB.	Q2
4F.9 Develop a proposal for an interprofessional governance structure setting out clear governance routes and alignment of education to strategic workforce planning and the quality, safety and experience of our services.	Q2
4F.2 Review and set out proposals to the Health Board on requirements to meet Memoranda of Understanding with Further and Higher Education Partners and reflect in delivery plans aligned to national programmes and strategies, with agreed key metrics and baselines.	Q3
4F.3 Review opportunities for BCUHB to support the Tertiary Alliance formed between Bangor University, Wrexham University, Grwp Llandrillo Menai and Coleg Cambria.	Q3
4F.10 Progress to the Design Phase for education and training, agreeing priorities together with the development of an underpinning Strategic Education Plan which aligns to HEIW and local commissioning of education and training.	Q4
4F.11 Collaboration with education colleagues to comply with the duties set out in the Additional Learning Needs and Education Tribunal (Wales) Act.	Q4
4F.4 Continue to support the development of the proposed Dental School and input into associated business cases.	Q4
4F.5 Submit an evaluation of progress against the aspirations set out in the Memoranda of Understanding with Further and Higher Education Partners, providing recommendations on how performance against key metrics may be enhanced.	Q4

Overview
As a University Health Board, we are proud of the opportunities and responsibilities that come with this status. In addition to research, development and innovation, being a university-designated organisation strengthens our commitment to high quality education and training, our partnerships with Higher and Further education and our development of academic careers. These areas are crucial for building a skilled workforce, improving the quality of our services, and making North Wales an appealing place for current and future healthcare professionals. Our approach is supported by clear internal governance and strong partnerships with universities and national bodies. These relationships help

ensure our work in education, research and innovation supports national expectations as well as local priorities. In Year 1 of this plan, we will build on the progress made in 2025/26, including our memoranda of understanding with universities and further education colleges, the creation of the Education Steering Group, and the establishment of the Academic Careers Community of Practice. Our focus will be on delivering key milestones, strengthening governance, commencing workforce planning to aid most effective working with Higher Education Partners to consolidate professional pipeline and creating the conditions for visible and meaningful improvements. This will build upon our Discovery Report as we progress our work through Design into the Delivery Phase. We will continue to play an active role in national programmes such as Health Care Research Wales (HCRW) academic careers programme and Health Education and Improvement Wales (HEIW) emerging education strategy. We also anticipate new opportunities from the Tertiary Alliance, which brings together further and higher education institutions across North Wales. Years 2 and 3 will consolidate our progress, strengthen our regional impact with partners and embed continuous improvement so that the delivery of education and development of academic careers remain central to how we deliver care. BCUHB has achieved University Designation Status, a Wales-wide accreditation awarded to organisations that demonstrate strong and purposeful activity in research, education, and innovation. This status reflects BCUHB's robust strategic partnerships, particularly with universities, which help shape shared priorities in training, research, and innovation. It also supports long-term academic collaborations that enhance staff development, attract and retain a skilled workforce, and ultimately improve patient care and outcomes. While centred on university partnerships, the designation also encompasses wider collaboration with both Higher and Further Education institutions, strengthening the pipeline of the future healthcare workforce. For BCUHB, University Designation Status reinforces its role as research active, education focused organisation and supports service quality, workforce sustainability, and better outcomes for the population it serves.

Key Delivery Priority Quarterly Update

Q1 has seen progress made across all areas for the deliverables under Education Partnership & Projects, Academic Careers and Strategic Alignment of Education.

Key areas of progress include:

- Agreement of Memoranda of Understanding (MoU) with all HE and FE partners.
- Establishment of Strategic Steering Groups to oversee the delivery of the aspirations laid out in the MoUs
- Positive responses to the planned engagement with HE and FE partners with regard to the Clinical Services Plan and opportunities that the North Wales Tertiary Alliance may bring.
- Governance structure and programme plan developed and implemented for the capital programme associated with the North Wales Medical School.
- Literature review undertaken to understand key barriers to embedding academic careers in the workforce.

The above puts in place the foundations for the future work under this strategic deliverable and, whilst there may be some lag between quarters, there is a high level of confidence in the overall delivery during 2026/27.

4G Value & Sustainability	Executive Director of Finance	Overall Delivery Confidence
4G.4 Develop a Clinical Variation programme to deliver against the core thematic, which have been identified through the national Clinical Variation & Service Reconfiguration Group, with a particular focus on reducing unwarranted clinical variation, minimising waste, improving efficiency and ensuring sustainable service configuration.		Q1
4G.5 Develop a Non-Pay & Procurement programme to deliver against the core thematic, which have been identified through the national Non-Pay & Procurement Value & Sustainability Group, with a particular focus on reducing clinical variation to maximise benefits in relation to price and product standardisation.		Q1
4G.6 Develop a Medicines Management programme to deliver against the seven priority areas, which have been identified through the Directors of Pharmacy's Medicines Value and Sustainability Delivery Assurance Group and endorsed by the NHS Value and Sustainability Board.		Q1
4G.7 Develop a CHC programme to deliver against the seven priority areas, which have been identified through the national CHC Value & Sustainability Group.		Q1
4G.9 Develop a robust benefits framework for the programme, which allows for the effective measurement of activity and resources linked to VBHC (clinical staff, administrative staff, budgets, buildings, energy etc) to improve patient outcomes, patient experience and resource efficiency to ensure value and patient-centred care.		Q1
4G.1 Review current progress with the implementation of the Value & Sustainability Board 'Bone Health' High Value High Impact (HVHI) pathway and produce a proposal to support further implementation.		Q2
4G.2 Review current progress with the implementation of the Value & Sustainability Board Diabetes' High Value High Impact (HVHI) pathway and produce a proposal to support further implementation. This is to be managed as part of the Primary Care IMTP plans.		Q3
4G.10 Use Value Based Health Care (VBHC) guidance for designing services, responding to key population level intelligence including OECD PaRIS report 2025 - Value in Health and through service level Patient Reported Outcome Measurements (PROMs), Patient Reported Experience Measurements (PREMs) and social value measures for procurement. This is to be managed as part of the Clinical Services Plan		Q4
4G.11 As part of our refined planning process, we will utilise the value-based approach that provides the discipline to stop low-value activity, shifting finite resources to prevention and earlier access, community-based care, better-value interventions, and supporting people to manage more of their own health. All of our major investment and dis-investment decisions should therefore be assessed according to their impact on outcomes, experiences, and the value generated from resources used. This is to be overseen by the Planning Team.		Q4

4G.12 Deliver a refreshed Value & Sustainability programme that realises the agreed recurrent savings target for 26/27, aligned with the national value and sustainability structure and associated priorities and which also ensures that savings and mitigations delivered in 2025/26 are maintained in full on a recurrent basis.	Q4
4G.3 Address variation reported in the National Outcomes Framework and National Clinical Audit and Outcome Review Programme.	Q4
4G.8 Develop a 'bottom-up' value programme for staff to register their value ideas/initiatives, with advice, guidance and resource provided where appropriate to mature ideas into delivery.	Q4

Overview
The Health Board supports the national focus on Value and Sustainability (V&S) and will implement V&S initiatives identified internally, by other Health Boards, or through the national Value and Sustainability Board. Focusing on the value of care helps ensure resources are used in ways that improve the outcomes that matter most to individuals. By weighing the costs against these outcomes, the Health Board can make decisions that deliver the greatest impact with available resources. Sustainability is a key part of Quality Planning. Services struggling with sustainability also often face challenges in Quality Control and the subsequent capacity to improve quality. The Health Board has made progress in developing a formal approach to its V&S goals, including embedding Value-Based Healthcare principles across the organisation. This approach focuses on workstreams that deliver better quality outcomes, experiences, and resource use, while contributing to and benefiting from the national Value and Sustainability Board's work. This national work covers six work-streams: 1) Clinical Variation, 2) Workforce, 3) Continuing Healthcare (CHC), 4) Medicines Management, 5) Non-Pay & Procurement and 6) Value Based Healthcare (VBHC).

Key Delivery Priority Quarterly Update
The V&S programme have identified a portfolio of projects (circa 136 schemes) to support the delivery of the Health Board's savings programme, with £43.7m of opportunities identified, of which £24.1m have transitioned to Green RAG delivery.

Work continues to transition the programme away from an exclusive CIP/Financial Recovery Programme and into a 'Value' programme, with equal emphasis on the other value lenses, particularly outcomes, experience & sustainability. To support this, a benefits framework has been developed to capture both financial and non-financial metrics of value.

A portfolio of Value-Based Health Care projects have been commissioned/funded through a ring-fenced value budget to support innovative practice, with schemes such as Lymphoedema showing demonstrable impact on reducing disease progression, through education and training, Community Health Pathways (CHP's) looking to improve referral quality, ensure patients transition to the right place, at the right time and reduce demand that is better managed in a non-acute setting and Prehab, which has a wealth of positive outcome data, including reductions in mortality.

To drive the long term direction of the programme (with a robust methodology and evidence-base), a Value Maturity Assessment Framework has been developed to assess organisational maturity and the score an insight will be used to drive the long term strategy.

4H Quality	Executive Director of Nursing	Overall Delivery Confidence
4H.4 Deliver on findings of internal audit of NICE compliance by focussing on areas where NICE guidance not implemented with clear process of reviewing impact and addressing if significant risk.		Q1
4H.5 Develop programme of Tier 2 audits based on current quality risks.		Q1
4H.1 Develop a comprehensive organisational plan, aligned to Foundations for the Future, to embed the QMS into all core business processes and fully onboard every service to the QMS Maturity App, enabling systematic identification and response to fragile services.		Q2
4H.11 We will reduce severe and catastrophic incident numbers and monitor improvement and learning through the Integrated concerns Hub.		Q2
4H.3 Re-design and implementation of quality governance framework to include implementation of quality issues log.		Q2
4H.8 Refresh of NatSSIPs programme to address recent Never Events and reintroduce a revised ward accreditation programme in line with the QMS methodology.		Q2
4H.9 Implement the new Listening to People Regulations and deliver on the 40% national performance target.		Q2
4H.10 Meet the nationally set Infection Prevention trajectories and reduce the incidents of infections (including C-Diff and E. coli) and associated harm, through implementation of the IPC improvement plan.		Q3
4H.12 We will reduce the number of avoidable falls and HAPU through continuing to implement the actions identified in the associated improvement groups.		Q3
4H.7 Develop a programme of work and governance framework to address digital safety.		Q3
4H.13 We will fully implement the learning repository and have clear outcomes with regard to robust and sustained organisational learning and how it positively impacts outcomes.		Q4
4H.14 Provide direction and oversight through the organisation's Quality governance for the application of appropriate best practice within the national Quality Statements - the ones not covered elsewhere in the plan are: Care of the critically ill, Respiratory Disease, Heart conditions, Kidney Disease, Liver Disease, Musculoskeletal health, Neurological conditions, Stroke, Infection prevention and control, Osteoporosis and bone health.		Q4
4H.2 Develop and begin implementation of a Health Board–wide Quality Accreditation Framework aligned to QMS and regulatory standards, recognising and incentivising excellence.		Q4

4H.6 Develop programme of work to address priority programmes and actions within National Patient Safety Strategy including key performance indicators to measure improvement.	Q4

Overview
High quality and safe care is the Health Board's foremost priority. Delivering safe, effective, compassionate and person-centred services is fundamental to building confidence, meeting statutory duties, and improving outcomes for the population we serve. Quality is not an isolated function; it is the collective responsibility of every part of the organisation and underpins our ability to meet safety standards, performance expectations, deliver value, and use our resources effectively. Sustained operational pressures, workforce constraints, financial challenge and rising demand all increase the risk of variable quality and unmet need. In this context, a consistent, transparent and well governed approach to quality is essential. A mature Quality Management System (QMS) provides the structure required to plan for high quality, intervene early where fragility exists, improve care where needed, control variation, and assure the Board and public of the standard of safe services delivered. Building on our current QMS, the organisation will systematically identify fragile and high risk services and ensure improvement plans are driven by real time intelligence and evidence of impact. Expanding quality control measures to include locally meaningful indicators will strengthen frontline ownership of quality, while reviewing and modernising our governance framework, aligned with internal audit recommendations, external scrutiny, and national policies, will reinforce interprofessional accountability. This includes the introduction of a Quality Issues Log to complement the risk framework and ensure clearer escalation, thematic analysis, and organisational learning. Quality and safety must also be rooted in learning. Strengthening our approach to mortality review, harm analysis, patient safety incidents and complaints will ensure that learning translates into meaningful improvement for patient safety, experience and

performance. Close partnership with operational teams is essential so that insights become action, and assurance reflects real change. 2026/27 brings several statutory and national changes that heighten the importance of a consistent approach to quality. These include: Listening to People Regulations, National Cleaning Standards, Duty of Quality and Duty of Candour and Infection Prevention national targets. Leadership in these areas is critical, along with ensuring that patients always have the option to converse through the medium of Welsh, which should also be considered an issue of quality and safety. The Health Board maintains strong governance structures aligned with the NHS Wales Safeguarding Network, which has highlighted national priorities such as improved child protection medical assessments, strengthened pathways for vulnerable groups, and enhanced support for professionals through reflective supervision. Embedding these requirements within our QMS and governance structures is essential to ensure compliance, transparency, and progress towards de-escalation from targeted intervention. Quality is therefore a critical enabler of organisational recovery, sustainable improvement, and the delivery of safe, effective and equitable care for our communities. Our 2026/27 priorities align to the statutory NHS Wales Planning Framework 2024–2027, which emphasises integrated, sustainable improvement within the constraints of unprecedented operational and financial pressures. These commitments support the Health Board's role in protecting the most vulnerable, reducing avoidable harm, and ensuring the safety and wellbeing of the population we serve. The Health Board is open regarding its biggest quality challenges, incorporating safety, effectiveness and experience. Access to services presents the single greatest quality problem in a number of areas, most visibly in urgent and emergency care pathways and in planned care, diagnostics and cancer pathways. Improving access will improve safety, effectiveness and experience and simultaneously will help improve colleagues' well-being and fulfilment in the workplace. This is why the Board places such emphasis on operational service planning and improvement in delivery, and the reason for external expertise being secured to help both target and accelerate the improvement work in this area.

Key Delivery Priority Quarterly Update

During Quarter 1, the Health Board has maintained its focus on strengthening quality and safety arrangements through the continued implementation of its Quality Management System (QMS). Work remains ongoing to ensure a consistent, transparent and evidence-based approach to quality governance, supporting organisational recovery, service improvement and assurance.

Progress has continued in the identification and oversight of fragile and high-risk services, with quality intelligence, performance information and risk data being reviewed through established governance arrangements. The Health Board has maintained a strong focus on ensuring that improvement actions are informed by real-time intelligence and evidence of impact, supporting earlier intervention where quality concerns emerge.

Development of the QMS continues, with ongoing work to strengthen quality control measures and promote greater ownership of quality at service level. Plans to enhance local quality indicators and improve the visibility of quality information remain on track, supporting a more proactive approach to improvement and assurance. Work is also continuing to review and modernise elements of the quality governance framework, ensuring alignment with internal audit recommendations, external scrutiny requirements and national policy expectations. The Quality Issues Log has been further embedded within governance processes to support escalation, thematic review and organisational learning.

The Health Board has sustained its commitment to learning from mortality reviews, patient safety incidents, complaints and harm events. Established mechanisms for sharing learning and monitoring improvement actions continue to support patient safety, quality of care and service experience. Close collaboration between quality and operational teams remains a key priority to ensure that learning translates into meaningful and measurable improvement.

Preparatory work and implementation activity relating to statutory and national requirements for 2026/27 continue to progress. This includes ongoing oversight of the Listening to People Regulations, National Cleaning Standards, Duty of Quality, Duty of Candour and Infection Prevention and Control requirements. Welsh language considerations continue to be promoted as an integral component of safe, person-centred and equitable care.

Safeguarding remains a priority area, with governance arrangements continuing to align with NHS Wales safeguarding expectations. Work is progressing to strengthen pathways

for vulnerable individuals, support professional practice and maintain compliance with national safeguarding requirements. Oversight through existing governance structures continues to provide assurance regarding delivery against national priorities.
Quality and safety continue to be recognised as critical enablers of organisational improvement and recovery. Quarter 1 has seen sustained focus on reducing avoidable harm, strengthening governance and embedding continuous improvement approaches across services.
The Health Board remains open about its most significant quality challenges. Access to services continues to represent the most significant quality risk across a number of pathways, particularly within urgent and emergency care, planned care, diagnostics and cancer services. While performance pressures remain considerable, improving access continues to be a major organisational priority, recognising the direct impact on patient safety, clinical outcomes, patient experience and staff wellbeing. Improvement programmes and operational recovery work remain underway, supported by external expertise where appropriate, with continued focus on improving performance and reducing variation across services.

4I Environment and Estates	Director of Environment & Estates	Overall Delivery Confidence
4I.3 Plas Gororau (Wrexham) Phase 2 - Commence construction.		Q1
4I.4 Develop and commence implementation of an organisation wide anti-ligature programme.		Q2
4I.7 Ensure strengthened actions are taken to improve estate utilisation including the appropriate repurposing & disposal of under-utilised estate and the reduction in the number of leases.		Q2
4I.8 Implement a computer aided facilities management system to support the management of the estate and the implementation of AI based energy management applications.		Q2
4I.9 Development of a pan-BCU approach to managing car parking for staff and patients.		Q2
4I.11 Maximising the access to grant funding through the Refit Framework to deliver a programme of works to support carbon reduction.		Q3
4I.6 Commence engagement regarding the potential future redevelopment of the Wrexham Maelor Hospital site.		Q3
4I.1 Develop long-term plans for the delivery of the key estates projects including 1) Business continuity scheme for Ysbyty Gwynedd, 2) Electrical infrastructure replacement scheme for Ysbyty Glan Clwyd, 3) Business Continuity scheme for Wrexham Maelor Hospital, 4) Replacement helipads at Ysbyty Gwynedd and Ysbyty Glan Clwyd.		Q4

4I.10 Develop a BCUHB Climate Adaptation plan aligned with the NHS Wales Decarbonisation Plan and in parallel implement estate decarbonisation programmes.	Q4
4I.12 Commence construction of the photo-voltaic array at Ysbyty Gwynedd as part of adopting renewable energy technologies.	Q4
4I.2 Royal Alexandra Hospital (Rhyl) Phase 2 – Complete the schedule of accommodation and strategic outline case	Q4
4I.5 Agree the approach to developing a revised Estates Strategic Plan, in line with the Health Board's 10-year Strategy and Clinical Services Plan.	Q4

Overview
The Health Board's estate is a valuable asset with the potential to create environments which are efficient and effective. The quality of the physical environment is a key element of the Health Board's strategic intent to create a modern, people-centred healthcare system. It is fundamental to the provision of patient care, and to staff well-being. The estate is ageing with over £240m of backlog maintenance recorded and therefore the Health Board should maximise opportunities to replace and refurbish estate using capital funding. In parallel, the Health Board should review the estate to explore opportunities to reduce space which can be undertaken allied to other objectives such as the move to community health care as well as prevention – a reduction in just 2% of the poorest or least used estate could support more cost-effective operations. The Health Board has a current Estate Strategy which was completed in January 2023 with many areas still relevant such as Rationalisation and the implementation of Health and Wellbeing Hubs, but it requires refreshing and potentially alignment with developing clinical service plans. The capital programme seeks to be a balance of investment in assets to address compliance, mitigate risks to service delivery and support the Health Board and Welsh Government priorities within the current plan. The programme contains capital projects that have followed a robust process of being evaluated and prioritised within the limited resources. The Health Boards capital programme comprises a number of potential funding sources, namely the All-Wales Capital Programme, project specific grant support, discretionary capital, property sale receipts and charitable funding. The Targeted Estates Fund has supported major refurbishments and energy efficiency programmes. The development of partnership schemes is important as part of the Health Board's obligations as an anchor institution in North Wales, as well as being part of the focus on health and wellbeing through every stage of life and supporting enhanced coordination of care. NHS Wales has a Decarbonisation Strategic Delivery Plan. The Health Board recognises the need to adapt to irreversible climate change and will respond at a range of levels aligned to the Plan. The response will include Buildings and land, Fleet, Staff Travel and Homeworking, Procurement and Supply Chain, Clinical Services and Waste utilising the relevant stakeholders

within the Health Board. The objective will be to develop strategies and progress decarbonising our operations as much as possible. Through coordinated and innovative approaches, we can deliver a fit for purpose, resilient, efficient and effective estate from which to deliver sustainable health care.

Key Delivery Priority Quarterly Update

The Environment and Estates Programme remain central to delivering the Health Board's ambition for a modern, sustainable and resilient healthcare estate capable of supporting future models of care. Progress has been made across a number of priority capital schemes, infrastructure developments and sustainability initiatives; however, several strategic programmes continue to face challenges associated with capacity, affordability and wider organisational dependencies.

Notable progress has been achieved within the capital programme. Construction activity has commenced on the replacement helipad programme, supporting improved resilience and emergency access arrangements at key acute hospital sites. Plas Gororau Phase 2 has also successfully progressed into delivery, with the construction contract awarded, the contractor now on site and completion scheduled for May 2027. In addition, preparatory work is underway for the proposed photovoltaic array at Ysbyty Gwynedd, with site valuation agreed and planning activities commencing, representing a significant step forward in the Health Board's renewable energy ambitions.

Work continues to progress on a number of strategic infrastructure priorities, including the development of long-term plans for major business continuity and infrastructure replacement schemes at Ysbyty Gwynedd, Ysbyty Glan Clwyd and Wrexham Maelor Hospital. Discussions with Welsh Government remain ongoing to establish future funding and delivery approaches for these significant investments, recognising their importance in addressing ageing infrastructure and mitigating operational risk across the estate.

A number of enabling programmes are also advancing. Initial work has commenced to strengthen estate utilisation through the development of space management and estate rationalisation approaches, supporting opportunities to improve efficiency, optimise asset use and reduce reliance on under-utilised accommodation and leased premises. Progress has also been made towards implementing a Computer Aided Facilities Management (CAFM) system, with market appraisal work underway and recruitment plans agreed for dedicated energy and sustainability leadership capacity. Stakeholder engagement has additionally commenced on the development of a pan-BCUHB approach to car parking management for staff and patients.

While progress has been made, several strategic deliverables remain at an early stage or are experiencing delays. Development of a revised Estates Strategic Plan has been constrained by the absence of an agreed Clinical Services Plan, alongside resource limitations affecting the ability to undertake the necessary planning and analytical work. Similarly, progress on the redevelopment of the Wrexham Maelor Hospital site remains limited, with financial considerations and broader stakeholder alignment continuing to present challenges despite ongoing engagement with Welsh Government.

The Health Board's sustainability and decarbonisation agenda has continued to move forward through ongoing discussions with the REFIT programme regarding potential grant funding opportunities to support carbon reduction initiatives. However, development of a comprehensive Climate Adaptation Plan remains delayed pending organisational decisions and the recruitment of dedicated resources to lead this agenda. Recruitment plans are in place and will be progressed once wider organisational programmes have concluded.

Overall, the programme reflects a mixed but positive position. Key capital projects are moving into delivery, strategic infrastructure planning is progressing, and important foundations are being established to improve estate utilisation, asset management and sustainability. Continued focus will be required to address resource constraints, strengthen alignment with emerging clinical strategies, secure future capital funding and accelerate progress on decarbonisation and long-term estate transformation priorities.

4J Workforce	Executive Director of People Services & Organisational Development	Overall Delivery Confidence
4J.1 Review of Consultant job plans – Operational Services to be targeted to reach >90% to ensure improved workforce productivity and alignment to demand and capacity. This will be measured through the Job Planning Dashboard and follows on from work undertaken in 2025/26.		Q2
4J.2 Review of agency expenditure. Operational Services to be targeted with a 30% reduction in agency expenditure. All services to be targeted with no off-contract agency use and not Admin and Clerical, Estates and Ancillary and Health care Support Worker agency use through effective workforce planning, optimising the benefits of the newly insourced medical bank resource and management controls. This will be measured through the Value & Sustainability (V&S) Group.		Q2
4J.3 Fully implement the actions outlined in the Variable Pay & Agency Control Framework Welsh Health Circular by continuing to reduce agency requirements and incentivise substantive positions through flexible working, effective rostering and employee health and wellbeing programmes of work.		Q4
4J.4 Work with operational and corporate directors to implement and deliver the Health Board's sickness absence delivery plan to improve workplace attendance levels and to meet national sickness absence and local stretch targets. Progress will be monitored through the People and Culture Committee.		Q4
4J.5 Implement and deliver the year 1 actions from the Culture, Leadership and Engagement 3-year Improvement plan 2026-29.		Q4
4J.6 Review and respond to staff survey feedback to support an improvement in staff engagement and satisfaction.		Q4
4J.7 Implement in partnership strategic workforce planning across the organisation, improving alignment with Clinical Service Plans, use of technology, Financial Plans linked to IMTP objectives. Progress will be measured through the Foundations for the Future programme board. Plans will proactively identify any workforce capacity, skills and talent gaps and set out initiatives to address these in order to meet organisational objectives.		Q4
4J.8 Prepare the annual social partnership report outlining what the Health Board has done to comply with the Social Partnership Duty, agreeing it with Trade Unions and submitting to the Social Partnership Council (SPC) as soon as possible after the end of the financial year.		Q4

Overview
Workforce planning is a core organisational priority because the Health Board's ability to deliver safe, effective and sustainable care depends on a workforce that is strategically aligned, with the right and capabilities, in roles designed to be adaptable to changing population needs. The system continues to face increased clinical complexity, rising demand

for services, complex population health needs and inequalities, all within a constrained financial environment. A structured, evidence-based approach to workforce planning is essential to ensuring that staffing models are directly aligned to service redesign, use of technology and the broader transformation ambitions underpinned by the Clinical Services Plan and Community by Design, as set out in the IMTP. Embedding Health Education and Improvement Wales' (HEIW) Six Steps Workforce Planning Methodology supports this strategic shift, enabling services to base decisions on robust data, demand modelling and integrated workforce, finance and activity assumptions. A clear example of the importance of this approach is the progress made within the qualified nursing workforce. Over the next three years, the Health Board expects to reach full establishment for registered nurses for the first time in over a decade, creating stability. As these pressures begin to ease, workforce planning allows the organisation to pivot toward emerging and persistent shortage areas, such as medical specialties with national supply challenges, mental health, primary care, and hard to recruit allied health and diagnostic professions. This shift will be supported by designing multidisciplinary teams around new roles, including Advanced Clinical Practitioners, ensuring that workforce models reflect the changing needs of patients/service users and the future direction of care delivery. Effective workforce planning also reduces reliance on agency staffing, strengthens job planning and improves quality, safety and productivity, supporting a more stable and attractive working environment. Ultimately, embedding workforce planning as a core organisational discipline ensures services remain clinically viable, financially sustainable and capable of delivering high quality, person-centred care for the population of North Wales, both now and in the years ahead.

Key Delivery Priority Quarterly Update

Workforce planning remains a critical enabling programme underpinning the Health Board's ability to deliver safe, sustainable and financially viable services. During the reporting period, progress has continued across a number of key workforce priorities aligned to the IMTP, Foundations for the Future Programme, Clinical Services Plan and wider organisational transformation agenda.

Strategic workforce planning activity has strengthened through direct support to Fragile Services, with workforce plans and associated action plans being developed to stabilise services and address workforce risks. Governance arrangements and standard operating procedures are being enhanced, with increased collaboration between Workforce, Transformation and Improvement teams to ensure workforce planning is embedded within service redesign activity. In parallel, the establishment of the Interprofessional Education Group is supporting greater alignment between workforce planning, education commissioning and future workforce supply requirements, whilst ongoing engagement with HEIW is informing the development of future workforce modelling and planning tools.

Delivery against workforce productivity priorities has continued, although progress has been impacted by delays in ratification of the revised Consultant Job Planning Policy. As a result, achievement of the target for over 90% consultant job plan compliance has been slower than anticipated, with compliance levels further affected by a significant number of historic job plans expiring at the end of March 2026. Operational teams continue to work towards improving compliance wherever possible, with progression expected once the policy is formally agreed and implemented.

Work to reduce temporary staffing reliance and optimise workforce deployment remains a key focus. Improved organisational visibility, scrutiny and challenge of long-term medical agency usage is now in place, supported by strengthened governance through the Value and Sustainability Programme. Actions are being taken alongside the insourced medical bank service to reduce agency dependence, with additional control measures identified through the Variable Pay and Agency Control Framework. Delivery remains achievable provided planned controls and workforce management interventions continue to be embedded over the coming months.

Workforce wellbeing and attendance continue to receive targeted attention. Enhanced localised sickness absence reporting has been introduced, enabling People Services and operational teams to focus interventions on identified hotspot areas. Progress is being monitored through local performance arrangements and the People and Culture Committee, supported by a detailed delivery plan aimed at improving attendance rates and achieving both national and local performance targets.

Progress has also been made in implementing the Culture, Leadership and Engagement Improvement Plan and responding to staff feedback. A number of foundational initiatives are now underway, including development and pilot testing of a values-based appraisal framework, strengthening organisational culture and behavioural expectations, enhancing induction and transition arrangements, reviewing governance processes to support more effective decision-making, and developing organisational metrics to measure cultural improvement and staff engagement. Further work is progressing on staff recognition, leadership role redesign and organisational development activities through the Foundations for the Future programme.

Social Partnership continues to be embedded as a core way of working, with engagement and partnership activity taking place throughout the year. Preparatory work for the Annual Social Partnership Report is progressing through routine workforce and partnership arrangements, ensuring compliance with statutory duties and continued collaboration with Trade Union partners.
Overall, progress demonstrates continued movement towards a more strategic, integrated and evidence-based approach to workforce planning. Whilst some key enablers, notably consultant job planning policy approval, have impacted the pace of delivery in specific areas, the Health Board is strengthening the systems, governance and workforce intelligence required to support sustainable workforce transformation, reduce temporary staffing dependence and align future workforce capacity and capability with service, financial and population health priorities.

4K Finance & Commissioning	Executive Director of Finance	Overall Delivery Confidence
4K.2 Contribute to the broader performance accountability agreements to ensure that budget owners are clear on their budget for the year and their accountabilities in relation to delivery within budget.		Q1
4K.1 Maintain financial control measures from start of financial year, with a view to step them down as assurance and confidence is being gained in delivery of the financial plan. Particularly important due to FFTF structure changes mid-year that could otherwise cause some disruption in delivery of financial plan.		Q2
4K.3 Contribute to all the workstreams within the Value & Sustainability programme with a particular focus on those that are more traditionally related to financial management such as non-pay and ensuring there is a focus and visibility associated to savings in non-core areas and overheads to prioritise front-line services.		Q2

4K.5 Develop and commence implementation of a Commissioning Strategic Approach for all externally commissioned healthcare activities, that provides direction to the organisation on the role of commissioned services as part of longer-term strategic planning. Forming strategic partnerships will be an important part of the Clinical Services Plan work.	Q2
4K.10 Develop robust commissioning plans for planned care services to secure additional capacity that addresses service backlogs and demand beyond internal capability. Establish and implement a comprehensive process that defines internal resource requirements and incorporates the full procurement, governance, and mobilisation pathway needed to deliver the required capacity.	Q3
4K.12 Work with the Joint Commissioning Committee (JCC) to develop a financially balanced plan for the delivery of specialist services for the Health Board's population. Ensure consistent and effective representation from BCU at all JCC meetings and support a constructive approach to handling challenges. Proactively engage with the JCC to contribute to: - Efficiency and productivity schemes that collaboratively manage demand and cost pressures e.g. referral management. - o New clinical models in relation to Emergency Ambulance Services. - Save a Life Cymru (SALC) defibrillator awareness. o New air bases for the Emergency Medical Retrieval Service (EMRTS).Adult Critical Care Transfer Service (ACCTS) in line with the Health Board's emerging Clinical Services Plan. o Non-Emergency Patient Transport Service (NEPTS) transformation. o Neonatal Transport (CHANTS) & Major Trauma pathways. o Clinical engagement and partnership in Sexual Assault Referral Centres (SARC). o Improved commissioning and strategic partnerships with hospices and the Voluntary Sector. o A strategic review of Mental Health, Learning Disabilities and Vulnerable Groups commissioning. o Strategic reviews and deep dives relating to specialised services commissioned services across Cancer & Blood, Cardiac, Kidney, Neurosciences and Women & Children's services.	Q3
4K.13 Prepare and commence execution of a robust and sustainable recovery plan, as detailed within Standing Financial Instructions, following submission of an in-year deficit outturn	Q3
4K.4 Repeat the exercise to quantify current spend on primary and community services to compare against the baseline produced in 2025/26, in order to ascertain whether the required strategic move to proportionately increasing investment into primary and community care when compared to secondary care is happening.	Q3
4K.6 Create an Integrated Commissioning Framework that includes commissioning assurance, and clarity of roles and responsibilities, ensuring that everyone across the organisation is clear on roles to enable effective commissioning with a focus on value, quality and patient outcomes.	Q3
4K.8 In advance of the annual review of all services, undertake a risk-based review of contracts to ensure they are delivering value against current population need.	Q3

4K.11 Complete a review of performance monitoring arrangements for all existing commissioned services, ensuring that an appropriately broad set of performance metrics are covered along with consistent periodic commissioned services partner review meetings.	Q4
4K.7 Individual services to undertake an annual review of all their commissioned and contracted services as part of the IMTP process to ensure that the right strategic decisions are made on what the organisation should provide or commission. This should trigger de-commissioning, re-commissioning, as well as commissioning of new services where that best meets the needs of the population.	Q4
4K.9 Undertake a review to provide assurance that the Health Board is operating in accordance with the national hospice commissioning guidance in relation to palliative and end of life care.	Q4

Overview

The core purpose of the Financial Plan is to reflect the financial impact of the decisions and service developments contained within the IMTP and support the fundamental aims and strategic objectives of the Health Board. As a Health Board there is a statutory duty to breakeven against the resource limit set by Welsh Government, over a three-year period. The financial planning element of the IMTP plays a critical role in ensuring the organisation can meet its obligations both to the public and to Welsh Government. A strong financial plan reflects the financial consequences of service choices, prioritises what can be delivered, and ensures that the organisation remains viable and resilient in the face of increasing pressure and demand. Given the financial climate facing the NHS, the priority placed on effective organisational planning, especially financial planning, now is greater than ever. As the Health Board enters 2026/27, it does so against a backdrop of ongoing financial challenge, with underlying deficits and rising service pressures continuing from 2025/26. Even with an uplift in funding, achieving financial sustainability requires robust financial governance, disciplined prioritisation, a credible savings programme, optimisation of resources, and a clear understanding of the three-year financial trajectory. The plan therefore focuses on delivering an ambitious but realistic position, whilst laying the foundations for a productive, efficient and financially sustainable workforce capable of delivering high quality care. The Health Board needs to strengthen its internal commissioning function to improve services contracted from other organisations, including healthcare providers, local authorities and third-sector partners. This will support the 'shift left' and de-medicalisation of some services in line with "A Healthier Wales." Following the pandemic, many services were contracted on a block basis, limiting the ability to focus on quality and outcomes. Moving towards a commissioning approach that better considers population needs, priorities, and quality monitoring will improve the value of these services and support local and third-sector involvement. A timely and systematic commissioning framework will also help partners plan and promote integrated care across North Wales. The Health Board has struggled to recover and improve the efficiency of planned care post-pandemic. Strengthening operational planning and applying commissioning principles will help improve this process. Prioritising these efforts will allow the Health Board to refocus contracts on value and quality, improving demand and capacity planning for better service procurement.

Key Delivery Priority Quarterly Update

1. What have we delivered so far this year towards the aim?

Significant progress has been made in strengthening the Health Board's commissioning and financial governance arrangements.
Key milestones delivered include:
• Approval of the Commissioning Assurance Framework (CAF) by the Board on 28 May 2026, establishing the governance framework for commissioning oversight and contract

assurance.
• Commencement of implementation planning for a dedicated Executive Commissioning and Contracts Group to oversee delivery of the CAF.
• Active participation in regional and national commissioning programmes, including specialist services through the Joint Commissioning Committee (JCC) and hospice commissioning through the North Wales Joint Commissioning Committee (NWJCC).
• Continuation of enhanced financial recovery and monitoring arrangements following submission of the Month 3 Monitoring Return, including strengthened divisional accountability, savings monitoring and executive scrutiny processes.
• Submission of the Month 3 Monitoring Return reporting a year-to-date deficit of £17.1m and implementation of recovery planning arrangements in accordance with Standing Financial Instructions.

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2. What impact (both qualitative and quantitative) has the work had on the population of North Wales compared to what it set out to achieve?
At this stage, the primary impact has been the establishment of the governance, assurance and commissioning infrastructure required to support longer-term service improvement and financial sustainability.
• Maintenance of the annual financial forecast aligned to the approved 2026/27 planned deficit of £43m, despite a reported year-to-date variance of £6.4m adverse to plan at Month 3.
As implementation remains in the early stages, direct population-level impacts on access, quality or outcomes are not yet evidenced and are expected to emerge through delivery of the commissioning review programme and associated service changes during 2026/27.

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3. What actions are we undertaking to ensure we are on track to deliver the full overarching aim and associated impact by the end of March 2027?
The Health Board is progressing the following actions:
• Implementing the Commissioning Assurance Framework across NHS-to-NHS, independent sector and subsequently wider commissioned services through a phased, risk-based approach.
• Establishing the Executive Commissioning and Contracts Group to provide strategic oversight and assurance of delivery.
• Undertaking annual reviews of commissioned services through the IMTP process to support commissioning, recommissioning and decommissioning decisions based on population need, quality and value.
• Continuing collaborative work with the JCC, NWJCC, local authorities, the voluntary sector and providers to strengthen commissioning arrangements and develop financially sustainable service models.
• Progressing work to align performance monitoring arrangements across commissioned services, including development of broader performance metrics and regular contract review processes.
• Maintaining enhanced financial recovery arrangements, including monthly executive scrutiny, divisional accountability processes, savings delivery monitoring and recovery planning actions.
Overall, delivery remains focused on establishing the governance, assurance, commissioning and financial management arrangements required to support improved value, service quality, integrated care and longer-term financial sustainability for the population of North Wales by March 2027.

ASSESSMENT	
Link to Strategic Priorities	4.Create a Modern, People Centred Healthcare System
	If more than one applies, please list below: 4. Improving quality, outcomes and experience
Design Principles	Consistency with Organisational Values If more than one applies, please list below: All design principles applied through the various key programmes.
Corporate Risks and Board Assurance Framework	Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)
	Not Applicable
	If more than one applies, please list below:

IMPACT ASSESSMENTS		
Equality *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	*Individual programmes will complete as appropriate.*
	Yes: ☐	No: ☒

Socio-Economic Impact Assessment *Have you undertaken a Socio-Economic Impact Assessment*	Outcome:	
	If no, please include rationale:	*Individual programmes will complete as appropriate.*
Have you undertaken a Quality Impact Assessment Screening?	**Enablers of Quality** All Apply	**Domains of Quality** All Apply
	If more than one applies, please list below:	If more than one applies, please list below:
Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	
Environmental /Sustainability Impact (5Rs)	If more than one applies, please list below:	
	No - Not Applicable	
	If more than one applies, please list:	*Individual programmes will complete as appropriate.*
Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: ☐	No: ☒
	Outcome:	*Individual programmes will complete as appropriate.*
	If no, please include rationale:	
Data Protection Impact Assessment	Yes: ☐	No: ☒
	Outcome:	

Have you undertaken a Data Protection Impact Assessment Screening?	If no, please include rationale:	*Individual programmes will complete as appropriate.*
Counter Fraud Impact Assessment *Have you considered the counter fraud impacts*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	*Individual programmes will complete as appropriate.*
Legal	There are no specific legal implications related to the activity outlined in this report.	
Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Planning, Population Health & Partnerships Committee

ENHANCING CARE THROUGH DIGITAL DEVELOPMENT REPORT

Date of Meeting	03 September 2026
Publication Status	Open/ Public
	Not Applicable
Report Author(s) name and title	Sophie Thomas- DDaT Business Manager
Lead Executive Team Member name and title	Justine Parry- Acting Director of Digital, Data and Technology

Report Purpose	For Approval

Executive Summary

Significant progress has been made across Digital, Data & Technology (DDaT), strengthening the Health Board's digital foundations while progressing key transformation programmes and improving the use and quality of data.

The Digital & Data Roadmap has been developed to provide a clear strategic direction for digital transformation, aligned to organisational and NHS Wales priorities. It sets out a phased approach covering the strengthening of digital foundations, improving organisational digital maturity and readiness for future Electronic Health Record (EHR) development, and enabling longer-term innovation, including the responsible use of Artificial Intelligence. The Roadmap is scheduled for consideration by the Planning, Population Health and Partnerships Committee prior to Board approval.

Digital governance and portfolio management have continued to mature, including the introduction of a strengthened Digital Benefits Management Framework and a prioritisation exercise covering 23 projects. This has enabled Executive-approved prioritisation of resources across the portfolio and provides a clearer focus on delivery of the highest-priority programmes.

There has been positive progress across a number of major programmes, including procurement of the All-Ages Mental Health and Learning Disabilities EHR, successful implementation of the Digital Maternity System and continued development of digital eye care services. However, delivery remains subject to a number of significant dependencies and risks, including delays to the national LIMS programme, national direction and funding arrangements for EHR

programmes, national capacity affecting WPRS and the NHS App, and funding/resource constraints affecting Dental, Therapy Management and the Scanning Outline Business Case.

Data, Intelligence & Insight has delivered significant improvements in clinical coding, moving from the lowest performance in Wales to achieving the national 95% completeness target within one month of discharge, with the 2025/26 backlog cleared. Focus has now shifted to coding quality, workforce development and exploring automation. The team is also increasingly using data to support service improvement, including through the Right Patient Right Place and OPEL dashboards and the Warm Homes initiative.

The migration to Microsoft Fabric has been completed, providing increased capacity, improved security and a stronger foundation for future cloud analytics. Data quality and governance have also been strengthened through the data quality kite mark, enhanced reconciliation and sign-off processes, improved pre-submission checks and the development of data audit functionality.

ICT Digital Services has maintained stable operational performance while managing sustained demand, implementing the major programme of local and national systems and delivering significant infrastructure modernisation, cyber security improvements and clinical systems development. More than 10,000 incidents and service requests are handled each month, with customer satisfaction maintained at 93–96%. The service has also achieved SDI 4-Star accreditation, making BCUHB the first Health Board in Wales to achieve this standard.

Overall, DDaT is strengthening the Health Board's digital foundations, data capability and governance while enabling major transformation programmes. The principal challenge remains the capacity to progress the scale of planned transformation alongside national dependencies, funding constraints and available resources. Continued prioritisation and strong governance will therefore be essential to maintain delivery and ensure digital investment delivers measurable benefits for patients, staff and the organisation.

Engagement (internal/external) undertaken to date (including receipt/ consideration at Committee/Group)

Committee / Group / Individuals	Date	Outcome, Evidence and Data
Digital, Data and Technology Senior Leadership Team Meeting	18/08/2026	Approved subject to minor amendments
Executive Committee	26/08/2026	Approved for onward presentation to the Board Committee

Acronyms / Glossary of Terms	
BCUHB	Betsi Cadwaladr University Health Board
DDaT	Digital, Data and Technology
DDSE	Digital Delivery, Strategy and Engagement
DI&I	Data, Intelligence and Insight
EHR	Electronic Health Record
ePMA	Electronic Prescribing and Medicines Administration
LIMS	Laboratory Information Management System
BT	Blood Transfusion
WPRS	Welsh Patient Referral System
PACS	Picture Archiving and Communication System
PROMs	Patient Reported Outcome Measures
DPIF	Digital Priorities Investment Fund
DHCW	Digital Health and Care Wales
OPEL	Operational Pressures Escalation Levels
SPC	Statistical Process Control
NDR	National Data Resource
RTT	Referral to Treatment
NCCQ	National Clinical Coding Qualification
BAU	Business as Usual
OBC	Outline Business Case

Enhancing Care through Digital Development Report

1. Situation This report provides an update on how Digital, Data and Technology (DDaT) is supporting the Health Board to enhance care, improve organisational resilience and enable digital transformation. It highlights progress across the Digital and Data Roadmap, digital delivery and programme governance, benefits and change management, project prioritisation, Data, Intelligence and Insight (DI&I), ICT infrastructure and clinical systems, and the delivery of major digital programmes. The report also sets out the key risks and dependencies affecting delivery across the DDaT portfolio, including national programme delays, funding and resource constraints, and reliance on national direction and external partners.

2. Background Digital, Data and Technology supports the delivery of digital systems, technology, information and intelligence that enable improvements in patient care, service delivery and organisational performance across BCUHB. The matters outlined within this report support the Health Board's strategic priority of improving quality, outcomes and experience and contribute to the management of BAF24-02: Not Delivering Strategic Development and Digital Transformation and BAF24-08: Not Implementing Evidence Based Improvement and Innovation.

3. Specific Matters for Consideration

3.1 Digital Roadmap

During the reporting period, the Digital and Data Roadmap has been developed to provide a clear strategic direction for digital transformation across the Health Board. The Roadmap adopts a phased approach focused on strengthening digital foundations, improving organisational digital maturity and readiness for future Electronic Health Record development, and enabling longer-term innovation, including the responsible adoption of Artificial Intelligence.

Successful delivery of the Roadmap is expected to support measurable improvements in patient access to services, patient experience, workforce productivity, digital maturity, interoperability, cyber resilience and organisational performance, ensuring that digital investment is strategically aligned and delivers tangible benefits for patients, staff and the wider Health Board.

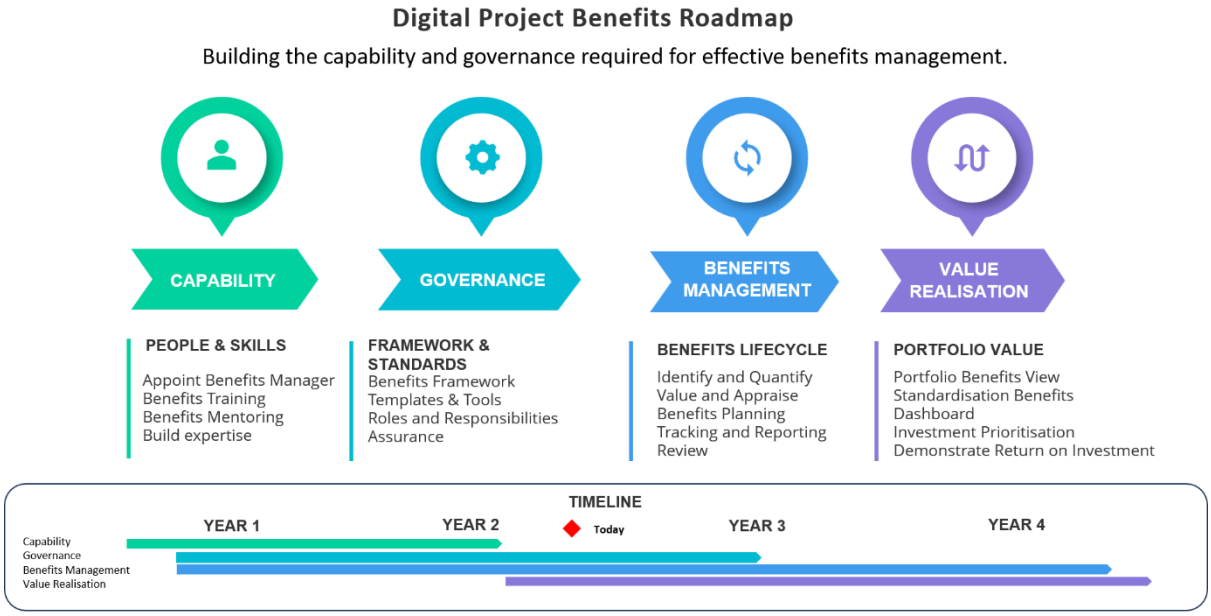
The Roadmap is scheduled for consideration by the Planning, Population Health and Partnerships Committee prior to submission for Board approval.

3.2 Digital Delivery, Strategy and Engagement

3.2.1 Strengthening Project Governance

Improvements within DDaT include Digital Benefits Management, which continues to mature as a more structured and consistent function, supporting the organisation to better identify, measure and demonstrate the value delivered through digital

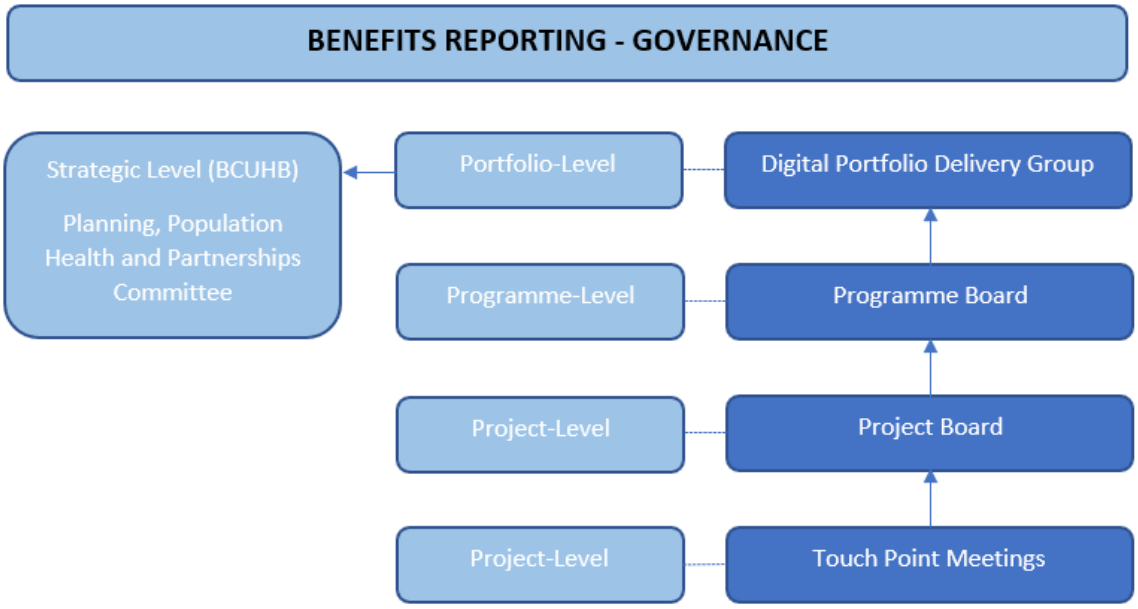
investment. The focus has been on strengthening the foundations required to support effective benefits realisation across the digital portfolio.



Outcome: Portfolio-wide visibility of benefits to evidence the value of Digital investment

An updated Digital Benefits Management Framework, **Appendix 1**, has been approved by the Digital Portfolio Delivery Group. This is underpinned by a recognised benefits management methodology and supported by practical tools and guidance, is being embedded across the digital portfolio to improve the planning, monitoring and realisation of benefits.

The Benefits Summary, **Appendix 2**, provides information on digital projects where work is ongoing. Governance and oversight arrangements are continuing to develop through project and programme boards, the Digital Portfolio Delivery Group, and this first report to this committee. As this work continues to mature, the organisation will be increasingly well positioned to understand, and evidence the impact and value of digital investment.



Another key area of progress within the digital project approach has been the development of a practical Change Management Approach Template and supporting framework Change Management Framework. This work has helped bring greater visibility to the practical realities of digital change. It has highlighted the importance of understanding current ways of working before designing future workflows, involving staff early, recognising local variation, and giving services the support they need to adopt change safely. It has also reinforced the need to consider the service user impact of digital change, particularly in services where information flow, record quality and timely access to information affect safe care. The All-Ages Mental Health and Learning Disabilities Electronic Health Record project has provided a major test case for this work.

3.2.2 Digital Prioritisation

A prioritisation exercise was undertaken between March and May 2026 utilising an agreed Prioritisation Framework, **Appendix 3** Prioritisation Framework. Twenty-three projects were considered against five key criteria:

Alignment: How well the project is aligned with the Annual Plan and Major Change Programmes
Value: The extent to which the project has an impact on quality, safety, harm reduction and the anticipated benefits or impact the project would deliver
Risk: The extent to which the project mitigates risks or gaps in current service provision, addresses underperformance, and the residual risk to the organisation if the project is not delivered.
Deliverability: The complexity and scale of the change, the affordability of implementation and long-term sustainability, and the organisation's capacity, capability, commitment, and clarity to deliver it.

Political Imperative: The extent to which the project will address Cabinet Secretary priorities and enhance the Health Board's reputation.

In addition to scoring, a range of contextual factors were considered to support final decision-making. These included mandated requirements, availability of external funding, current delivery status, organisational risk, and senior stakeholder input.

The outputs of this assessment have been considered alongside senior stakeholder input and contextual factors to inform the proposed priority groupings set out below.

The Executive team reviewed and approved the recommended Project Priorities for the remaining months until December 2026, to allow DDaT to realign resources subject to agreement, with a caveat to discuss PROMs further. The approved list is:

	Project Name	Priority Group
1	LIMS	1
2	All-Ages Mental Health and Learning Disabilities	1
3	Essential Services Programme	1
4	WPRS - Welsh Patient Referral System	1
5	Open Eyes	1
6	Operai	1
7	Connecting Care	1
8	Therapies	1
9	PROMs	2
10	Dental	2
11	Cardiology PACS	2
12	EPRO - Digital Dictation Upgrade	2
13	EHR - Electronic Health Records	3
14	Digital Maternity (Phase 2)	3
15	Optimisation / Legacy Systems Decommissioning	3
16	Scanning Project	3
17	Single Sign-On	3
18	Patient Flow (Stream)	3
19	My Medical Record / My Health Record	4
20	Emergency Admissions System (Phase 2)	4
21	NHS App	4
22	Diabetes	4
23	WICIS - Welsh Intensive Care Information System	4

High priority	Priority 1 & 2
Moderate priority	Priority 3
Not Yet	Priority 4

3.2.3 Project progress

A dashboard is included **Appendix 4** PPMO Dashboard, as well a summary position in **Appendix 5** Digital Update, which details the current progress, key risks, mitigations, plans to go forward, milestones, and deliverables. As a high level summary:

The national **LIMS** Programme continues to experience further delays, significantly increasing delivery risk, particularly for Blood Sciences and impact upon the patient critical Blood Transfusion (BT) implementation.

Procurement is now completed for the **All-Ages Mental Health & Learning Disabilities EHR Programme**. A key risk relates to the change in approach to digital programme funding by Welsh Government and the potential impact on future funding arrangements.

Progress has been limited for the **Acute and Community EHR Programme** while we await national direction from Welsh Government.

The **Digital Maternity System** implementation has been successful, however outstanding work, mainly integration, has resulted in a Phase 2 being developed to manage these elements. Progress is slow nationally.

ePMA continues to progress with BAU bedding in and dealing with issues as they arise. Integration issues are being managed, however the system is reliant on one specialist to resolve issues which can occur 24/7 and require immediate resolution.

Digital Eye Care: BCUHB was the first Health Board in Wales to go-live with the OPERAi Electronic Referral System in Primary Care (March 2026). Secondary care functionality is still being developed nationally, which is the key element for secondary care benefits. OpenEyes is live for the Glaucoma pathway at Wrexham Maelor Hospital. Both systems have contract end dates within the next six months with no clear national plan for going forward.

WPRS (Welsh Patient Referral Service) is progressing slowly due to national resource constraints.

Dental: The Executive Committee and the Health Board have approved the Outline Business Case and recommended progression to procurement and Full Business Case development. Delivery risk remains high due to funding and resource constraints, and no current framework to procure from.

The **Therapy Management Replacement System** (Ymholi) is replacing the legacy Therapy Manager system which has been in use since 2006. The project was paused in June 2025 with further discussions and agreements are in progress prior to the project recommencing.

The **Connecting Care Community Health Record** Outline Business Case was approved at the Health Board on 30th July.

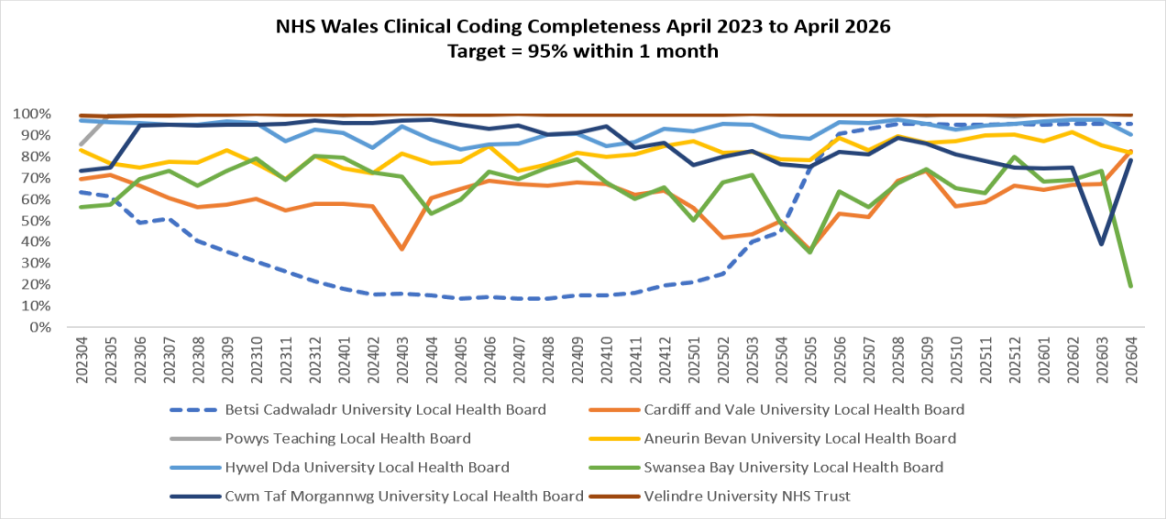
The **NHS App** work is currently on hold nationally. DHCW advised that they are awaiting a decision from Welsh Government on future direction of the App.

Scanning Outline Business Case: The requirement for a Health Board-wide scanning solution has been identified. With no approved funding for project resources to develop the Outline Business Case, this is progressing on best endeavours.

3.3 Data, Intelligence & Insight (DI&I)

3.3.1 Clinical Coding

Clinical coding performance has significantly improved, moving from the lowest in Wales to achieving the national target of 95% completeness within one month of discharge since August 2025. The 2025/26 coding backlog has been cleared, with the full year coded to 95%, and the service received positive feedback from the annual DHCW external audit.



With the backlog resolved, the focus has shifted to coding quality. An errors dashboard is now embedded, enabling timely identification and correction of errors and supporting coder development. Workforce stability has also improved, with six new trainees recruited, five having passed the National Clinical Coding Qualification (NCCQ) in the latest examinations and two more due to sit exams later this year. A pilot exploring automation of clinical coding in Ophthalmology is also underway.

3.3.2 Intelligence Led Organisation Using Data to Drive Change

The Data Intelligence and Insight service continues to use data collaboratively to support service improvement and outcomes. Recent examples include the Right Patient Right Place dashboard, supporting timely transition from hospital to social

care, and the Operational Pressures Escalation Levels (OPEL) dashboard, supporting the Urgent and Emergency Care programme and readiness for national reporting developments.

The team is also working with Public Health and Local Authority colleagues on a Warm Homes initiative, using hospital activity data to identify patients who may benefit from improved heating and insulation.

To strengthen organisational data capability, Analysis colleagues have delivered lunch and learn/drop-in sessions and developed Statistical Process Control (SPC) resources, which are now embedded within the Health Board's leadership programme.

3.3.3 Data Quality and Governance

The programme to roll out the data quality kite mark across core datasets continues, with the kite mark currently applied to RTT and waiting times data within IRIS reports. It provides an assessment across six measures: timeliness, duplication, completeness, consistency, load and validity.

Following two unrelated data submission incidents, focus on data governance, reconciliation and sign-off has been strengthened. Executive-level sign-off for RTT is now embedded, with learning being applied across other data areas. External submission mapping, additional pre-submission checks, strengthened standard operating procedures and new data-checking tools have been introduced. Further developments include trigger-based data warehouse audits and enhancements to the metadata viewer application to track change requests, justification and impact. Learning from the incidents will inform a wider programme of data audits.

3.3.4 Cloud Analytics

The migration from Power BI Premium to Microsoft Fabric has been completed. While there is no change to user experience, the move provides greater capacity for reporting, improved security and future-proofs the Health Board's cloud analytics capability.

As part of ongoing work with the National Data Resource (NDR), the team has documented the conceptual cloud architecture, with the next phase focusing on Data Plex discovery and data management within the NDR.

3.4 ICT Digital Services

3.4.1 Overview

ICT Digital Services has continued to provide the Digital Foundations that support patient care, workforce productivity and organisational resilience across the Health Board. Despite sustained growth in service demand, ICT has maintained stable operational performance while progressing a significant programme of infrastructure modernisation, cyber security improvement, clinical systems enhancement and digital transformation. The service has successfully balanced the twin challenge of

maintaining business-critical digital services whilst enabling major strategic change programmes.

3.4.2 Strategic Delivery Across Programmes and Projects

The Service has supported delivery of national and local digital priorities through investment in resilient infrastructure, service management transformation, clinical systems development and digital programme delivery. Key achievements include:

- Delivery of major infrastructure and cloud upgrades, improving reliability, performance and resilience of core ICT services.
- Progression of significant cyber security improvements and protective controls, strengthening organisational resilience against emerging cyber threats.
- Continued implementation and maturity of modern IT Service Management (ITSM) processes through HaloITSM, supporting improvements in workflow automation, transparency and customer experience.
- Delivery of ICT roadshows, digital engagement activities and customer insight programmes, including a large-scale customer survey that generated more than 1,700 responses to inform service improvement priorities as part of the continuous improvement of the service.
- Through the Digital Academy, the establishment of Digital Champions and workforce digital learning initiatives to improve digital maturity and adoption across the Health Board.

3.4.3 ICT Clinical Systems Team: Supporting Frontline Care

The ICT Clinical Systems Team has played a critical role in enabling safer, more effective and more digitally integrated clinical services. In addition to maintaining and supporting existing clinical applications, the team has been central to major national and local programme delivery. Key achievements include:

- Successful implementation of the Radiology Information System (RISP), improving radiology workflows and reporting capability.
- Delivery of multiple enhancements and upgrades to clinical applications including the Welsh Clinical Portal (WCP), improving stability, usability and clinician experience.
- Supported the delivery of major national programmes including Electronic Prescribing and Medicines Administration (EPMA) and Digital Maternity, covering system configuration, user acceptance testing, device deployment and implementation planning.
- Ongoing support for strategic Electronic Health Record programmes, including the All-Ages Mental Health and Learning Disabilities EHR programme, which aims to improve workflow efficiency, quality of care, information sharing and patient safety.
- Continued focus on improving reliability, resilience and usability of clinical systems to minimise disruption to frontline services and support safer clinical decision making.

- Optimisation programme supporting local and National Target Architecture has deprecated a small number of legacy clinical systems most notably Emergency Point of Care (EPOC) helping to reduce the overall estate of clinical applications.

3.4.4 Operational Excellence and Service Performance

ICT Digital Services continued to operate at scale while maintaining strong service performance:

- More than 10,000 incidents and service requests handled each month while maintaining customer satisfaction levels between 93% and 96%.
- Sustained growth in self-service adoption, with around half of all requests now raised digitally, enabling faster access to support and improved efficiency.
- Strong operational performance maintained despite increasing demand, reducing service backlog and improving service stability.
- Achievement of SDI 4-Star accreditation for the ICT Service Desk, making BCUHB the first Health Board in Wales and one of only a small number of organisations in the UK to reach this standard.

3.4.5 Enterprise Architecture and National Target Architecture

The Service will continue to develop and strengthen its Enterprise Architecture capability as a key enabler of digital transformation across the Health Board in supporting an Electronic Healthcare Record (EHR) convergence strategy. The ambition is to establish a mature architecture function that provides clear technology standards, strategic roadmaps and governance to ensure digital investment is aligned to organisational priorities, national direction and long-term sustainability. A significant focus has been on active participation in NHS Wales National Target Architecture groups, helping to shape and influence the future digital landscape whilst ensuring the Health Board remains aligned to emerging national standards, platforms and interoperability requirements. This work will support the transition towards a more integrated, secure and resilient digital ecosystem, reducing unnecessary complexity
and technical debt while creating the foundations required for future innovations in areas such as Electronic Health Records, data sharing, cloud services, cyber resilience and digital patient services.

3.4.6 Impact

Collectively, these achievements have strengthened the Health Board's Digital Foundations, improved resilience and cyber security, enhanced user experience and enabled progression of major digital transformation programmes. Most importantly, they have supported clinicians and staff to deliver safer, more efficient and more effective care to patients across North Wales.

4. Key Risks / Matters for Escalation

The key risks affecting delivery include:

- Continued delays to the national Laboratory Information Management System (LIMS) Programme, increasing operational, clinical, financial and delivery risk, particularly in relation to Blood Sciences and Blood Transfusion.
- Uncertainty regarding future Welsh Government funding arrangements for major digital programmes, including the potential impact on the All-Ages Mental Health and Learning Disabilities EHR.
- National dependencies affecting programmes including the Acute and Community EHR, WPRS, NHS App and Digital Maternity Phase 2, which may impact planned delivery timescales.
- Funding and resource constraints affecting programmes including Dental, Therapies and the Health Board-wide Scanning Outline Business Case.
- Specialist resource dependency within some clinical systems, including ePMA, where immediate resolution of issues can depend on limited specialist capacity.
- Uncertainty regarding future arrangements for elements of the Digital Eye Care programme, with current contract end dates approaching and no clear national plan for continuation.
- Risks associated with data quality, governance and national reporting requirements, following two unrelated data submission incidents and the need for strengthened controls and assurance.
- The continued requirement to balance delivery of major digital transformation alongside maintaining resilient, business-critical digital services and responding to increasing operational demand.

These risks are being actively managed through project and programme boards, the Digital Portfolio Delivery Group, Executive oversight, strengthened benefits and change management arrangements, contingency planning and enhanced data governance and assurance controls.

The risks identified within the DDaT portfolio align with the following Corporate Risks:

- **CRR REF: 25-04 – Modernising Digital Infrastructure to Enable Safe, Integrated Care**
- **CRR REF: 25-11 – ICT Failure and Cyber**

These Corporate Risks reflect the wider organisational risks associated with maintaining resilient digital infrastructure, enabling safe and integrated care, ensuring continuity of critical ICT services and managing cyber security threats.

The DDaT portfolio risks also align to the following Board Assurance Framework (BAF) risks:

- **BAF24-02: Not Delivering Strategic Development and Digital Transformation**

- **BAF24-08: Not Implementing Evidence Based Improvement and Innovation**

The risks are subject to ongoing monitoring and mitigation through established governance arrangements. Where risks are dependent on national programmes, funding decisions, specialist resources or external partners, these dependencies continue to require Executive and Board oversight.

Failure to effectively manage these risks may impact delivery timescales, service resilience, organisational priorities and the realisation of anticipated benefits from digital investment.

5. Recommendations

The Committee is asked to:

- **NOTE** the progress made and ongoing activity across the Digital, Data and Technology (DDaT) portfolio.
- **TAKE ASSURANCE** from the governance and mitigation arrangements in place to manage delivery of the DDaT portfolio and associated risks.

ASSESSMENT	
Link to Strategic Priorities	3. Improve Access, Outcomes and Experience
	• **Enhancing Patient Experience** Supporting more coordinated, joined-up care • **Improving Quality and Safety of Care** Enabling real-time access to patient information, reducing clinical risk associated with fragmented and paper-based systems **4.Create a Modern, People Centred Healthcare System** Delivering safer, more efficient and more personalised care through digital

Design Principles	Digital First • **Digital by Default** Moving away from paper-based processes to improve efficiency, accuracy, and accessibility
Corporate Risks and Board Assurance Framework	• **BAF24-02: Not Delivering Strategic Development and Digital Transformation** • **BAF24-08: Not Implementing Evidenced Based Improvement and Innovation**
Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable

IMPACT ASSESSMENTS		
Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): https://www.gov.wales/public-sector-equality-duty-htmlPublic Sector Equality Duty [HTML] | GOV.WALES	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	This report is administrative in nature and provided for information only. Assessments are undertaken at individual project level.
Equality Act 2010 - Socio-economic Duty *Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	This report is administrative in nature and provided for information only. Assessments are undertaken at individual project level.
Have you completed an Integrated Equality Impact Assessment WP8a? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	Naddo/No: NO
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is administrative in nature and provided for information only.

	Canlynaid/Outcome:	Assessments are undertaken at individual project level.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	This report is administrative in nature and provided for information only. Assessments are undertaken at individual project level.
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is administrative in nature and provided for information only. Assessments are undertaken at individual project level.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant *Have the principles of the Armed Forces Covenant been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is administrative in nature and provided for information only. Assessments are undertaken at individual project level.
Quality		
		This report is administrative in nature

Have you undertaken a Quality Impact Assessment Screening?NO		and provided for information only. Assessments are undertaken at individual project level.
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	
Environmental /Sustainability Impact (5Rs)	Yes - Reduce	
	If no, please include rationale:	This report is administrative in nature and provided for information only. Assessments are undertaken at individual project level.
Data Protection Impact Assessment *Have you undertaken a Data Protection Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	This report is administrative in nature and provided for information only. Assessments are undertaken at individual project level.
Counter Fraud Impact Assessment *Have you considered the counter fraud impacts*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	This report is administrative in nature and provided for information only. Assessments are undertaken at individual project level.
Legal	Yes (Include further detail below)	
	DPIA, Cyber and NIS requirements are considered at individual project or task level.	
Reputational	Yes (Include further detail below)	

	The modernisation of the establishment though digitisation, if not achieved, would have a reputational impact from a public, national and ministerial perspective.
Resource Impact *(People / Financial)*	Yes (Include further detail below)
	The level of resources required to implement and support digitisation is significant and are considered at individual project level. Changes to project prioritisation may result in financial impacts, requiring additional costs or reallocation of resources depending on the extent of the adjustments needed.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Planning, Population Health & Partnerships Committee

NORTH WALES APPROACH TO PREVENTION: REGIONAL WELLBEING, PREVENTION, ANCHOR FRAMEWORK AND MARMOT PLACE

Date of Meeting	03 September 2026
Publication Status	Open/ Public Not Applicable
Report Author name and title	- Dafydd Gwynne, Strategic Partnerships Manager, BCUHB Public Health Directorate - Natalie Anderson, Marmot Place Project Manager, Denbighshire County Council
Lead Executive Team Member name and title	Dr Jane Moore, Executive Director of Public Health

Report Purpose	For Approval

Executive Summary

The purpose of this report is to provide PPHP with an update on progress with developing a whole system approach to prevention and addressing health inequalities across North Wales, through the Regional Wellbeing, Prevention and Anchor Framework, and the Marmot Place work in Denbighshire. The report seeks approval of the recommendations.

Regional Wellbeing, Prevention and Anchor Framework

Building on the foundation provided by the Well North Wales programme, the Regional Wellbeing, Prevention and Anchor Framework has been co-produced by a range of partner organisations to support a whole system approach to improving life expectancy, healthy life expectancy, and reduce inequalities by addressing the wider determinants of health. Incorporating the Wellbeing of Future Generation Act's Wellbeing Goals and Ways of Working, and the Marmot Principles, the Framework's core components include a:

- Series of Prevention Missions and high-impact actions
- Regional Anchor Charter, optimising the role of Anchor Organisations
- Resources to strengthen system learning around wellbeing, prevention, and early intervention, including a repository of notable practice
- A commitment to working with our communities as equal partners

Work is progressing with partnerships and individual organisations in North Wales to utilise the Framework components, including adoption of the Anchor Charter.

Whilst the Framework represents a strategic resource for prevention and tackling inequalities across North Wales, the Denbighshire Marmot Place programme provides an opportunity to apply the Marmot principles in practice within a local place-based setting.

Marmot Place: Denbighshire

Welsh Government issued a public statement in June 2025 that Wales would become the world's first Marmot Nation by adopting the Marmot Eight Principles to tackle health inequalities. Bids were invited from Local Authority Areas in Wales to become Marmot Places, which entailed a national package of support from the Institute of Health Equity (IHE) over a period of two years from 1st April 2026. Denbighshire County Council's successful bid was confirmed later in 2025/26, along with Merthyr Tydfil and Neath Port Talbot.

The project is recognised as a two-year period to test and evaluate a place-based approach to addressing health equity by focussing resources on the Marmot Principles that matter most to Denbighshire. Initial priorities that have emerged and are being scoped in further detail with partners, including an opportunity to develop a Denbighshire Poverty Strategy, a renewed focus on nature and the environment, and an opportunity to take a place-based approach to health equity in Rhyl.

Conclusions

The case for shifting further to prevention and early intervention is stronger than ever. Healthy life expectancy in North Wales is reducing, and the gap between those who are most, and least deprived, is increasing.

Adoption of the Regional Wellbeing, Prevention and Anchor Framework, and the Marmot Place work in Denbighshire, will enable local and regional partners, including the Health Board, to respond to this opportunity. It will also support our response to the new Welsh Government's manifesto, including the following relevant areas:

- Review of health-based inequalities in Wales
- Development of a new Public Health Strategy and Framework for Wales
- Progressive shift of resources to measures that promote better health and well-being, including promoting healthy lifestyles, support for community arts, culture and sports, and tackling poor housing and health inequalities.
- Promotion of social prescribing and nature-based interventions to improve people's health and well-being.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome, Evidence and Data**
Broad range of system partners (partnerships and individual organisations)	September 2025-February 2026	- Co-production of the Prevention Missions and Anchor Charter - Capturing examples of notable practice
Regional System Engagement Event	19th March	- Approx 100 partners in attendance, including from WG - Endorsement of Prevention Missions and Anchor Charter, and commitment from PSB partners to utilise these tools to develop Wellbeing Plans. - System commitment to mobilise and sign-up to the Regional Anchor Charter - Agreement to evaluate the impact of the Anchor Charter within Agenda Cymru (North Wales Insight Partnership)
Regional Partnership Board	8th May	- Approval of recommendations, including the revised versions of the Anchor Charter and Missions, and engagement on maximising social value of our public estates.
Stakeholder Reference Group	1st June	- Updated version well received with commitment to delivery; positive feedback provided from Third Sector partners re: co-production approach taken in its development
SPSCG	24th June	- Recommendations accepted, including completing a baseline Anchor Charter assessment and responding to identified gaps and opportunities through the BCUHB planning process.

Acronyms / Glossary of Terms	
RPB	Regional Partnership Board
PSB	Public Service Board (of which there are three across North Wales)

IHE	Institute of Health Equity (supporting Marmot Places in Wales)
Anchor Organisation	Place-based organisations that have a significant impact on the wellbeing of their local population, often through ways that are in addition to their core business, such as their role as employers, procurers of goods and services, owners of buildings and land, their impact on the environment, and how they engage and involve their communities.

REGIONAL WELLBEING, PREVENTION AND ANCHOR FRAMEWORK & MARMOT PLACE

1. Background

1.1 Following the Well North Wales Task and Finish Scoping Study that was presented to the RPB in July 2025, it was agreed that the following outputs be developed to facilitate a whole system approach to prevention:

- A Regional Prevention Framework that would incorporate a focus on the missions (relating to the wider determinants of health), a charter to optimise the role of Anchor Organisations in North Wales, and a commitment to working with our communities as equal partners
- A repository of notable practice to capture and share the learning from existing examples of delivery against prevention, early intervention, and tackling inequalities in North Wales

It was envisaged that the Framework should be developed as a resource for the whole system in North Wales, and members of the BCUHB Public Health Directorate were invited to support the RPB to progress this work.

1.2 A multiagency steering group representing RPB members was formed to scope of development of the Framework between September and November 2025. The group agreed that the Framework would:

- Support a whole system approach to improving life expectancy and healthy life expectancy for people in North Wales, and to reduce the gap between the most and least deprived in our communities.
- Be referred to as the 'Regional Wellbeing, Prevention and Anchor Framework' to recognise the key focus on wellbeing
- Adopt the Wellbeing Goals and Ways of Working within the Wellbeing of Future Generations Act and align with the Marmot Principles.

1.3 A comprehensive programme of engagement was undertaken from November 2025 to early March 2026 with key partners across the region to co-produce the content of the Framework, including high impact actions for each Mission. The draft Framework components were consolidated and shared at a regional engagement event on the 19th March 2026.

2. System Engagement Event

2.1 A successful and high-profile event was held on 19th March in Conwy Business Centre, led by an introduction by the Chair of the Health Board, followed by a panel discussion involving CMO for Wales, Deputy Commissioner for Future Generations Act, CEOs of the Health Board and Denbighshire County Council, Chief Officer of Medrwn Môn, alongside the Deputy Director for Futures and Integration from Welsh Government. With approx. 100 people attending, and a waiting list of over 20 colleagues, there was great regional interest and enthusiasm for the work, and broad

support for the Prevention Missions and Anchor Charter. Further details about the event are available on request.

2.2 Progress Secured Following the Event

2.2.1 Following responding to feedback from the event, the Regional Partnership Board (RPB) approved revised versions of the Missions and Anchor Charter, including stronger integration between the two components. Supporting resources, case studies and implementation materials are being made available through dedicated RPB webpages.

2.2.2 The Strategic Planning and Service Change Group (SPSCG) endorsed Health Board adoption of the Regional Anchor Charter and Missions. A baseline assessment of BCUHB's existing Anchor activity is being undertaken through IMTP delivery tracking and wider identification of Anchor practice across the organisation, supported by the Director of Partnerships, Communications and Engagement.

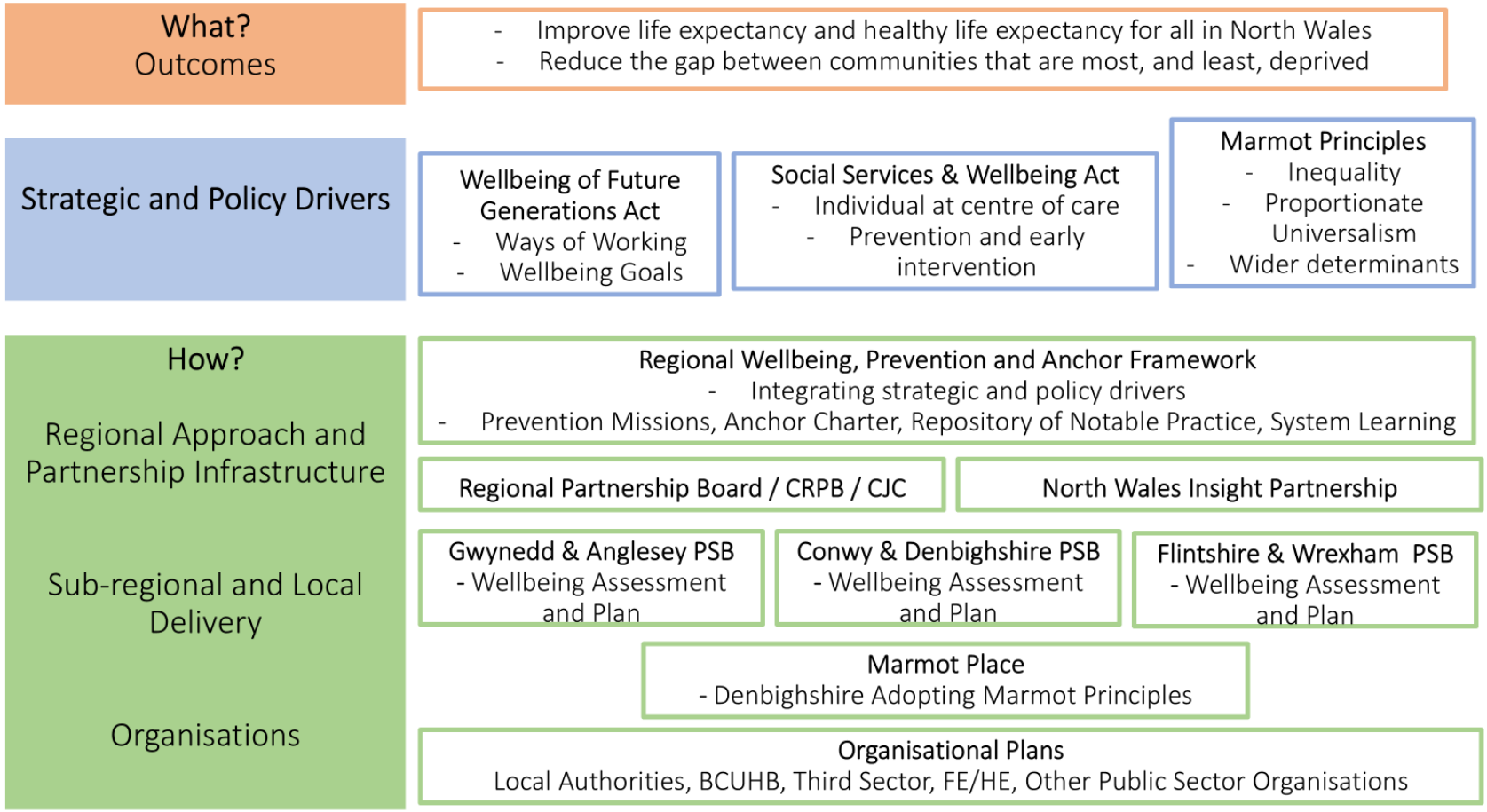
2.2.3 An Anchor Charter self-assessment tool has been developed and piloted. Engagement is now underway with Local Authorities and Third Sector partners to support self-assessment and encourage formal commitment to the Charter.

2.2.4 The Public Service Boards have identified opportunities to use the Prevention Missions and Anchor Charter to inform the development of future Well-being Plans. Discussions are underway regarding a regional approach, potentially through Agenda Cymru, to coordinate implementation and develop a shared set of mission indicators. A similar opportunity is being scoped to inform the next iteration of the RPB's 5-Year Regional Plan, which will respond to the key findings from the Regional Population Needs Assessment.

2.2.5 Planning is underway for a regional system learning event with the RPB to maintain momentum, share emerging practice, build consensus on indicators, and support wider adoption and formal sign-up to the Anchor Charter.

2.2.6 Figure 1 below has been drafted to provide clarity on how the key policy and strategic drivers around prevention align in North Wales. It is important to note that the list of regional partnership forums is not exhaustive. The next phase of delivering the Framework will involve collaborating with individual organisations and regional partnerships to implement and embed the Framework at both organisational and system levels.

Figure 1: How strategic and structural drivers align in North Wales to deliver the prevention agenda



2.3 Alignment of the Regional Wellbeing, Prevention and Anchor Framework and the Marmot Place work in Denbighshire

Careful consideration was given to ensuring that the Marmot Principles were incorporated into the development of the Regional Wellbeing, Prevention and Anchor Framework, including mapping the Principles against the Prevention Missions and Anchor Charter. Implementing the Framework therefore represents a way of delivering on the Marmot Principles in North Wales.

Another approach to delivering on the Marmot Principles has been taken in Denbighshire, which is described in the following section. It is important to acknowledge the benefits of this focussed place-based approach in terms of enabling both local and regional learning opportunities about what works to address health equity, thereby complementing, and adding value to, the approach taken through the Regional Wellbeing, Prevention and Anchor Framework.

3. Marmot Place – Denbighshire

3.1 Background

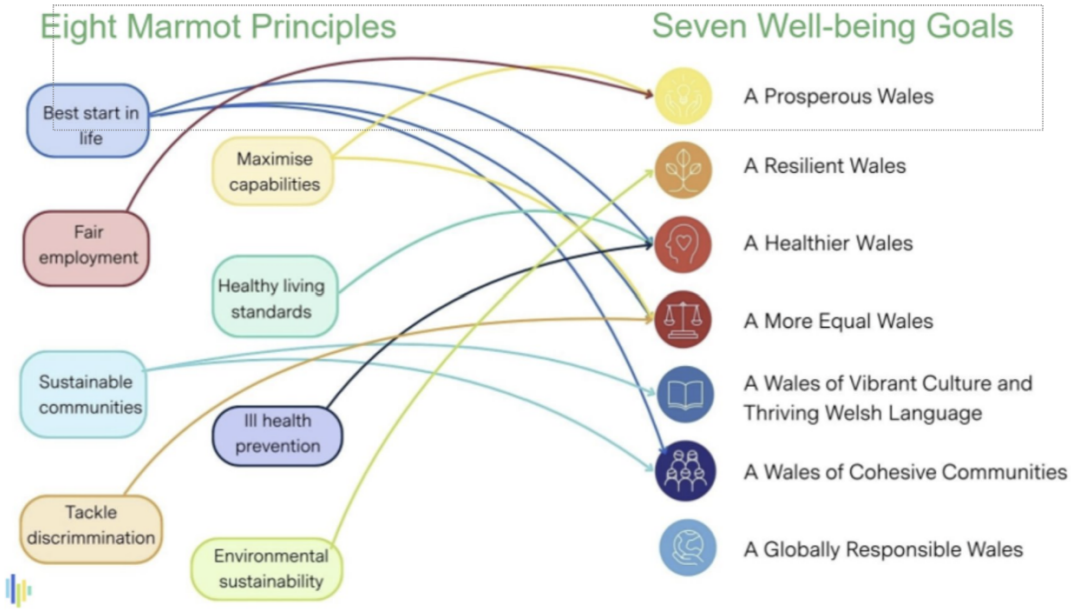
Welsh Government issued a public statement in June 2025 that Wales would become the world's first Marmot Nation[1] by adopting the Marmot Eight Principles to tackle health inequalities[2]. Figure 2 below outlines how the Marmot Principles (left hand side) align with the Wellbeing of Future Generations Act's Wellbeing Goals.

As an initial step to secure early progress and learning, Welsh Government invited bids from Local Authority Areas in Wales to become Marmot Places, which entailed a national package of support from the Institute of Health Equity (IHE) over a period of two years from 1st April 2026. Support also included funding to develop and implement local responses in line with the Marmot principles, and an expectation to share good practice regionally and across Wales.

Denbighshire County Council's successful bid, developed by reviewing service plans, corporate reports, relevant performance indicators and known upcoming activity, was confirmed later in 2025/26, along with Merthyr Tydfil and Neath Port Talbot.

[1] Wales - A Marmot Nation - IHE
[2] Marmot Places - IHE

Figure 2: Alignment between the Marmot Principles and the Wellbeing Goals



3.2 Approach

The project is recognised as a two-year period to test and evaluate a place-based approach to addressing health equity by focussing resources on the Marmot Principles that matter most to Denbighshire.

Two cross-council and multi-agency workshops brought together Denbighshire County Council (DCC), Denbighshire Leisure Ltd (DLL), Denbighshire Voluntary Services Council (DVSC), Betsi Cadwaladr University Health Board (BCUHB) and the IHE. The first workshop established a shared understanding of Denbighshire and ambitions for participation; the second developed more specific programme aims and a route for the next six months. The project plan for this initial phase has been reviewed through senior leadership and DCC Cabinet briefing routes and was shared at the Welsh Government Delivery Board on 30th April 2026. A Denbighshire Marmot Project Manager was appointed in July 2026 to provide additional capacity to support delivery.

Initial priorities that have emerged include an opportunity to develop a Poverty Strategy, a renewed focus on nature and the environment, and an opportunity to take a place-based approach to health equity in Rhyl, building on a broad range of existing activity in the town. A Marmot Place Steering Group meeting in October will

provide further opportunities to scope and agree these priorities with key stakeholders.

3.3 Next steps

Following the Steering Group meeting in October, a plan will be developed that will outline key deliverables, actions and outputs over the remaining project timescale, including a theory of change. Significant interdependencies with this work include:

- Utilising the findings from the Marmot project to inform the next iteration of Denbighshire County Council's Corporate Plan, due to be finalised in 2028
- Embedding Marmot Principles into the business culture across the Local Authority, and with partner organisations
- Aligning the work to capture the impact of, and learning from, the Marmot Project with other regional activity, including the Wellbeing, Prevention and Anchor Framework. This could include utilising the Prevention Missions and Anchor Charter to support delivery of Marmot priorities, sharing notable practice via the RPB's repository and regional learning events, collaborating on developing KPIs and other impact metrics, and informing PSB Wellbeing Plans and the RPB's Plan.

4. Conclusions and Recommendations

The case for shifting further to prevention and early intervention is stronger than ever. Healthy life expectancy in North Wales is reducing, and the gap between those who are most, and least deprived, is increasing.

We acknowledge the strong national strategic and policy context that can help us achieve this new direction. This includes the Wellbeing of Future Generations Act and the Marmot Principles, which were incorporated into the co-produced Regional Wellbeing, Prevention and Anchor Framework. It is the same context that underpins Denbighshire's ambition to secure Marmot Place status, which represents an important opportunity to test and evaluate a place-based approach to applying the Marmot principles in practice, and share learning regionally.

Adoption of the Regional Wellbeing, Prevention and Anchor Framework, and the Marmot Place work in Denbighshire, will enable the Health Board and region to respond to, and deliver against, key population health and prevention priorities as outlined in the new Welsh Government's manifesto. Relevant areas include:

- Review of health-based inequalities in Wales
- Development of a new Public Health Strategy and Framework for Wales
- Progressive shift of resources to measures that promote better health and well-being, including promoting healthy lifestyles, support for community arts, culture and sports, and tackling poor housing and health inequalities.

- Promotion of social prescribing and nature-based interventions to improve people's health and well-being.

The recommendations for the PPHP are:

1. To **SUPPORT** the Regional Partnership Board, Public Service Boards, and individual member organisations to utilise the Prevention Missions and Anchor Charter as key tools in informing the development of associated plans, building on the findings from the Regional Needs Assessment / Wellbeing Assessments.
2. To actively **ENCOURAGE** organisations and services to share examples of notable practice in relation to prevention and early intervention, aligned to the Prevention Missions and Anchor Charter, to be shared on the RPB website and explored in regional learning events: Wellbeing Case Study – Fill in form.
3. To continue to **SUPPORT**, and secure alignment with, the Marmot Place work in Denbighshire by contributing to the Steering Group, building on existing good practice to address inequalities, and sharing learning.
4. To **NOTE** and **ENDORSE**:
   - the work undertaken with partners to co-develop the Prevention Missions and Anchor Charter.
   - the key findings and themes emerging from the System Engagement Event on the 19th of March, including the commitment to enable and strengthen a culture of continuous learning in relation to wellbeing, prevention and early intervention.
   - the approval of the revised Prevention Mission Actions (Appendix 1) and Anchor Charter (Appendix 2) by the RPB on the 8th May, and the work to secure a visible presence on the RPB webpages along with the repository of notable practice.
   - the approval from the SPSGC on the 24th June to:
     - collaborate with the North Wales Insight Partnership as a vehicle to promote and sustain regional commitment to the Anchor Charter and the Missions, and to refine the indicators
     - adopt the Prevention Missions and Regional Anchor Charter in BCUHB through completing a baseline assessment and respond to identified gaps and opportunities through the 2027/2028 IMTP planning process, Community by Design, Clinical Services Plan, and the 10-year Strategic Plan
     - participate in a Regional Learning and Signing Event to mobilise the Anchor Charter, drawing learning from the successful process used with the Healthy Travel Charter.

ASSESSMENT	
Link to Strategic Priorities	4.Create a Modern, People Centred Healthcare System
	If more than one applies, please list below: - Building an effective organisation - Improving quality, outcomes and experience - Establishing an effective environment for learning
Design Principles	Simplify, Standardise, and Adopt Best Practices If more than one applies, please list below: - Equity and accessibility - Simplify, standardise and adopt best practice - Consistency with organisational values
Corporate Risks and Board Assurance Framework	Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR) CRR 25-03 Risk Title: Population Needs There is a risk that the organisation will fail to meet the health needs of the population and will not enable good health and wellbeing of the population.
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	If more than one applies, please list below: - All apply.

IMPACT ASSESSMENTS		
Equality *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Yes: ☒	No: ☐
	Outcome:	Initial assessment undertaken on the current draft of the Missions and Anchor Charter. The findings will inform the approach that BCUHB will take to implement the Anchor Charter & Missions. The assessment will also be shared with partner organisations to support their approach to equality.
	If no, please include rationale:	
Socio-Economic Impact Assessment	Yes: ☒	No: ☐
	Outcome:	Initial assessment undertaken on the current draft of the Anchor Charter and the Missions. The

Have you undertaken a Socio-Economic Impact Assessment		findings will inform the approach that BCUHB will take to implement the Anchor Charter. The assessment will also be shared with partner organisations to support their approach to optimising socio-economic impacts.
	If no, please include rationale:	
Quality *Have you undertaken a Quality Impact Assessment Screening?*	**Enablers of Quality** Whole-systems Perspective	**Domains of Quality** All Apply
	If more than one applies, please list below: - Leadership - Learning, Improvement and Research - Data to knowledge	If more than one applies, please list below:
	QIA undertaken. Positive impacts identified.	
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	

Environmental /Sustainability Impact (5Rs)	If more than one applies, please list below:	
	No - Not Applicable	
	If more than one applies, please list:	
Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: ☒	No: ☐
	Outcome:	Initial assessment undertaken as part of the EqIA. The findings will inform the approach that BCUHB will take to implement the Anchor Charter. The assessment will also be shared with partner organisations.

	If no, please include rationale:	
Data Protection Impact Assessment *Have you undertaken a Data Protection Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	Not required for the current programme of work
Counter Fraud Impact Assessment *Have you considered the counter fraud impacts*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	Not required for the current programme of work
Legal	Yes (Include further detail below)	
	Expectation that Health Board can demonstrate how it responds to the Ways of Working and Wellbeing Goals outlined in the Wellbeing of Future Generations (Wales) Act.	
Reputational	Yes (Include further detail below)	
	Expectation that the Health Board operates as a trusted partner and Anchor Organisation e.g. our role in supporting wellbeing, prevention and reducing inequalities as members of the RPB and PSBs, and our role in involving communities.	
Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	Expectation that the Health Board will adopt and implement the Anchor Charter and the Missions, which may involve reallocating resources to enable delivery.	

Planning, Population Health & Partnerships Committee

NORTH DENBIGHSHIRE SUSTAINABILITY PROGRAMME: HEALTHY PRESTATYN IACH BOUNDARY CHANGE

Date of Meeting	03 September 2026
Publication Status	Open/ Public
	Not Applicable
Report Author(s) name and title	Alison Kemp - Associate Director, Primary Care & Community Services Central IHC Robyn Watson -Primary Care Programme Manager Central IHC
Lead Executive Team Member name and title	Tehmeena Ajmal - Chief Operating Officer

Report Purpose	For Assurance

Executive Summary

This paper outlines the rationale and process leading to the approval of a boundary change for the Healthy Prestatyn Iach Managed Practice, and agreement to disperse patients living outside its revised boundary to neighbouring GP Practices.

Healthy Prestatyn Iach (HPI), which operates in the North Denbighshire Cluster, was established in 2016 following the resignation of three independent GP practices to support a registered population of approximately 23,000 patients. Since that time, the practice list size has reduced by 5,700 patients (approximately 25%) to around 17,600 patients and is continuing to fall. Maintaining services over such a wide geographical area and five sites, with a falling patient list has become increasingly challenging.

All of the other GP Practices in the Cluster area have expressed their desire to improve their own Practices' long-term sustainability, through growing their list size. Discussions held by the North Denbighshire GP Collaborative, over a two-year period, culminated in a proposal to improve the sustainability of Practices across the Cluster. This is achieved through a boundary change and dispersal of approximately 4,600 patients living outside HPI's revised boundary to neighbouring GMS Practices. Practices have stated they could accept up to 7,490 patients, and

have outlined the actions they are planning, for example increasing their staffing, demonstrating sufficient potential capacity to support a dispersal.

A comprehensive engagement exercise, informed by the 'Welsh Government How to Make Changes to NHS Services' guidance, was agreed with Llais. The engagement took place over an eight-week period between 4th June and 31st July 2026. This included written correspondence to the affected households and to elected officials and officers in Local Authorities. Stakeholders were able to ask questions and to feed-back via phone and email and to complete an online questionnaire. Five drop-in sessions were also held in community locations. The final proposal has incorporated changes arising from the engagement, for example the inclusion of the village of Gwaenysgor in the boundary (previously was outside the proposed new boundary). The Health Board also confirmed that the branch surgery in Rhuddlan will continue to operate. A report of the engagement undertaken, feedback, themes and actions identified as a result of the engagement has been produced.

Advice has been sought from the NHS Wales Shared Services Partnership on our approach to the allocation of patients, ensuring that all contractual and procurement requirements are followed. Receiving practices will be required to confirm the number of patients they can accommodate and any additional workforce they will be recruiting to support the additional demand. A structured and phased patient dispersal approach will be used to ensure patients continue to have access to primary care services throughout the process. Patients will only be allocated to Practices that wish to grow and have robust plans in place. Patient dispersals would not commence until January 2027 and would take place over a number of weeks.

Work to review HPI's operating model has commenced to ensure services and workforce arrangements are aligned to the revised patient population. Any workforce implications arising from this review will be managed through the Health Board's Organisational Change Policy (OCP). An assessment of the financial impact of the transfer of patients to GMS Practices has also been undertaken and plans to reprofile resources within the GMS budget have been identified to support these proposals.

This is a complex boundary change, with the dispersal of 4,600 patients. A formal Project structure has been established, led by the Associate Director for Primary Care & Community Services, Central IHC. A full time Project Manager has been employed for 12 months to support the work. Project documentation has been developed, including a Risk Register, Equality, Quality and Socio-Economic Impact Assessments and quality indicators. These assessments will be regularly reviewed and updated, informing our work.

The Health Board's Primary Care Panel met on 25th August to consider the application. The meeting was chaired by the Deputy Executive Medical Director

(Panel Vice Chair) and was quorate. Following discussion, the Panel approved the application, in line with its authority to agree contractual changes.

Given the nature of the proposals and the need to engage with stakeholders on the potential impact, the Strategic Planning and Service Change Group ratified the Primary Care Panel's decision in its meeting on 26th August 2026.

Engagement (internal/external) undertaken to date (including receipt/ consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome, Evidence and Data**
North Denbighshire General Practice Collaborative	Ongoing from 2024	All six practices in the Cluster are supportive of the proposal. Practices have expressed appetite to grow their own list size to support long term sustainability and partnership succession planning
Llais	2025 onwards	Discussions with Llais regarding the proposals and approach to engagement. Discussions have continued and Llais officers have supported the current engagement process. Chief Officer attended engagement event in Trelawnyd on 9th July 2026.
Paper to Operational Leadership Team	28/10/25	Supported rationale and need to engage on proposals. Requested that engagement take place in late Spring.
Conwy & Denbighshire Wellbeing Network	04/06/26	Briefed approx. 40 attendees from local statutory and third sector organisations on the proposals and engagement plans and invited feedback
Email to elected officials and senior officers in DCC and FCC.	10/06/26	Informed elected officials (MS, MPs, Leader of DCC and FCC Councils) and senior officers of the proposals, and shared a copy of the letter being sent to affected patients and details of the engagement process.
Email to affected GP Practices outside North Denbighshire Cluster	10/06/26	Email to six GP Practices outside the North Denbighshire Practice whose boundaries overlap HPI's current boundary, informing them of the proposals and seeking feedback.
Ageing Well in Denbighshire Forum	16/06/26	Attended meeting to brief attendees (statutory and third sector organisations), and to support dissemination of information

Letter outlining proposals	04/06/26-31/07/26	Letters sent to 2,535 households identified as falling outside of the proposed boundary, detailing the proposed changes, the potential impact, and details on how to feedback questions, concerns and views.
Feedback received via Microsoft forms	04/06/26-31/07/26	107 responses have been received to date. The most common feedback themes are around continuity of care, with patients noting their relationships with the team at HPI; concerns about those with complex care needs changing practices; access and transport to alternative practices; capacity of receiving practices; future of Rhuddlan Surgery.
Feedback received via email	04/06/26-31/07/26	37 emails have been received to date. The main issue raised (n=14) related to patients requesting additional information such as the proposed boundary map or asking if their postcode would be affected. 11 patients noted that they wished to remain with HPI and therefore objected to the proposal. Other themes included continuity of care, access and transport, and concerns around the impact of moving to a different practice.
Feedback received via telephone		32 calls have been received to date. The largest category of calls related to patients requesting additional information (n=8). Five patients noted that they wished to remain with HPI and therefore objected to the proposal. Other themes included access and transport, complex health needs, and continuity of care.
Patient engagement event at Rhyl Library	23/06/26	Led by BCU team, representatives from Clarence Medical Centre and Lakeside GP Practices. Around 10 members of the public and a town councillor attended to discuss the proposal and provide feedback. Patients were supportive of sustainable GP services but sought reassurance around continuity of care, communication and access to local services.

Attendance at Workforce Planning Forum	26/06/26	Briefed Trade Union and Workforce team on the boundary change proposals and possible impact on staffing configuration in HPI, which would be managed in line with the Health Board's Organisation Change Policy (OCP). EqIA requested prior to an OCP commencing.
Patient engagement event at Rhuddlan surgery (HPI branch)	26/06/26	Led by BCU team, Senior GP Partner and Practice Manager from Madryn House Surgery attended. About 22 members of the public attended, including patients, the mayor of Rhuddlan, County and Town councillors. Attendees asked about maintaining access to the Rhuddlan branch site and continuity of care.
Meeting with Becky Gittins, MP	02/07/26	Meeting to provide background to the proposals, discuss issues raised by constituents and discuss engagement activity.
Patient engagement event at Trelogan Community Centre	02/07/26	Led by BCU team, Senior GP Partner, Practice Manager and Deputy Practice Manager from Park House Surgery attended. Around 30 members of the public attended, including patients, town councillors and local MP. Residents expressed significant concern about transport (limited public transport to Prestatyn or Holywell), continuity of care and maintaining relationships with trusted healthcare professionals. Attendees welcomed the opportunity to ask questions directly and appreciated the reassurance that feedback would help shape the final proposals. Patients were also reassured that all affected patients would be allocated to a new GP Practice.
Patient engagement event at Trelawnyd Memorial Hall	09/07/26	Led by BCU team, with approximately 20 members of the public attending, including patients and town councillors. Those present asked about the impact of the proposals on continuity of care if they were transferred to a different GP practice. There were also questions about what services would continue to be available at HPI if the proposals were approved.

Text message to 200 parents of children aged under 7 years registered with HPI	10/07/26	Text message sent with a link for responses due to low response rate from this group to previous methods. 14 responses received to date.
Patient engagement event at Gwespyr Community Centre	23/07/26	Led by BCU team and Senior GP lead at Park House Surgery. The event had approximately 25 members of the public attending, including patients and town councillors. Feedback focused on the potential impact of increased travel for patients living in Trelogan, Trelawnyd and Llanasa if they were required to access GP services in Holywell. Attendees highlighted that Prestatyn is their natural town for accessing general practice, pharmacy and other local services. Concerns were also raised regarding continuity of care and the impact of transferring to a different GP practice.
Strategic Planning & Service Change Group	27/07/26	Paper presented and approach endorsed by Group.
Health Board's Annual General Meeting in Rhyl	29/07/26	The BCU team hosted an information stand at the AGM and spoke with approximately 10 attendees about the proposal. Whilst no specific feedback themes were identified, attendees were provided with information about the proposed boundary changes and had the opportunity to ask questions and discuss the proposal with members of the team.
Health Board's Board Meeting	30/07/26	Chief Operating Officer Tehmeena Ajmal presented an update on the proposal. Board members heard that around 5,000 patients could transfer to neighbouring GP practices, with all patients automatically allocated to a new practice. The Board agreed the proposed next steps to finalise the engagement process and develop the recommendations for approval.
Primary Care Panel	25/08/26	Application, for boundary change and dispersal of patients living outside the new

		boundary, in a phased approach in Quarter 4, was approved.
Strategic Planning and Service Change Group	26/08/26	Panel decision was ratified. Action to brief Executive Team members.

Acronyms / Glossary of Terms	
HPI	Healthy Prestatyn Iach / Healthy Rhuddlan Iach
North Denbighshire Cluster	Designated geographical area covering the north of the county of Denbighshire, with established arrangements for collaborative working across health, social care and third sector organisations, including independent primary care contractors.
Practice Boundary / Area	Designated area, marked on a map, which forms part of each General Medical Services contract. Patients living within a practice area are entitled to register with the GP Practice (unless they have been excluded following a formal process).
EqIA	Equality Impact Assessment
OCP	Organisational Change Policy
GP	General Practitioner
NWSSP	NHS Wales Shared Services Partnership
GPOOH	GP Out of Hours Service
GP2GP	GP2GP is a service that allows patients' electronic health records to be transferred securely and quickly between their old and new practices when they change GPs.
Primary Care Panel	Health Board Group with responsibility to make decisions on Primary Care Contractual issues, including applications from Contractors to amend service provision, for example boundary changes and list closures.
Strategic Planning and Service Change Group	Formal Group, chaired by Chief Executive Officer, overseeing strategic planning and service change programmes within the Health Board.

NORTH DENBIGHSHIRE SUSTAINABILITY PROGRAMME: HEALTHY PRESTATYN IACH BOUNDARY CHANGE

1. SITUATION

1.1 On the 30th July Chief Operating Officer Tehmeena Ajmal presented an update on proposals to revise the Healthy Prestatyn Iach practice boundary to support the long-term sustainability of GP services across North Denbighshire to the Board. The Board agreed the proposed next steps to finalise the engagement process and develop the recommendations for approval.

1.2 Informed by the engagement feedback, the final application was submitted to the Health Board's Primary Care Panel, requesting approval to reduce HPI's boundary to consolidate its services over a smaller area, from fewer sites. The application also sought approval to disperse the patients living outside its new boundary to neighbouring practices. It is expected that around 4,600 patients will be reallocated to a neighbouring practice.

1.3 The request to the panel was for the boundary change to be effective from the 1st January 2027. This provides time to undertake the preparatory work required, including patient allocation arrangements, workforce planning and communication with patients, practices and staff.

1.4 The following approval route was agreed;

- 30th July 2026: Proposals and update on engagement presented to the Health Board for information and discussion.
- 25th August 2026: Application presented to the Primary Care Panel for consideration and decision(meeting initially scheduled for 18/08/26).
- 26th August 2026: Primary Care Panel decision to be presented to the Strategic Planning and Service Change Group for ratification.
- 3rd September 2026: Outcome reported to the People, Planning and Performance Committee.

1.5 The proposal was considered by the Primary Care Panel on the 25th August 2026, where the application was approved.

1.6 The Strategic Planning and Service Change Group ratified this decision in its meeting on 26th August 2026.

2. BACKGROUND

2.1 Healthy Prestatyn Iach (HPI) was established in 2016 following the resignation of three independent GP practices and was designed to support a registered population of approximately 23,000 patients. Since that time, the registered population has reduced by almost 25% to approximately 17,600 patients. Despite this reduction, the practice has continued to operate across five sites, and its contractual boundary has remained unchanged.

2.2 Over the last two years, discussions have taken place through the North Denbighshire GP Collaborative, with individual practices and the HPI management team, regarding the long-term sustainability of general practice services across the Cluster. These discussions identified an opportunity to review HPI's boundary to support a more sustainable distribution of patients across practices within North Denbighshire.

2.3 Practices within the Cluster advised that an increase in patient list size would support workforce development, partnership succession planning and the long-term sustainability of services. As part of this work, Madryn House Surgery and Park House Surgery have already increased their practice boundaries to support future growth.

2.4 Following these discussions, a proposal was developed to reduce HPI's boundary and reallocation approximately 4,600 patients to neighbouring practices.

2.5 In line with Welsh Government guidance "Making Changes to NHS Services", the proposal was assessed as a Moderate Service Change. An eight-week engagement programme was undertaken between 4th June 2026 and 31st July 2026, involving patients, stakeholders, elected members, neighbouring practices and Llais.

2.6 Feedback was received through multiple channels, including engagement events, telephone, email, written correspondence and an online questionnaire. Key themes identified included continuity of care, access and travel arrangements, complex healthcare needs, patient choice, vulnerable patients and the capacity of receiving practices. The findings informed the final application for the change to the practice boundary and dispersal of patients.

2.7 The application was presented to the Health Board's Primary Care Panel on 25th August. The application was supported by the following documents:

- HPI Contract Variation – Boundary Amendment Application
- Application for Boundary Change and Removal of Patients Outside Practice Boundary – Healthy Prestatyn Iach

- Integrated Equality Assessment – North Denbighshire Sustainability Proposal
- North Denbighshire GP Collaborative and Holywell Practice Views
- Llais Service Change Protocol
- Risk Matrix
- Healthy Prestatyn Iach Proposed Boundary Map
- Patient engagement report
- HPI Boundary Change Risk Register

2.8 The Panel was asked to agree:

- The change (reduction) in the HPI Boundary, from 1st January 2027
- The dispersal of patients living outside the boundary to neighbouring Practices
- The dispersal to be phased from 1st January to 31st March
- Madryn House Surgery to accept up to 128 HPI registered patients living in Bodelwyddan, (outside their boundary)
- Park House Surgery to accept up to 200 HPI registered patients living in Trelawnyd, Trelogan and Llanasa (outside their boundary)

2.9 The Primary Care Panel approved the application.

2.10 The Primary Care Panel's decision was ratified by the Strategic Planning and Service Change Group at its meeting on 26th August 2026.

3. SPECIFIC MATTERS FOR CONSIDERATION

3.1 Engagement with patients and stakeholders was undertaken across an eight-week period. The engagement report identified themes including continuity of care, support for patients with complex needs, travel and transport, capacity within receiving practices, access to services within the town of Rhuddlan, arrangements for end-of-life patients and those on 62-day cancer pathways.

3.2 The final proposal submitted to the Primary Care Panel for consideration included mitigation for concerns raised during the engagement period. To support continuity of care for patients with complex needs, a risk based patient allocation and transition process will be developed. Patients will be categorised according to the level of support required during transfer, ensuring those with the most complex needs receive a more supported transition and clinical oversight.

3.2.1 Patients receiving palliative or end-of-life care will remain registered with HPI regardless of where they reside.

3.2.2 Clinical exemption criteria will also be developed for patients awaiting diagnosis, investigation or treatment planning. The current proposal is that these patients will remain registered with HPI until their diagnosis and treatment pathway have been agreed or an appropriate point for transfer has been identified.

3.3 This approach aims to ensure patients with the greatest clinical need receive a more detailed and supported transition whilst supporting continuity of care and minimising disruption for patients.

3.4 Initial review of the affected patients demonstrated that the vast majority of patients would transfer to a practice that is as close, or closer, to their home address than HPI premises. Exceptions, explored further through our engagement sessions, are patients residing in and around Llanasa, Trelawnyd, Trelogan and Bodelwyddan (n=340).

3.4.1 For Llanasa, Trelawnyd and Trelogan residents, feedback highlighted concerns regarding increased travel times, additional travel costs and reduced public transport links. Many respondents advised that Prestatyn is their nearest community for accessing healthcare, pharmacy services and shopping, they advised that it feels more accessible than travelling to Holywell. Patients living in these areas will be able to register with Park House Surgery, retaining access to services in Prestatyn for these patients.

3.4.2 Residents living in Bodelwyddan typically access services from HPI's Rhuddlan branch site. It is proposed that the practice receiving the Rhuddlan patient population and branch site will also register HPI patients residing in Bodelwyddan, even if they fall outside of the practice boundary.

3.5 The original proposed boundary did not include the village of Gwaenysgor, which has 95 registered HPI patients. There was significant feedback and attendance at engagement sessions from this population, many of whom were elderly and all expressed concerns about having to change practice. The proposed boundary in the final application now incorporates Gwaenysgor, and residents of the village would not be affected by the boundary change.

3.6 With these mitigations in place, no patient should have to travel any further than they do now to access in person GP services. Affected households will also still be served by more than one GP Practice.

3.7 Advice has been sought from the NHS Wales Shared Services Partnership (NWSSP) on our approach to the allocation of patients, ensuring that all contractual and procurement requirements are followed. Receiving practices will be required to confirm the number of patients they can accommodate

and any additional workforce they will be recruiting to support the additional demand. A structured and phased patient dispersal approach will be used to ensure patients continue to have access to primary care services throughout the process. Patients will only be allocated to Practices that wish to grow and have robust plans in place. Patient dispersals would not commence until January 2027 and would take place over a number of weeks.

3.8 The Panel was asked to approve a boundary change to come into effect from 1st January 2027. This implementation date recognises the programme of work required prior to patient transfer, including governance approvals, contractual and procurement considerations, patient allocation processes, and communication with patients. After the Panel's decision, new patients wishing to register with HPI who live outside a revised boundary will continue to be eligible to register with HPI until 31st December 2026 but will be informed of the changes which would come into effect from 1st January 2027, where they would be allocated to a new Practice.

3.9 Work has commenced with the team in HPI to review and revise the Practice's staffing model. This is being supported by professional leads and trade union colleagues. Any proposed changes will be subject to consultation with staff, in line with the Health Board's Organisational Change Policy.

4. KEY RISKS / MATTERS FOR ESCALATION

4.1 The implementation of the boundary change is being led by the Associate Director for Primary Care & Community Services and supported by a full-time Project Manager. Formal project governance arrangements are in place, including a project risk and issues log. Risks are being actively monitored and managed and will be reported through the relevant governance structures.

4.2 The key risks have been categorised under three headings; Organisational Change Policy (OCP) Capacity, Practice Capacity, Patient Dispersal Arrangements

4.3 <u>Organisational Change Policy (OCP) Capacity</u>
Implementation of the agreed boundary changes will result in workforce implications for HPI. There is a risk that limited People Services capacity could delay implementation of any required workforce changes through the OCP process. Early discussions with People Services are being undertaken to understand capacity requirements and timescales. Opportunities to minimise the number of staff directly affected will be explored throughout the process.

4.4 Practice Capacity

There is a risk that receiving practices may not have sufficient clinical, administrative or estate capacity to safely accommodate the number of patients transferring. However, all receiving practices have requested additional patients, and the total number exceeds the number of patients that will need to be allocated to new Practices. Each practice has confirmed they are developing plans to manage the associated increase in demand, including workforce. Patient dispersal will be undertaken on a phased basis to support safe implementation. Capacity, access and quality indicators will be monitored through established performance and contract management arrangements.

4.5 Patient Dispersal Arrangements

Disruption to patient care during dispersal carries risks relating to continuity of care, delays in the provision of timely care, and delays in diagnosis or treatment. A structured handover process will be implemented, supported by an agreed traffic light clinical review process, to ensure that the level of handover is proportionate to each patient's clinical needs. NWSSP will support the transfer of patients in line with established protocols, and patients will only be transferred once the receiving capacity has been confirmed to ensure a safe transition of care.

4.6 Governance arrangements are in place to monitor, manage and escalate risks associated with implementation. Risks are maintained within the project risk register and reported through the Central Integrated Health Community governance structure and the monthly Welsh Government service change submission.

5. RECOMMENDATIONS

5.1 The Planning, Population Health & Partnerships Committee is asked to:

- **NOTE** the decision of the Primary Care Panel and ratification by the Strategic Planning and Service Change Group to approve the application to change the HPI Practice boundary and partial list dispersal.

ASSESSMENT		
Link to Strategic Priorities	3. Improve Access, Outcomes and Experience	
Design Principles	Simplify, Standardise, and Adopt Best Practices	
Corporate Risks and Board Assurance Framework	Approximately 90% of patient contacts take place in Primary Care. Stable primary care provision is essential to enable timely access to care for our population. These proposals seek to improve the sustainability of GP Services within the Cluster, ensuring provision in the long term.	
Wellbeing of Future Generations Act – Wellbeing Goals	A Resilient Wales	
IMPACT ASSESSMENTS		
Equality *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Yes: ☒	No: ☐
	Outcome:	Screening identified that a full EqIA was required. An Integrated Equality Assessment has been completed and has been signed off by the Equality and Inclusions Manager and project lead.
	If no, please include rationale:	n/a
Socio-Economic Impact Assessment *Have you undertaken a Socio-Economic Impact Assessment*	Yes: ☒	No: ☐
	Outcome:	Screening identified that a full Socio-Economic Impact Assessment was required. This assessment has been completed and has been signed off by the Equality and Inclusions Manager and Project Lead.
	If no, please include rationale:	n/a
Quality *Have you undertaken a Quality Impact Assessment Screening?*	**Enablers of Quality** All Apply	**Domains of Quality** All Apply

	Outcome:	A Quality Impact Assessment has been undertaken. Appropriate mitigations identified and documented.
Wellbeing of Future Generations Act – Wellbeing Goals	A Resilient Wales	
Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: ☒	No: ☐
	Outcome:	Formed part of the Integrated Equality Assessment that has been completed.
	If no, please include rationale:	n/a
Data Protection Impact Assessment *Have you undertaken a Data Protection Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome:	A DPIA screening has been undertaken. The national 'light touch' DPIA has since been completed following advice from Information Governance and has been submitted.
	If no, please include rationale:	
Counter Fraud Impact Assessment *Have you considered the counter fraud impacts*	Yes: ☒	No: ☐
	Outcome:	No risks identified at this stage
	If no, please include rationale:	
Legal	Yes (Include further detail below)	
	Any relevant procurement and contractual legislation will be followed in the dispersal of patients to new Practices.	

	GDPR and Information Governance requirements will be met, in partnership with Digital Health & Care Wales and all participating practices. All relevant employment law will be followed in the planning and implementation of any workforce changes.
Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Resource Impact *(People / Financial)*	Yes (Include further detail below)
	People: A review of staffing levels in HPI is required due to the fall in patient numbers which has taken place over recent years. Agreement to a change in the boundary as proposed, would result in a further reduction of around 4,600 patients in the number of registered patients in HPI, impacting further on the revisions needed in the staffing model. Work has commenced on proposals and the process will be managed in line with the Health Board's Organisational Change Policy. Engagement with staff is taking place and the Workforce Planning Forum have been briefed. Financial: There will be some transitional costs associated with the changes, for example in communicating with patients and supporting safe transfers of care. This will be managed within existing budgets. GP Practices receiving transferred patients will be reimbursed through the GMS budget and funding arrangements. The assessment undertaken has identified sufficient funding to support the reallocation of patients to GMS Practices.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Planning, Population Health and Partnerships Committee

PHARMACEUTICAL NEEDS ASSESSMENT FINAL REPORT AND APPROVAL FOR PUBLICATION

Dyddiad y Cyfarfod **Date of Meeting**	03 September 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Dr Adam Mackridge, Strategic Lead for Community Pharmacy
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Jane Moore, Executive Director for Public Health Lois Lloyd, Chief Pharmacist

Pwrpas yr Adroddiad **Report Purpose**	For Approval

Crynodeb Gweithredol
Executive Summary

This report presents the final Betsi Cadwaladr University Health Board (BCUHB) Pharmaceutical Needs Assessment (PNA) 2026 for approval, following completion of the statutory 60-day consultation, which ran from 10 June to 9 August 2026. Five responses were received. Respondents confirmed that the purpose of the PNA had been clearly explained and that it reflects current pharmaceutical service provision, and no respondent identified a gap in provision or a planned development that had been missed. Community Pharmacy Wales submitted a detailed response setting out its view on the way in which certain future needs have been described. All responses have been considered and only one change to the draft PNA was deemed necessary by the Steering Group – namely the clarification that cessation of dispensing by a dispensing doctor would create a gap for essential pharmaceutical services **only** where there was no pharmacy provision to that area.
The Health Board remains on track to publish the PNA bilingually by the statutory deadline of 1 October 2026.

Recommendations
The Planning, Population Health and Partnerships Committee are asked to:

- **NOTE** the process and outcome of the statutory 60-day consultation.

- **NOTE** that only one minor change to the draft PNA was required as a result of the consultation responses.
- **APPROVE** the final PNA for publication by 1 October 2026 (appendix 1)

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
Executive Committee	January 2025	Governance, oversight arrangements, and timeline approved
PNA Steering Group	January 2025 to May 2026	Development, review, and agreement of the draft. Membership includes Community Pharmacy Wales, the North Wales Local Medical Committee, the Dispensing Doctors' Association, and Llais
Executive Lead	June 2026	Draft PNA approved for statutory consultation
Statutory consultees - Regulation 7 of The National Health Service (Pharmaceutical Services) (Wales) Regulations 2020	10 June to 9 August 2026	Statutory 60-day consultation. Five responses received. No changes to the draft PNA required
PNA Steering Group	August 2026	Agreement of the final version of the PNA.

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
	BCUHB - Betsi Cadwaladr University Health Board CPW - Community Pharmacy Wales LHB - Local Health Board PCC CIC - Primary Care Commissioning Community Interest Company PNA - Pharmaceutical Needs Assessment PPHP - Planning, Population Health and Partnerships Committee SRO - Senior Responsible Officer

PHARMACEUTICAL NEEDS ASSESSMENT 2026: FINAL REPORT AND APPROVAL FOR PUBLICATION

1. Situation

The draft Betsi Cadwaladr University Health Board (BCUHB) Pharmaceutical Needs Assessment (PNA) 2026 has completed the statutory 60-day consultation required by the NHS (Pharmaceutical Services) (Wales) Regulations 2020. The consultation ran from 10 June to 9 August 2026.

Only one clarifying change to the draft PNA was required as a result of the consultation responses received. This was to clarify that a dispensing doctor ceasing to dispense would only create a gap in pharmaceutical services availability in the event that there is no pharmacy providing services to the affected population.

The final PNA is presented for approval so that it can be published by the statutory deadline of 1 October 2026. Approval is sought from the Executive Committee and, subsequently, from the Planning, Population Health and Partnerships Committee (PPHP), in line with the governance pathway approved by the Executive Committee in January 2025.

2. Background

The Public Health (Wales) Act 2017 and the NHS (Pharmaceutical Services) (Wales) Regulations 2020 require Welsh Local Health Boards to prepare and publish a PNA at least once every five years. BCUHB published its first PNA on 1 October 2021, and an updated version must therefore be published no later than 1 October 2026.

The PNA provides the evidential basis for decisions on applications to open or relocate an NHS pharmacy or dispensing appliance contractor premises, and for GP practices to dispense. Those decisions are subject to direct appeal to Welsh Government or to judicial review, so the accuracy and robustness of the document are critical.

The Executive Committee approved the governance arrangements and timeline in January 2025. The Senior Responsible Officer is the Executive Director for Public Health, supported by the Chief Pharmacist as professional adviser. Preparation of the document was commissioned from Primary Care Commissioning CIC (PCC CIC), and the work has been overseen by a PNA Steering Group chaired by the Associate Director Primary Care (West), which includes BCUHB officers and representatives of the North Wales Local Medical Committee, the Dispensing Doctors' Association, Community Pharmacy Wales (CPW), and Llais.

The Senior Responsible Officer approved the draft PNA for statutory consultation in June 2026.

3. Specific Matters for Consideration

Consultation process & response

The Health Board consulted the parties specified under regulation 7 of the Regulations. These included CPW, the North Wales Local Medical Committee, contractors included in the pharmaceutical list, dispensing doctors and GP practices, Llais, the North Wales Regional Partnership Board, the six North Wales local authorities, and the two neighbouring health boards.

Consultees were invited by email, with links to the draft PNA and to an online questionnaire. All documents were made available bilingually. Respondents were able to answer a set of questions and to submit additional comments and were not required to answer every question.

The consultation ran for the statutory 60 days, from 10 June to 9 August 2026 and five responses were received: one on behalf of a pharmacy, dispensing appliance contractor, or dispensing practice, two on behalf of organisations, and two personal responses. This includes a response from CPW submitted outside the online questionnaire. No responses were received in Welsh.

The consultation report, which records the responses received in full together with the Health Board's consideration of each, is included at Appendix K of the PNA.

Outcome of the consultation

All responses have been considered by the PNA Steering Committee. Only one clarifying change to the draft PNA was required as a result of the consultation, and the document presented for approval is therefore largely the same in substance as the version consulted upon, with this one clarification, and the consultation report in Appendix K being the only changes.

Publication

Subject to approval, the final Welsh translation will be completed during September 2026 and the PNA will be published bilingually on the Health Board's website by 1 October 2026.

4. Key Risks / Matters for Escalation

Failure to publish by 1 October 2026 would place the Health Board in breach of its statutory duty. The process remains on track, with only approval and the final translation outstanding. As there are minimal changes to the main document and the consultation report is considerably shorter, there are no concerns regarding completion of translation prior to the end of September 2026.

No new corporate risks are identified as a result of this report.

5. Recommendations

The Planning, Population Health and Partnerships Committee are asked to:

- **NOTE** the process and outcome of the statutory 60-day consultation.
- **NOTE** that only one minor change to the draft PNA was required as a result of the consultation responses.
- **APPROVE** the final PNA for publication by 1 October 2026 (appendix 1)

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	3. Improve Access, Outcomes and Experience
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 Public Sector Equality Duty: **Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty):** https://www.gov.wales/public-sector-equality-duty-htmlPublic Sector Equality Duty [HTML] | GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not relevant
Equality Act 2010 - Socio-economic Duty	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	

Has BCUHB provided evidence of 'Due Regard' to compliance of their Socio-economic Duty when making strategic decisions?	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not relevant
Have you completed an Integrated Equality Impact Assessment WP8a? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	Not relevant
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not relevant
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Final document will be published bilingually
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant *Have the principles of the Armed Forces Covenant been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not relevant
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Not relevant

Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not relevant
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not relevant
Cyfreithiol **Legal**	Yes (Include further detail below)	
	Publication of the PNA is a statutory requirement under the Public Health (Wales) Act 2017 and the NHS (Pharmaceutical Services) (Wales) Regulations 2020. Decisions on market entry applications made on the basis of the published PNA are subject to appeal to Welsh Government and to judicial review	
Enw Da **Reputational**	Yes (Include further detail below)	
	Failure to publish the PNA by 1 October 2026 would represent a breach of statutory duty and would carry a reputational risk for the Health Board.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Betsi Cadwaladr University Health Board pharmaceutical needs assessment

September 2026

This document is available in Welsh / Mae’r ddogfen hon ar gael yn Gymraeg.

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Executive summary

The health board has a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services for the population in its area, referred to as a 'pharmaceutical needs assessment'. This is Betsi Cadwaladr University Health Board's second pharmaceutical needs assessment, and its development has been overseen by a steering group which included representation from the health board, Community Pharmacy Wales, North Wales Local Medical Committee and Llais.

The pharmaceutical needs assessment:

- Sets out the current health needs of the population and how they will change over the five-year lifetime of the document (1 October 2026 to 30 September 2031),
- Describes the current provision of pharmaceutical services by pharmacies, dispensing appliance contractors and dispensing doctors both within and outside of the health board's area,
- Takes into account known changes that will arise during the lifetime of the document such as demographic changes, housing developments, regeneration projects, and changes to the location of other NHS service providers, and
- Identifies any current gaps in service provision and any that will arise during the lifetime of the document.

From 1 October 2026 the pharmaceutical needs assessment will be used by the health board when considering whether or not to grant applications to join its pharmaceutical list or dispensing doctor list under The National Health Service (Pharmaceutical Services) (Wales) Regulations 2020. Decisions on such applications may be appealed to Welsh Ministers who will then also refer to the document when hearing any such appeal. It will also be used to inform decisions on applications for the relocation of existing pharmacy and dispensing doctor premises, applications to change pharmacy core opening hours, and in relation to the commissioning of new services from pharmacies.

The footprint of Betsi Cadwaladr University Health Board is coterminous with the footprint of the following local authority areas:

- Conwy County Borough Council,
- Denbighshire County Council,
- Flintshire County Council,
- Gwynedd Council,
- Isle of Anglesey County Council, and
- Wrexham County Borough Council.

The health board's area is bordered by the Irish Sea to the north and west, Ceredigion and Powys to the south, and England to the east. The region is defined by coastland, rural areas particularly in the west, and more urban areas in the east predominantly in and around Wrexham and Deeside. The majority of settlements are

along the coast, including resorts popular with tourists such as Rhyl, Llandudno, Pwllheli, Prestatyn and Tywyn. It is mountainous and contains Eryri National Park, and the mix of natural features is a strong draw for tourists and visitors.

There is a stronger sense of Welsh identity in the area, and it is home to more Welsh-language speakers than elsewhere in Wales.

The population of North Wales is increasing and ageing. It is anticipated that there will be a reduction in the proportion of people aged 64 and under during the lifetime of this pharmaceutical needs assessment (and until 2047) and an increase in the proportion of people aged 65 and over (34%), particularly for those aged 85 and over (98% increase).

Chapter 1 sets out the regulatory framework for the provision of pharmaceutical services which, for the purpose of this document, include those services provided by pharmacies and dispensing appliance contractors (referred to as essential, advanced and enhanced services) and the dispensing service provided by some GP practices to eligible patients. It also contains the views of 123 residents of the health board's area on their use of pharmacies and dispensing doctors which were gained from an online questionnaire. These show:

- Pharmacies are mainly used for the dispensing of prescriptions, to buy medicines or to get advice.
- Most people visit a pharmacy on a monthly basis.
- For those who have a preference as to the time at which they visit a pharmacy, 09.00 to 12.00 and 15.00 to 18.00 are the most popular times, followed by 18.00 to 21.00.
- With regard to the preferred day of the week on which to visit a pharmacy, 44.2% of responders didn't have a preference, 29.2% said weekdays in general and 13.3% said weekends in general.
- The most common influences on the choice of which pharmacy to use are proximity to home address or GP practice, a location that is easy to get to, there is a private area for conversations with the pharmacist, always having the pharmacy, and trust in the staff.
- 67.5% of respondents drive to a pharmacy and 24.2% walk.
- 95.0% of respondents can travel to a pharmacy within 20 minutes.

The health board has noted a high degree of commonality in responses to this questionnaire when compared to those received when the first pharmaceutical needs assessment was written.

This chapter also contains information provided by contractors which could not be nationally sourced. It should be noted that the response rate to the pharmacy contractor questionnaire was lower (58.7%) than for the previous pharmaceutical needs assessment (100%). This is due to the fact the questions in the previous questionnaire were incorporated into the All Wales Pharmacy Database validation exercise which all contractors are required to participate in.

- 96.4% of pharmacies are accessible by wheelchair,

- 79 of the 84 who responded have consultations areas that meet the required standards. Of the five whose consultation areas aren't compliant, two have alternative arrangements for confidential discussions,
- 88.4% of pharmacies said that they have sufficient capacity within their existing premises to meet an increase in demand, 8.1% said they do not but could make adjustments, and 2.3% said they do not and would have difficulty managing an increase in demand.
  26.7% said they have sufficient capacity within their staffing levels to manage an increase in demand, 67.4% said they don't but could make adjustments, and 5.8% didn't answer this question.

Following an overview of the demographic characteristics of the residents of the health board's area in chapter 2, chapter 3 focusses on their health needs.

In order to ensure that those sharing a protected characteristic and other patient groups are able to access pharmaceutical services chapter 4 identifies the specific groups that are present in the health board's area and their likely health needs.

Chapter 5 focusses on the provision of pharmaceutical services in the health board's area and those providers who are located outside of the area but who provide services to those living within the health board's area. As of April 2026, there are 143 pharmacies included in the health board's pharmaceutical list (a reduction of nine since the previous pharmaceutical needs assessment), operated by 44 different contractors. There are no dispensing appliance contractors in the health board's area. Of the 96 GP practices, 34 dispense to their eligible patients (a reduction of three) from 42 sites. The pharmacies are generally located in areas of greater population density and deprivation, with the dispensing practices generally in areas of lower population density.

In order to assess whether there is currently a good geographical spread of pharmacies the health board adopted a travel time of 20 minutes by car to a pharmacy. This is in line with the previous pharmaceutical needs assessment and reflects the rural nature of much of North Wales. The health board has noted that the vast majority of its population is within a 20-minute drive of a pharmacy. Google Maps reveals that those areas that are not within a 20-minute drive generally have no resident population or only a few scattered houses, farms, camping and caravan sites.

The vast majority (84.3%) of items prescribed by the GP practices were dispensed by one of the 143 pharmacies in 2024/25, with a further 13.1% dispensed or personally administered by the dispensing practices and 0.9% personally administered by the non-dispensing practices. The remaining 1.7% was predominantly dispensed in England by pharmacies just over the border or by dispensing appliance contractors, although 0.3% was dispensed by 209 different pharmacies elsewhere in Wales and the dispensing appliance contractors in Cardiff. A very similar pattern of dispensing was seen for items prescribed by GP practices in the first nine months of 2025/26.

Services which affect the need for pharmaceutical services either by increasing or reducing the demand for a particular service or services are identified in chapter 6.

Such services include the hospitals, personal administration of items by GP practices, the GP out of hours service, Help Me Quit, substance misuse services, sexual health clinics and other community based services.

Having considered the general health needs of the population, chapter 7 focusses on those that can be met by pharmacies, dispensing appliance contractors and the dispensing service provided by some GP practices.

The health board has divided its area into 14 localities for the purpose of this document, based upon the GP clusters. The clusters bring together local services involved in the provision of health and care, across a geographical area typically serving a population between 25,000 and 100,000. Working as a cluster ensures care is better co-ordinated to promote the wellbeing of individuals and communities. They are therefore a natural footprint for the localities within this pharmaceutical needs assessment.

Each locality has a dedicated chapter which looks at the needs of the population, considers the current provision of pharmaceutical services to residents and identifies whether or not current provision meets the needs of those residents. Each chapter goes on to consider whether there are any gaps in service delivery that may arise during the lifetime of the pharmaceutical needs assessment. As with the previous pharmaceutical needs assessment, the health board has future-proofed this version so that it responds should a pharmacy close permanently or a GP practice ceases to provide the dispensing service. This is important because applications for new pharmacies may only be granted if they meet a current or future need identified in the pharmaceutical needs assessment in accordance with the regulations.

Chapter 22 sets out the current and future needs that have been identified by the health board. The health board has determined the following services as those that are necessary to meet the need for pharmaceutical services in its area:

- Essential and additional clinical services provided at all premises included in a pharmaceutical list, and
- The dispensing service provided by those GP practices included in a dispensing doctor list.

The pharmaceutical needs assessment has identified the current need for a pharmacy in Betws-y-Coed which is open six days a week, providing the following services.

- Essential services,
- Clinical community pharmacy service,
- Return of patient sharps,
- Smoking cessation level 2, and
- Help me quit @ pharmacy service.

No other current needs have been identified in relation to the provision of essential services, additional clinical services, or the GP dispensing service.

The health board has also looked at changes which are anticipated within the lifetime of the document for example the predicted population growth. In addition, it has taken account of ‘Pharmacy; Delivering A healthier Wales’ which sets outs the long-term goals for service transformation to ensure the most health gain from prescribed medicines. As a result, the pharmaceutical needs assessment has identified a number of future needs for additional clinical services in specific circumstances, although it is the health board’s preference that the existing pharmacies provide the services required by the population.

An aspiration in ‘Pharmacy: Delivering a Healthier Wales’ is for each pharmacy to have an independent prescriber by 2030 and has set interim targets of 50% of pharmacies to be providing this service in each locality by April 2027 and 70% by April 2029. From 2026 it is anticipated that all newly qualified pharmacists will also qualify as independent prescribers on completion of their undergraduate programme. Should these interim targets not be met within one or more localities there will be a future need for the provision of this service by sufficient pharmacies in the locality to meet the two targets.

142 of the pharmacies provide the clinical community pharmacy service which includes the common ailments service, contraception, and emergency medicines supply. The pharmaceutical needs assessment has identified that if the remaining pharmacy has not started to provide this service by 1 April 2027 there will be a future need for the provision of this service in Bodelwyddan, seven days a week for:

- eight hours a day Monday to Friday,
- six hours on Saturdays to include 13.00 to 15.00, and
- three hours on Sundays after 12 noon.

The pharmaceutical needs assessment has identified that should there be a loss of supplementary opening hours in any locality on Saturdays from 1 October 2026 which results in less than three hours of provision of pharmaceutical services within a town/village there will be a future need for the provision of essential services for three core opening hours on Saturdays in the town/village or towns/villages where the reduction in supplementary opening hours has occurred, between 09.00 and 17.00, unless there is another pharmacy in that town/village and then the future need will not arise.

The pharmaceutical needs assessment has identified that should there be a loss of essential services due to the withdrawal of a pharmacy from the pharmaceutical list there will be a future need for either:

- a new pharmacy in the same town/village providing essential services, the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services for 40 core opening hours per week, or
- the GP dispensing service if the town/village is in a controlled locality,

unless there is another pharmacy in that town/village and then this future need will not arise.

The pharmaceutical needs assess has also identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all of the essential services, and
    - the clinical community pharmacy service, patient sharps, smoking cessation level 2, and help me quit @ pharmacy service.

A 60-day consultation will be undertaken on the findings of a draft of the pharmaceutical needs assessment, as required by the regulations, and the document will be reviewed in light of the responses.

1 Introduction

1.1 Purpose of a pharmaceutical needs assessment

The purpose of the pharmaceutical needs assessment is to assess and set out how the provision of pharmaceutical services can meet the health needs of the population of a health board's area for a period of up to five years, linking closely to the health board's Health and Wellbeing Profile 2026. Whilst the profile focusses on the general health needs of the population of the health board's area, the pharmaceutical needs assessment looks at how those health needs can be met by pharmaceutical services commissioned by the health board.

If a person (a pharmacy or a dispensing appliance contractor) wants to provide pharmaceutical services, they are required to apply to the health board, in whose area the premises are to be located, to be included in its pharmaceutical list. In general, their application must offer to meet a need that is set out in that health board's pharmaceutical needs assessment. There are however two exceptions to this; change of ownership applications and relocations for business purposes.

If a GP wishes to dispense to a new area or from new or additional premises, they are also required to apply to the health board to be included in its dispensing doctor list, or for a new area or new or additional premises to be listed in relation to them. In general, their application must also offer to meet a need that is set out in that health board's pharmaceutical needs assessment.

As well as identifying if there is a need for additional premises, the pharmaceutical needs assessment will also identify whether there is a need for an additional service or services. Identified needs could either be current or will arise within the five-year lifetime of the pharmaceutical needs assessment.

1.2 Health board duties in respect of the pharmaceutical needs assessment

Betsi Cadwaladr University Health Board published its first pharmaceutical needs assessment on 1 October 2021. Further information on the health board's specific duties in relation to pharmaceutical needs assessments and the policy background to pharmaceutical needs assessments can be found in appendix A, however in summary the health board must:

- publish revised statements (ie subsequent pharmaceutical needs assessments), on a five-yearly basis, which comply with the regulatory requirements,
- publish a subsequent pharmaceutical needs assessment sooner when it identifies changes to the need for pharmaceutical services which are of a significant extent, unless to do so would be a disproportionate response to those changes, and
- produce supplementary statements which explain changes to the availability of pharmaceutical services in certain circumstances.

1.3 Pharmaceutical services

The services that a pharmaceutical needs assessment must include are defined within both the National Health Service (Wales) Act 2006 and the NHS (Pharmaceutical Services) (Wales) Regulations 2020.

Pharmaceutical services may be provided by:

- a pharmacy contractor who is included in the pharmaceutical list for the area of the health board,
- a dispensing appliance contractor who is included in the pharmaceutical list held for the area of the health board, and
- a doctor or GP practice that is included in a dispensing doctor list held for the area of the health board.

Each health board is responsible for preparing, maintaining, and publishing its lists. In Betsi Cadwaladr University Health Board there are 143 pharmacies and 34 dispensing practices (March 2026).

Contractors may operate as either a sole trader, partnership, or a body corporate. The Medicines Act 1968 governs who can be a pharmacy contractor, but there is no restriction on who can operate as a dispensing appliance contractor.

1.3.1 Pharmaceutical services provided by pharmacy contractors

Unlike for GPs, dentists and optometrists, Betsi Cadwaladr University Health Board does not hold contracts with the pharmacy contractors in its area. Instead, they provide services under a contractual framework, sometimes referred to as the community pharmacy contractual framework, details of which (the terms of service) are set out in schedule 5 of the NHS (Pharmaceutical Services) (Wales) Regulations 2020, The Pharmaceutical Services (Clinical Services) (Wales) Directions 2022, and the Pharmaceutical Services (Advanced Services) (Appliances) (Wales) Directions 2010.

Pharmacy contractors provide three types of service that fall within the definition of pharmaceutical services and the community pharmacy contractual framework. They are:

- Essential services – all pharmacies must provide these services
    - Dispensing of prescriptions, including urgent supply of a drug or appliance without a prescription
    - Dispensing of repeatable prescriptions
    - Disposal of unwanted drugs
    - Promotion of healthy lifestyles
    - Signposting, and
    - Support for self-care

- National community pharmacy and appliance contractor services – pharmacies may choose whether to provide these services or not. If they choose to provide one or more of these services, they must meet certain

requirements and must also be fully compliant with the essential services and clinical governance requirements.
    - Clinical community pharmacy service
    - Discharge medicines review service
    - Pharmacist independent prescribing service
    - Seasonal influenza vaccination service
    - Stoma appliance customisation
    - Lateral flow test supply service
    - Appliance use review

- Additional clinical services – service specifications for this type of service are developed by the health board and then commissioned to meet specific health needs. The list of additional clinical services that may be commissioned are:
    - Anticoagulation monitoring
    - Care home service
    - Disease specific medicines management service
    - Emergency pandemic treatment and prophylaxis supply service
    - Emergency pandemic vaccination service
    - Gluten free food supply service
    - Home delivery service
    - Language access service
    - Medication review service
    - Medicines assessment and compliance support service
    - Needle and syringe supply service
    - On demand availability of specialist drugs service
    - Out of hours service
    - Patient group direction service
    - Prescriber support service
    - Schools service
    - Screening service
    - Stop smoking service
    - Supervised administration service
    - Prescribing service
    - An anti-viral collection service
    - A waste minimisation service

Further information on the essential, national community pharmacy and appliance contractor and additional clinical services requirements can be found in appendices B, C and D respectively.

Underpinning the provision of all these services is the requirement on each pharmacy contractor to participate in a system of clinical governance. This system is set out within the NHS (Pharmaceutical Services) (Wales) Regulations 2020 and includes:

- A patient and public involvement programme
- A clinical audit programme
- Collaboration with other healthcare professionals through clusters in order to identify and improve the health and wellbeing of the population service by the pharmacy

- A risk management programme
- A clinical effectiveness programme
- A staffing and staff management programme,
- An information governance programme, and
- A premises standards programme.

Pharmacies are required to open for not less than 40 hours per week, and these are referred to as core opening hours, but may choose to open for longer and these additional hours are referred to as supplementary opening hours. Under the NHS (Pharmaceutical Services) (Wales) Regulations 2020 it is possible for pharmacy contractors to successfully apply to open a pharmacy with a greater number of core opening hours in order to meet a need identified in a pharmaceutical needs assessment. If a pharmacy wishes to reduce its core opening hours to fewer than 40 per week it must first apply to the health board, however the health board is not required to agree to such a request.

The proposed opening hours for each pharmacy are set out in the initial application, and if the application is granted and the pharmacy subsequently opens these form the pharmacy's contracted opening hours. The contractor can subsequently apply to change their core opening hours and the health board will assess the application against the needs of the population of its area as set out in the pharmaceutical needs assessment to determine whether to agree to the change in core opening hours or not. If a pharmacy contractor wishes to change their supplementary opening hours, they simply notify the health board of the change, giving at least 12 weeks' notice.

1.3.2 Pharmaceutical services provided by dispensing appliance contractors

As with pharmacy contractors, Betsi Cadwaladr University Health Board does not hold contracts with dispensing appliance contractors. Their terms of service are set out in schedule 6 of the NHS (Pharmaceutical Services) (Wales) Regulations 2020 and the Pharmaceutical Services (Advanced Services) (Appliances) (Wales) Directions 2010.

Dispensing appliance contractors provide the following services for appliances (not drugs), for example catheters and colostomy bags, which fall within the definition of pharmaceutical services:

- Dispensing of prescriptions (both electronic and non-electronic), including urgent supply without a prescription
- Dispensing of repeatable prescriptions
- Home delivery service for some items
- Supply of appropriate supplementary items (e.g. disposable wipes and disposal bags)
- Provision of expert clinical advice regarding the appliances, and
- Signposting

They may also choose to provide national community pharmacy and appliance contractor services. If they do choose to provide them then they must meet certain

requirements and must also be fully compliant with their terms of service and the clinical governance requirements. The two national community pharmacy and appliance contractor services that they may provide are:

- Stoma appliance customisation
- Appliance use reviews

As with pharmacies, dispensing appliance contractors are required to participate in a system of clinical governance. This system is set out within the NHS (Pharmaceutical Services) (Wales) Regulations 2020 and includes:

- A patient and public involvement programme
- A clinical audit programme
- A risk management programme
- A clinical effectiveness programme
- A staffing and staff programme,
- An information governance programme, and
- A premises standards programme.

Further information on the requirements for these services can be found in appendix E.

Dispensing appliance contractors are required to open not less than 30 hours per week, and these are referred to as core opening hours. They may choose to open for longer and these additional hours are referred to as supplementary opening hours. Under the NHS (Pharmaceutical Services) (Wales) Regulations 2020 it is possible for dispensing appliance contractors to successfully apply to open premises with a greater number of core opening hours in order to meet a need identified in a pharmaceutical needs assessment.

The proposed opening hours for each dispensing appliance contractor are set out in the initial application, and if the application is granted and the dispensing appliance contractor subsequently opens then these form the dispensing appliance contractor's contracted opening hours. The contractor can subsequently apply to change their core opening hours. The health board will assess the application against the needs of the population of its area as set out in the pharmaceutical needs assessment to determine whether to agree to the change in core opening hours or not.

1.3.3 Pharmaceutical services provided by doctors

The NHS (Pharmaceutical Services) (Wales) Regulations 2020 allow doctors to dispense to eligible patients in certain circumstances. The regulations are complicated on this matter but in summary:

- Patients must live in a 'controlled locality' (an area which has been determined by the health board or a preceding organisation as rural in character, or on appeal by the Welsh Ministers), more than 1.6km (measured in a straight line) from a pharmacy, and

- Their practice must have premises approval and outline consent to dispense to that area.

There are some exceptions to this, for example patients who have satisfied the health board that they would have serious difficulty in accessing a pharmacy by reason of distance or inadequacy of means of communication.

1.4 Other NHS services

Other services which are commissioned or provided by Betsi Cadwaladr University Health Board which affect the need for pharmaceutical services are also included within the pharmaceutical needs assessment.

1.5 How the assessment was undertaken

1.5.1 Pharmaceutical needs assessment steering group

Betsi Cadwaladr University Health Board has overall responsibility for the publication of the pharmaceutical needs assessment, and the executive director for public health is accountable for its development. Betsi Cadwaladr University Health Board established a pharmaceutical needs assessment steering group whose purpose was to ensure that the development of a robust pharmaceutical needs assessment that complies with the NHS (Pharmaceutical Services) (Wales) Regulations 2020 and meets the needs of the local population. The membership of the steering group ensured all the main stakeholders were represented and can be found in appendix F.

1.5.2 Pharmaceutical needs assessment localities

The localities that have been used for the pharmaceutical needs assessment match the boundaries of the GP clusters, namely:

- Anglesey
- Arfon
- Dwyfor and North Meirionnydd
- South Meirionnydd
- Conwy West
- Conwy East
- North Denbighshire
- Central and South Denbighshire
- North West Flintshire
- North East Flintshire
- South Flintshire
- North and West Wrexham
- Central Wrexham
- South Wrexham

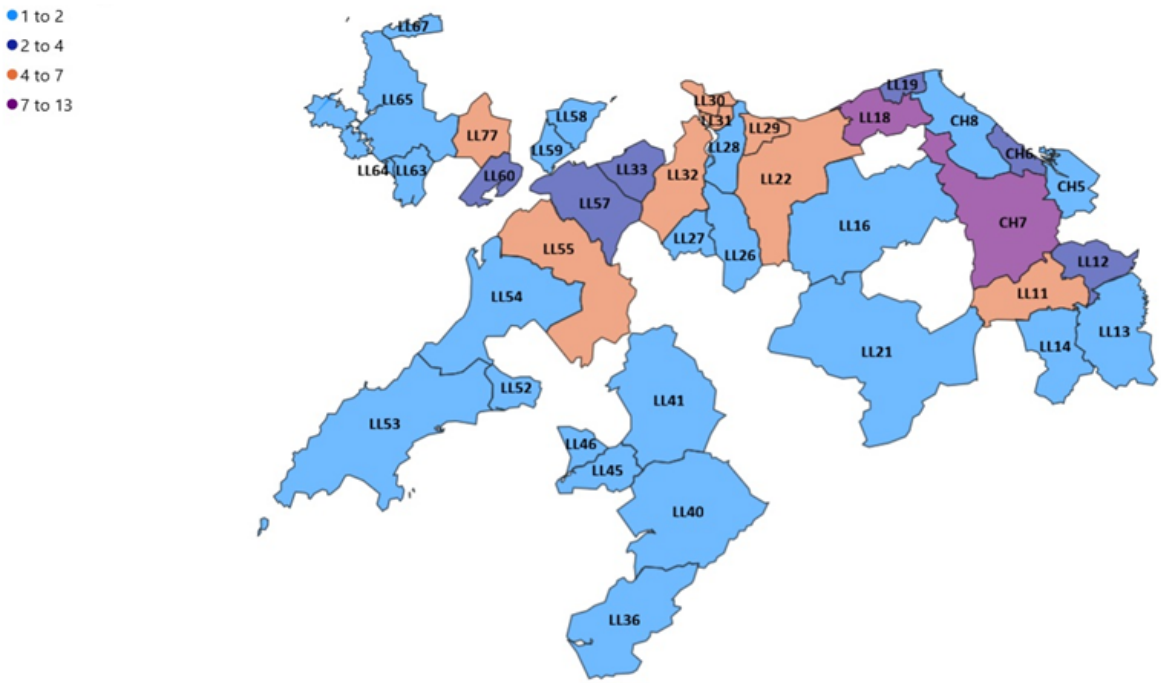
The clusters bring together local services involved in the provision of health and care, across a geographical area typically serving a population between 25,000 and 100,000. Working as a cluster ensures care is better co-ordinated to promote the wellbeing of individuals and communities. They are therefore a natural footprint for the localities within this pharmaceutical needs assessment.

1.5.3 Patient and public engagement

In order to gain the views of the public on pharmaceutical services, a questionnaire was developed and made available online from 26 March 2026 to 27 April 2026. The questionnaire was promoted on the health board's website and via social media platforms. It was made available in Welsh and English and a copy, which shows the questions asked, can be found in appendix G. The full results can be found in appendix H.

A total of three people completed the questionnaire in Welsh and 123 in English. The heat map below shows the location of those who responded based upon the postcode district that they live in. It should be noted that the postcode districts do not fully map to the boundaries of the health board's area and responses were not received from all the postcode districts.

Map 1.1 - map showing the postcode districts of those responding to the patient and public questionnaire



When asked where they collect their medicines from:

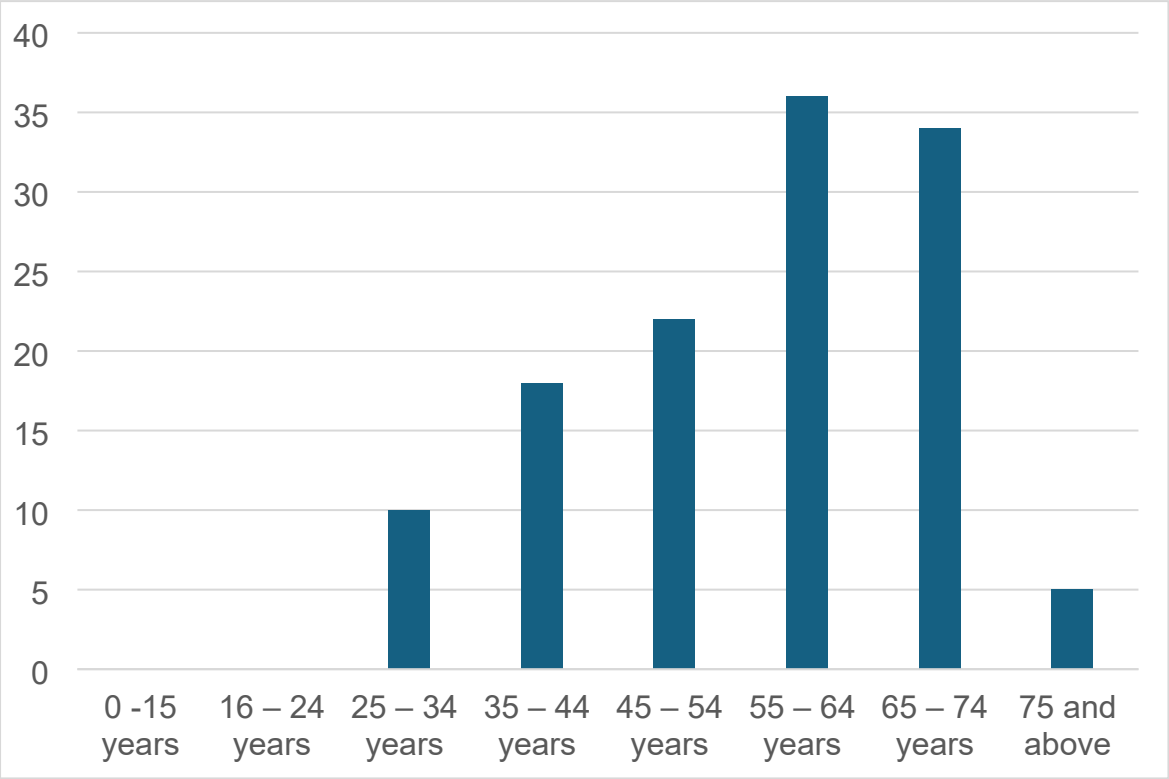
- 92.1% of people said from a pharmacy
- 7.9% said from their doctor's surgery.

In relation to their preferred language when accessing services at a pharmacy or GP practice:

- 87.2% of respondents said English,
- 12.0% said Welsh,
- 0.8% chose not to answer the question.

82.4% of respondents were female, 16.0% as male, 1.6% preferred not to say. The figure below shows the age breakdown of respondents.

Figure 1.1 – how old are you?



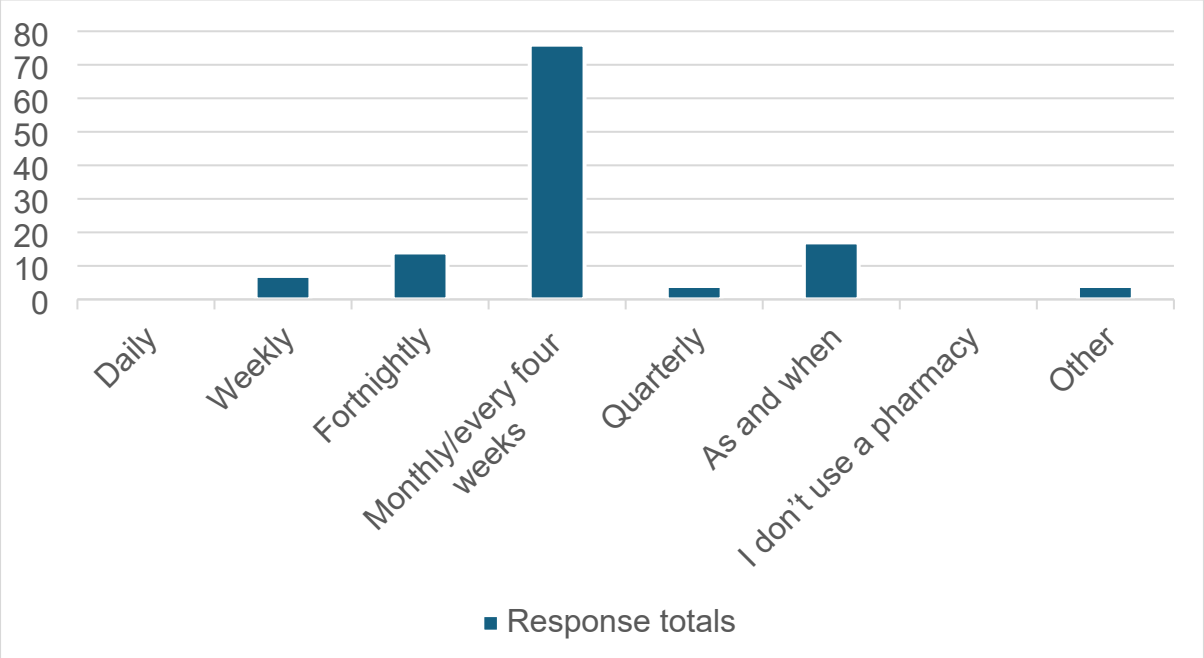
When asked why they usually visit a pharmacy the most common responses were as follows:

- To get a prescription for myself – 104 people
- To get a prescription for someone else – 55 people
- To buy medicines for myself – 46 people
- To get advice for myself – 39 people
- To buy medicines for someone else – 23 people
- To get advice for someone else – 12 people.

Multiple answers could be given to this question.

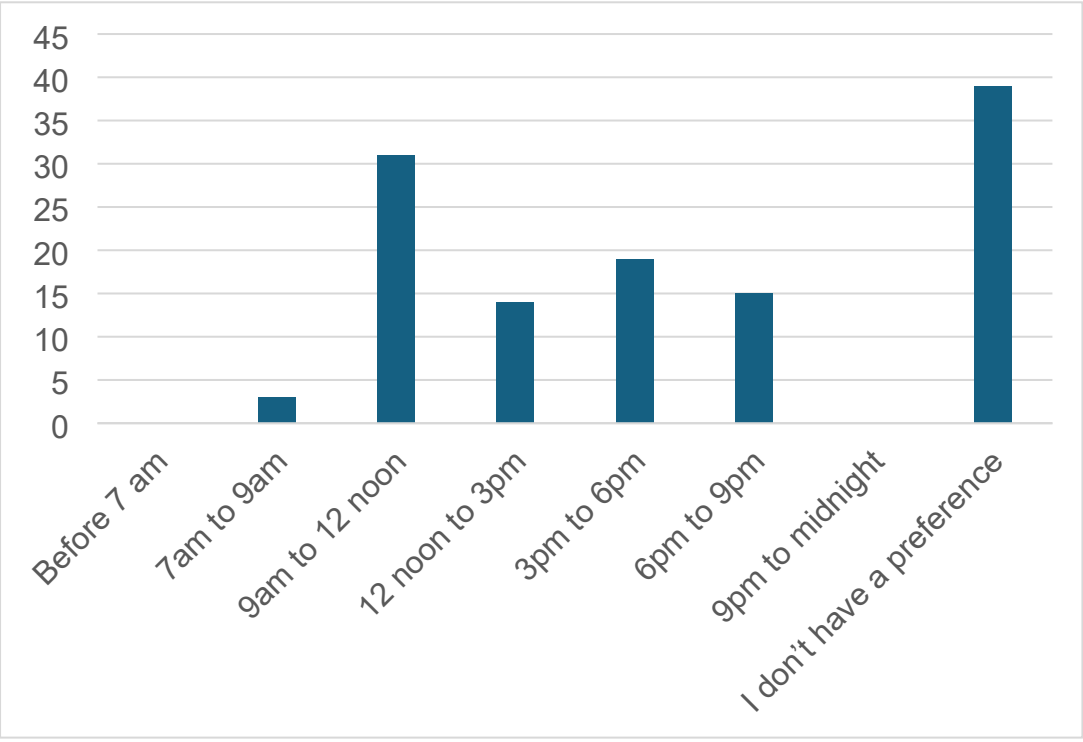
The figure below shows how frequently responders visit a pharmacy. As may be expected most people visit monthly which will reflect prescription length.

Figure 1.2 – How often do you visit a pharmacy?



Whilst 32.2% of respondents didn't have a preference as to the most convenient time to use a pharmacy, for those that did the most convenient time was 09.00 to 12.00 (25.6% of responses), followed by 15.00 to 18.00 (15.7% of responses), then 18.00 to 21.00 (12.4%), and then 12.00 to 15.00 (11.6%).

Figure 1.3 - What time is the most convenient for you to use a pharmacy?



When asked which day is the most convenient to access a pharmacy:

- 45.1% said they didn't have a preference,
- 28.7% said weekdays in general,
- 13.1% said weekends in general,
- 6.4% said Saturdays, and
- The remaining 13.1% were evenly spread between specific weekdays and Saturday.

31 people said that there had been a time recently when they had not been able to use their normal pharmacy. When asked what they did instead:

- 20 people went to another pharmacy,
- 8 people waited until it was open,
- 3 people called NHS Direct Wales or NHS 111 Wales, two contacted their GP practice, one contacted the GP out of hours service, and
- one asked a friend.

The questionnaire asked people about their choice of pharmacy. 81.1% said that they always use the same pharmacy, 16.4% said they use different pharmacies but prefer to visit one most often, 1.6% said they always use different pharmacies, and 0.8% said they never use a pharmacy.

The table below shows the top 11 things that influence choice of pharmacy.

Table 1.1 – what influences your choice of pharmacy?

Reason	Number of respondents
Close to my home	85
Close to my doctor	51
The location of the pharmacy is easy to get to	41
There is a private area if I need to talk to the pharmacist	37
I've always used this pharmacy	35
It is easy to park at the pharmacy	30
The staff know me and look after me	29
The customer service	27
The pharmacy provides good advice & information	26
The pharmacy has good opening hours	25
They usually have what I need in stock	24

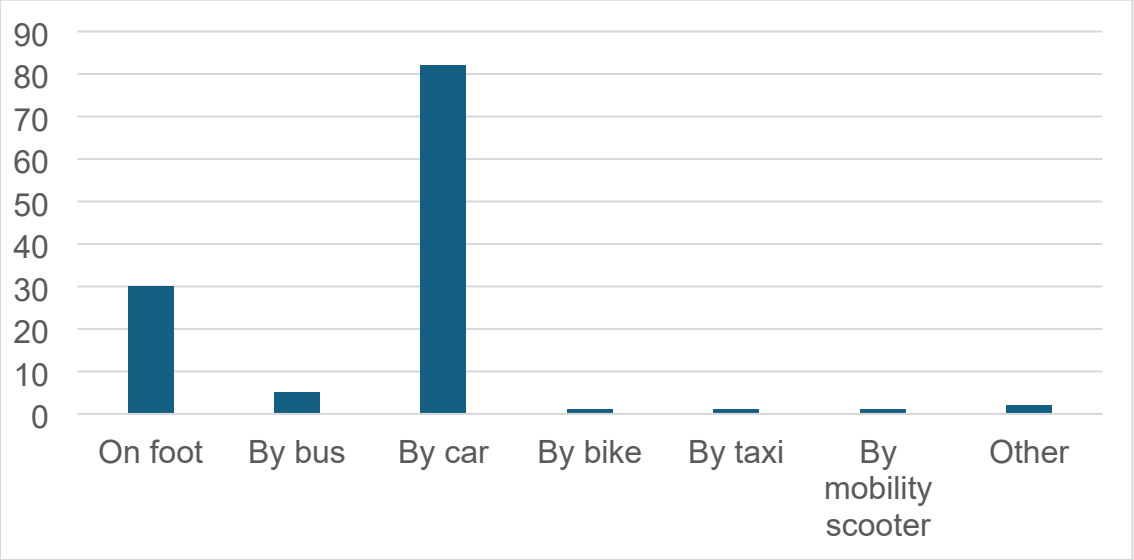
When asked if there is a more convenient and/or closer pharmacy that they don't use, 30 (24.6%) said yes and the following reasons were given.

Table 1.2 – reasons for not using a more convenient and/or closer pharmacy

Reason	Number of responses
The service is too slow	8
I have had a bad experience in the past	5
It is not easy to park at the pharmacy	3
There is not enough privacy	3
They don't have what I need in stock	3
Prescriptions are sent to another pharmacy	2
It's not open when I need it	1
The staff don't know me	1
It's not wheelchair/baby buggy friendly	1

The questionnaire then looked at how people travel to pharmacies.

Figure 1.4 - if you go to the pharmacy by yourself or with someone, how do you usually get there?

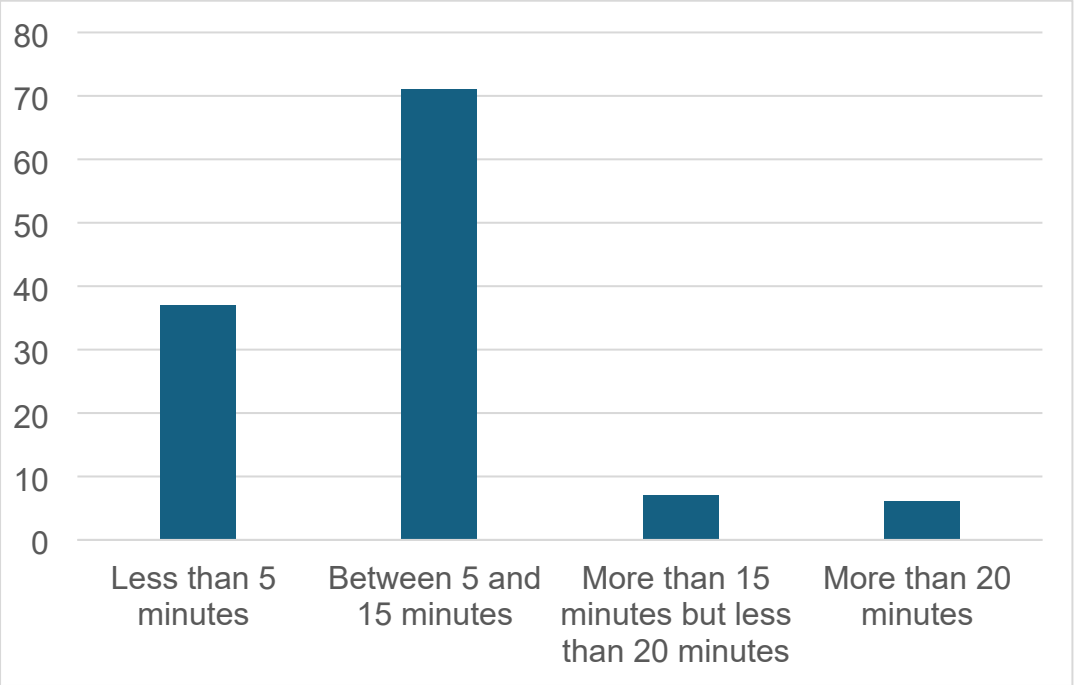


For those who chose "other":

- one person doesn't visit pharmacies,
- One person travels by car and on foot.

For the majority of the responders their journey time takes less than 15 minutes (89.3%), with 95% within 20 minutes of a pharmacy. For 5.0% of people it takes more than 20 minutes to travel to a pharmacy.

Figure 1.5 - how long does it usually take to get to the pharmacy?



For those whose journey takes more than 20 minutes:

- four people go by car,
- one travels on foot, and
- one travels by bus.

When asked if they would say that they have difficulty in getting to a pharmacy, 93.4% said no. For the seven respondents who said they have difficulty the following information was provided.

- One person is housebound,
- One person has physical disabilities,
- One person finds it difficult to park,
- One person has difficulty in getting to another pharmacy,
- One person has a long-term condition which means that they sometimes cannot drive and rely on their husband,
- One person doesn't drive, and
- One person has mobility issues.

Searching via the internet was the most popular way of finding information on a pharmacy for example opening hours and services offered (85 respondents) followed by phoning the pharmacy (37 respondents), popping in and asking (23 respondents), using social media (18 respondents), looking in the window (15 respondents), calling NHS 111 Wales or using its website (six people), and asking a friend (four respondents). Multiple options could be selected for this question.

When asked if they feel able to discuss something private with a pharmacist the majority either answered yes (56.6%) or they had never needed to (22.1%). 14.8% of respondents however said no.

Whilst most respondents use a pharmacy in order to have a prescription dispensed, pharmacies do provide a range of clinical services. The questionnaire listed a number of services that are provided by all or the majority of pharmacies in the health board's area and asked if respondents were aware of them. The table below shows their responses.

Table 1.3 – are you aware that you may be able to access the following services from pharmacies as part of the NHS?

Service	Number of people aware of the service
Flu vaccinations	101
Common ailments scheme	95
Help to stop smoking	48
Emergency hormonal contraception, also referred to as the 'morning after pill'	44
Discharge medicines review service	32
Appliance use review service	15

63 people had further comments to make on their experience of their local pharmacy. There were 24 positive comments, 35 negative, and four which were both positive and negative.

The positive comments focussed on the service provided and the friendly helpful staff who do their utmost to meet people's needs.

Examples of the positive comments include:

- "Wonderful, knowledgeable staff. Always helpful"
- "Prescribing service very helpful"
- "I have to say that the Pharmacy I use is great the staff are great and so helpful, They know me and we have good banter. If I have a problem they are very good and explain everything."
- "My pharmacy is a vital part of our community especially for the young and elderly and like myself those that don't drive or have any means of transport."
- "Friendly staff. Always ready to help. They go out of their way to help us every time"

With regard to the negative comments, the main themes were:

- Slow service and time spent queuing
- Pharmacies not being open at the weekends or later on weekday evenings

- Prescriptions cannot be found and so dispensing is delayed
- Length of time for prescriptions to be dispensed, in particular when they are sent to a dispensing hub
- Lack of stock or items not being included leading to repeat visits (it was not clear if this was an issue with the relevant pharmacies or whether this is due to the national shortages)
- Poor customer service
- Mistakes made

Examples of the negative comments include:

- “Always issue with stock. Waiting time for prescription to be dispensed. Lack of space.”
- “I have a repeat prescription for medication I will be on for the rest of my life. I put my prescription in at the doctors who then authorise it and send it across to the pharmacy. I cannot say how many times my prescription cannot be found at the pharmacy. Almost every time not all of the drugs I need are available which necessitates another walk down to the pharmacy. There is always a problem sometimes the prescription has vanished into a blackhole between the doctors and the pharmacy.”
- “I used to leave my repeat prescription at the pharmacy for the next month. They would send the prescription request to the Dr and then txt me when it was ready. On occasions I found it had been sent to the wrong GP. It came to a point when I was frequently without medication because of this now I keep my repeat prescription and take it to the doctors now myself. The time it takes to get the prescription to the chemist and the medication ready now takes more than 7 days.”
- “I've had to change my pharmacy to another one due to long waiting times. 50mins waiting time was the last time I had to stand and wait...no explanation, no communication, by time I received my prescription there was 7 others also waiting and 5 where elderly with not even a chair to sit on...”
- “Being notified prescription is ready even though they have contact number they don’t notify, prescription is never ready and often not available that day”

The questionnaire then asked if there are any barriers to accessing services at a pharmacy that have not already been mentioned. The main themes of the 18 responses received were:

- Opening hours (eight people) – closed at lunchtimes, evenings and at the weekend,
- Inconsistent/inconvenient service offer (three people),
- Lack of delivery service (two people).

For the ten people who are dispensed to by their GP practice:

- Seven do not have a preferred time to use the dispensary, two said 14.30 to 18.30, and one said 12.00 to 14.30.
- Four do not have a preferred day, two said Thursdays, two said weekdays in general, one said Wednesdays and 10.0% said Fridays.

- Two people said there was time recently when they were not able to use the dispensary. One went to a pharmacy and the other waited until the dispensary was open.
- All seven people drive to the dispensary.
- For two people their journey takes less than five minutes, for five it takes between five and 15 minutes, for one person it takes more than 15 minutes but less than 20 minutes, and for two people it takes more than 20 minutes. These two people drive to the dispensary.
- One person said they have difficulty in getting to the dispensary because they work full time so have to ask a family member to collect their repeat prescription.

When asked if there is anything else they would like to say about their experience of the dispensary at their GP practice, the themes of the comments are as follows.

- Excellent customer service
- Limited opening hours/use of facilities on the NHS app
- Incomplete prescriptions received
- Preference for a pharmacy to be involved in the dispensing service.

One person said the dispensary opening hours is a barrier as they work during the same hours.

Six people said they also use a pharmacy.

1.5.4 Contractor engagement

An online questionnaire for pharmacies was undertaken, and the approach was taken to only ask contractors for information that could not be sourced elsewhere.

A copy of the questionnaire can be found in appendix I.

The questionnaire was open from 9 March to 7 April 2026 and the results are summarised below. 84 pharmacies in the health board's area responded.

81 pharmacies confirmed that the premises are accessible by wheelchair. 84 pharmacies confirmed that they have a consultation area, 77 of which are accessible by wheelchair with another one that is accessible being built for summer 2026.

Having a consultation area that meets four specific requirements is a pre-requisite for being able to provide the national pharmacy and dispensing appliance contractor services. The four requirements are as follows:

1. the consultation area is a closed room,
2. the consultation area is a designated area where both the patient and pharmacist can sit down together,
3. the patient and pharmacist able to talk at normal volumes without being overheard by pharmacy staff or visitors to the pharmacy, and
4. it is clearly designated as an area for confidential consultations distinct from the general public areas of the pharmacy.

Based on the responses from the pharmacies:

- 83 consultation areas meet requirements one, two and four, and
- 79 meet requirement three.

One pharmacy whose consultation area does not meet all the requirements confirmed it has alternative arrangements in place for confidential discussions.

56 have Welsh speakers in their staff, and 32 pharmacies provided information on languages other than English that are spoken by staff.

- Polish – 12 pharmacies
- Urdu – seven pharmacies
- Hindi – five pharmacies
- Gujarati – three pharmacies
- Romanian – three pharmacies
- Arabic – two pharmacies
- French – two pharmacies
- Malay – two pharmacies
- Punjabi – two pharmacies
- Spanish – two pharmacies
- Asante Twi, Begali, Farsi, German, Ghanaian, Italian, Mandarin, Parsi, Portuguese and South Korean – one pharmacy each.

Whilst pharmacies are required to dispense all valid NHS prescriptions for drugs, they may choose which appliances they supply “in the normal course of business”. 82 pharmacies confirmed that they dispense all appliances, one only dispenses dressings, and one doesn’t dispense any appliances.

81 of the pharmacies collect prescriptions from GP practices as a private, free-of-charge service.

66 pharmacies deliver dispensed items to patients as a private, free-of-charge service and 13 provide it as a private, chargeable service.

58 pharmacies restrict the service to elderly and housebound patients.

Six pharmacies restrict the delivery service to specified areas.

One pharmacy has an automated collection point at the premises and another plans to install one in 2026/27.

In order to assist in the identification of any gaps in the current provision of additional clinical services pharmacies were asked to confirm whether or not there is a requirement for an existing additional service which is not currently provided in the area, and to provide the evidence to support this. Six pharmacies suggested services.

- Extension of the pharmacist independent prescriber service outside of normal working hours.
- Travel health vaccinations on the NHS (two pharmacies).
- Blood pressure checks (two pharmacies).
- Ear microsuction via the NHS.

Six pharmacies suggested there is a requirement for the following new services.

- Inclusion of more prescribing services.
- Blood pressure checks (two pharmacies).
- Monitored dosage systems.
- Mole checking and cryotherapy.
- Increased vaccinations eg shingles.

When asked if there is a requirement for a new service that is not currently available the following were suggested:

- Blood pressure checking service
- Inclusion of more prescribing services
- Monitored dosage systems
- Mole checking service
- Cryotherapy
- Increased range of vaccinations, eg shingles.

Recognising that the demand for pharmaceutical services is increasing for a number of reasons including the continued increase in the number of items being prescribed and a growing population, the pharmacies were asking whether they can meet this increase.

- 76 pharmacies said that they have sufficient capacity within their existing premises to meet an increase in demand, seven pharmacies said they didn't but could make adjustments in order to do so, and one pharmacy said it does not have capacity and would have difficulty in managing an increase in demand.
- 23 pharmacies said that they have sufficient capacity within their existing staffing levels to meet an increase in demand, 57 pharmacies said they didn't but could make adjustments in order to do so. Four pharmacies did not respond to this question.

A number of the pharmacies have plans to develop or expand their service provision.

- Nine plan to start providing the pharmacist independent prescriber service in 2026, seven plan to increase provision of the service, and three have pharmacists who are training to become an independent prescriber.
- Eight have plans to expand the premises or relocate to new premises in order to incorporate more consultation rooms.
- One is exploring the option to extend its opening hours.
- One plans to start providing a smoking cessation service.
- One is looking into automation.

- One has a second pharmacist starting who will quality as an independent prescriber in 2026. It also has two technicians who are providing services under patient group directions.
- One plans to increase the provision of private service eg travel vaccinations and weight loss if there is no increase in NHS services.

An online questionnaire for dispensing practices was also undertaken and was open 9 March to 7 April 2026. As with pharmacies the approach was taken to only ask contractors for information that could not be sourced elsewhere.

A copy of the questionnaire can be found in appendix J.

Of the 34 dispensing practices six responded.

The opening hours of the dispensaries vary from practice to practice but generally reflect the opening hours of the practice premises ie Monday to Friday between 08.30 and 18.00.

With regard to dispensing appliances, all six said they dispense all types of appliances from the premises.

In relation to delivery services, three practices said they provide a delivery service, two to specific areas and one to housebound patients only. One practice said it used to provide a delivery service but stopped it in 2024.

Five practices confirmed that they have Welsh speakers in their staff. Other than English, no other languages were reported as spoken.

Three of the practices have sufficient capacity within their existing premises to manage an increase in demand for the dispensary service, two said they do not but could make adjustments, and one said it does not and would have difficulty managing an increase in demand. Two of the practices have sufficient capacity within their existing staffing levels to manage an increase in demand for the dispensary service, two said they do not but could make adjustments, and one said it does not and would have difficulty managing an increase in demand.

The following dispensing related services are also provided by the practices:

- Three provide medicines administration record charts to residents of care homes, and one provides them in general.
- Three provide blister packs.
- Three accepted sharps from patients.
- One has an automated collection point.

1.5.5 Consultation

A report of the consultation including any changes to the pharmaceutical needs assessment is included at appendix K.

2 Overview of North Wales

2.1 Introduction

North Wales has a resident population of 697,115 persons, living across an area of approximately 2,500 square miles. It is bordered by the Irish Sea to the north and west, Ceredigion and Powys to the south, and England to the east. The region is defined by coastland, rural areas particularly in the west, and more urban areas in the east predominantly in and around Wrexham and Deeside. The majority of settlements are along the coast, including resorts popular with tourists such as Rhyl, Llandudno, Pwllheli, Prestatyn and Tywyn. It is mountainous and contains Eryri National Park, and the mix of natural features is a strong draw for tourists and visitors.

There is a stronger sense of Welsh identity in the area, and it is home to more Welsh-language speakers than elsewhere in Wales.

Many rural areas have experienced migration patterns that have resulted in ageing populations with increasing health and social care needs. The provision of services to dispersed, isolated populations presents particular challenges.

North Wales is served by six unitary authorities:

- Conwy County Borough Council,
- Denbighshire County Council,
- Flintshire County Council,
- Gwynedd Council,
- Isle of Anglesey County Council, and
- Wrexham County Borough Council.

The map below shows the area covered by each council.

Map 2.1 – map of the geographical area for each unitary authority in North Wales

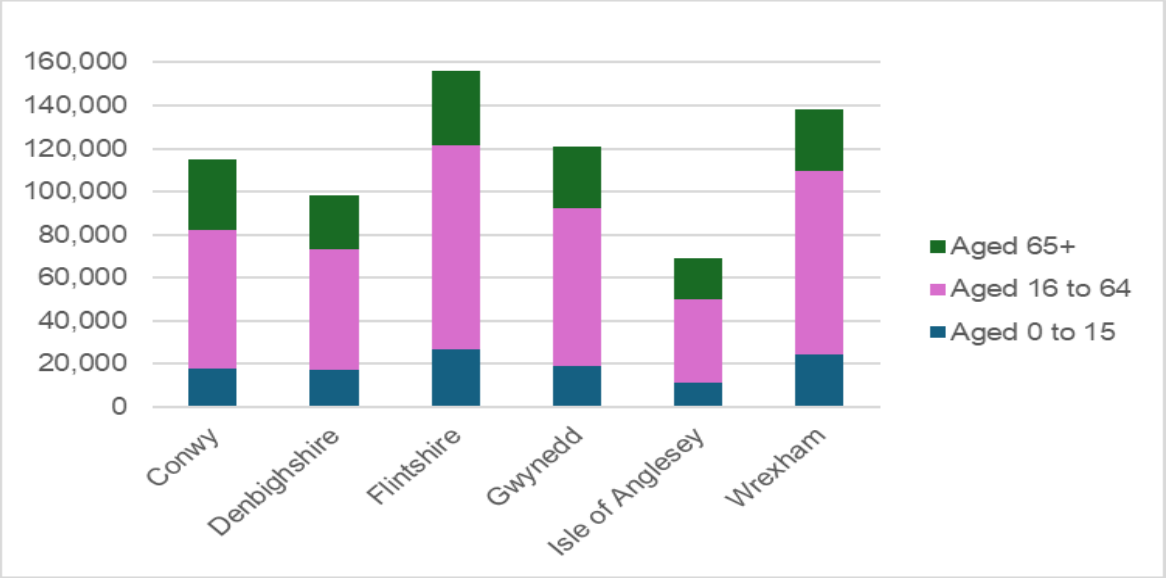


Betsi Cadwaladr University Health Board is the largest health organisation in Wales, and is responsible for providing primary, community, mental health and acute hospital services for the population of North Wales.

2.2 Population[1]

As can be seen from the figure below, Flintshire has the largest population (155,867) followed by Wrexham (138,245). Isle of Anglesey has the smallest population at 69,097.

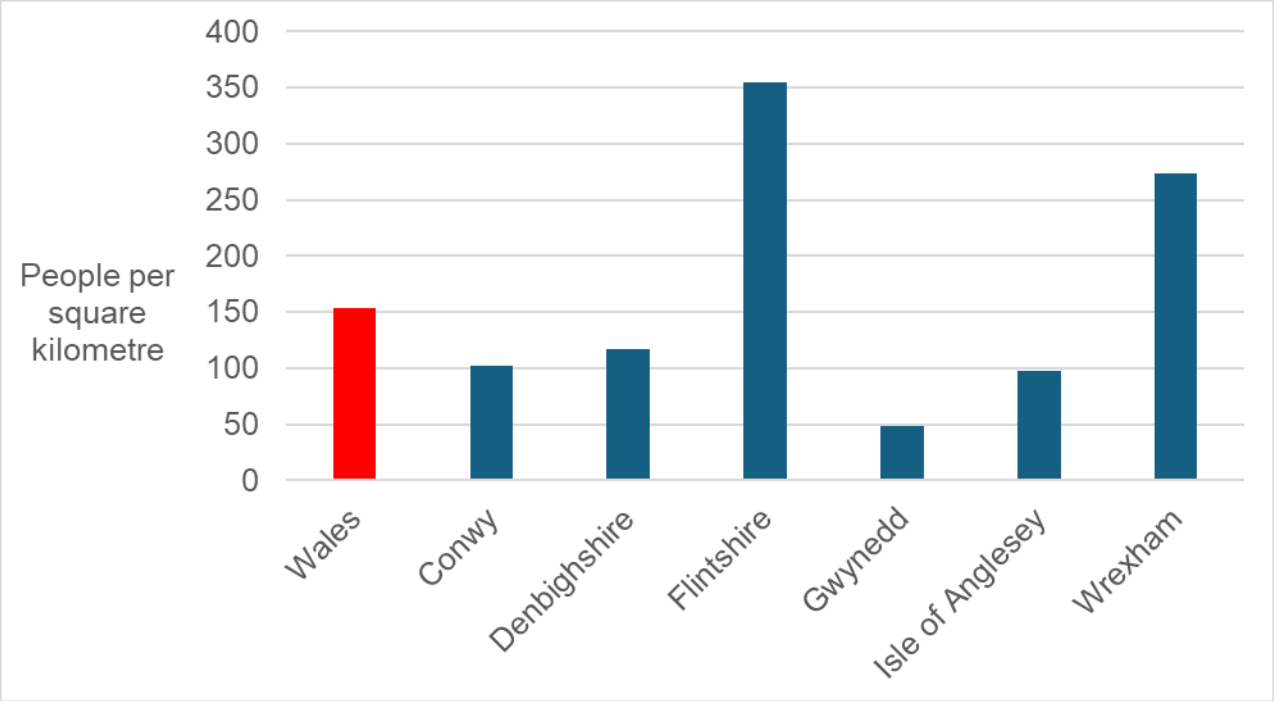
Figure 2.1 - population estimates, all persons, by age group, and unitary authority, 2024



The has been a general increase in population density across North Wales between 2020 and 2023. As shown in the figure below, population density is greatest in the east with both Flintshire and Wrexham having a greater density per square kilometre (354 and 274 respectively) than the average for Wales (154).

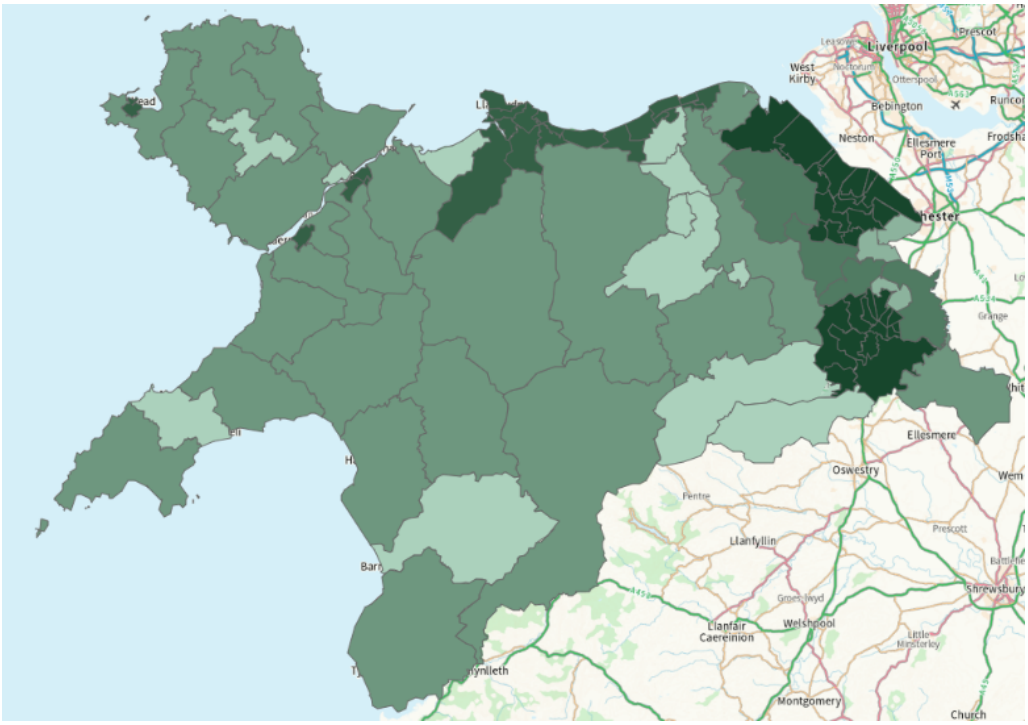
[1] StatsWales – Population estimates by local authority, year, sex and age mid-year 2024

Figure 2.2 – population density (persons per square kilometre) at local authority and Wales level, 2024



The map below reflects the generally rural nature of the western side of the health board's area compared to the more urban eastern side.

Map 2.2 – rural urban classification (2021) Betsi Cadwaladr University Health Board[2]



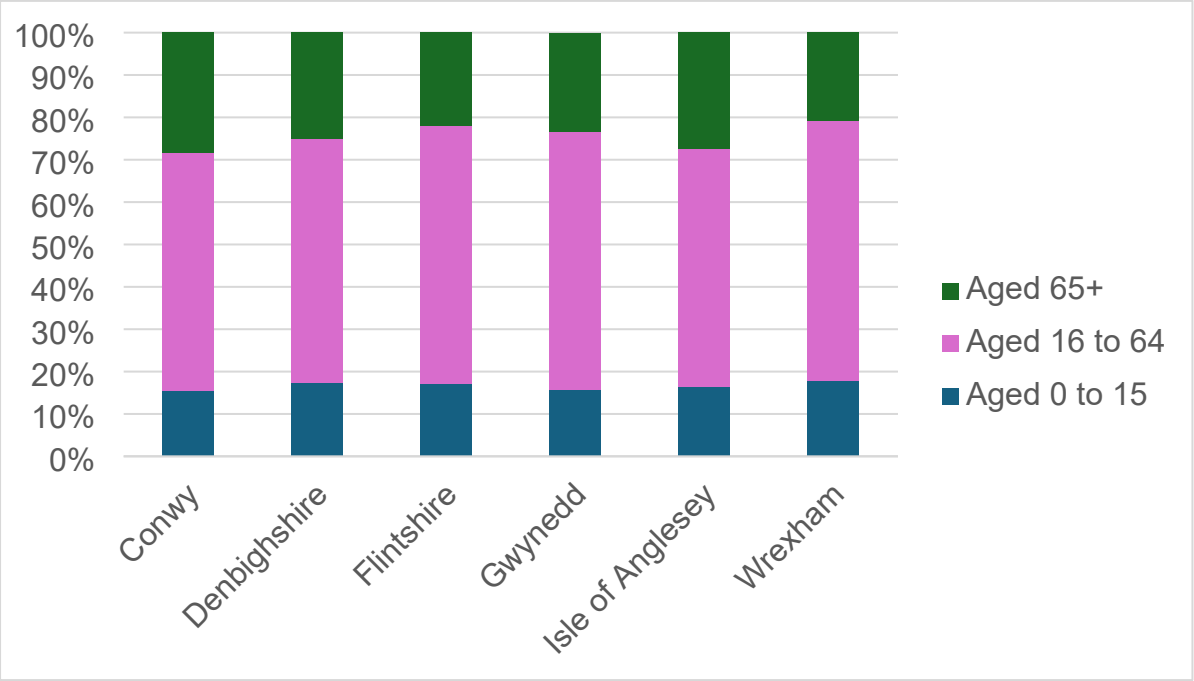
[2] Digital Health and Care Wales – Health Maps Wales

Contains OS data © Crown copyright and database rights 2026 (Terms), Polygon features source: Office for National Statistics licensed under the Open Government Licence c.3.0 Powered by ESRI

Larger rural: further from a major town city
Larger rural: nearer to a major town or city
Smaller rural: further from a major town or city
Smaller rural: nearer to a major town or city
Urban: further from a major town or city
Urban: nearer to a major town or city

Flintshire, Denbighshire, and Wrexham have a younger population with 17% of the population aged 15 years and under, and Isle of Anglesey and Conwy have an older population with 28.3% and 27.4%respectively aged 65 and over. The picture is similar for residents aged 85 years and over, with Conwy (3.9%) and the Isle of Anglesey (3.6%) having the highest proportions; only Wrexham (2.6%) is below the average for Wales (2.7%)

Figure 2.3 - population percentages, all persons, by age group, and unitary authority, 2024



The population of North Wales is increasing and ageing.

The overall population is expected to increase by just over 50,000 residents (6.8%) between 2022 and 2047. At unitary authority level, the largest increases are expected in Gwynedd (10.8%) and Denbighshire (10.4%). The smallest increase is predicted to be in Wrexham (2.4%).

Overall, the numbers of children and young people in the population have been decreasing across North Wales in the past decade. Table 2.1 shows the numbers of children and young people (aged 0 to 17 years) in North Wales have declined by around 6,200 between 2013 and 2023. The largest decline (1,350) has been in Wrexham.

Table 2.1 – number of people aged 0 to 65 years, North Wales and unitary authorities, 2013 to 2023[3]

Area	2023 number	2023 percent	2013 number	2013 percent	Change 2013-23
Isle of Anglesey	13,050	18.9%	13,650	19.6%	- 600
Gwynedd	21,700	18.2%	23,350	18.8%	- 1,650
Conwy	20,450	17.9%	21,700	18.8%	- 1,250
Denbighshire	19,300	19.8%	19,400	20.5%	- 100
Flintshire	30,800	19.8%	32,050	21.0%	- 1,250
Wrexham	27,750	20.4%	29,150	21.4%	- 1,350
North Wales	133,050	19.2%	139,300	20.2%	- 6,200

Numbers have been rounded so may not sum to total. Percentage is to the total population of the area.

Conversely, between 2013 and 2023, the population aged 65 and over in North Wales increased by 17,800, rising from 21.4% of the total population to 23.9% as can be seen from the table below.

Table 2.2 – number of people aged 0 to 17 years, North Wales and unitary authorities, 2013 to 2023[3]

Area	2023 number	2023 percent	2013 number	2013 percent	Change 2013-23
Isle of Anglesey	18,800	27.1%	16,500	23.6%	2,300
Gwynedd	27,950	23.4%	26,400	21.9%	1,500
Conwy	32,000	28.0%	29,450	25.5%	2,550
Denbighshire	24,300	25.0%	21,200	22.5%	3,100
Flintshire	34,050	21.9%	29,300	19.2%	4,750
Wrexham	28,300	20.8%	24,700	18.2%	3,550
North Wales	165,350	23.9%	147,550	21.4%	17,800

Numbers have been rounded so may not sum to total. Percentage is to the total population of the area.

[3] Office for National Statistics - Mid-year population estimates. Produced by the North Wales Regional Innovation Coordination Hub

2.3 Temporary residents

2.3.1 Long-term caravan residents

There is a high concentration of caravan sites on the coastal strip of North Wales, predominantly around Kinmel Bay and Towyn.

There are likely to be substantial numbers of long-term caravan residents in North Wales who access local health services. However, research from Lincolnshire[4] has found that the Census, electoral register and council tax register all seriously under-record this population. The omissions from the Census are particularly important because Census data (and the mid-year population estimates built upon Census data) plays a central role in public sector funding formulas.

Key findings on demography of the surveyed caravan population in Lincolnshire include:

- nearly three-quarters are over 55, and more than 40 per cent over 65,
- over 60% describe themselves as 'retired', and
- fewer than a quarter have a job – and this low figure includes a number of site workers for whom the caravan came with the job.

The households surveyed spend a large proportion of the year living in a caravan:

- 85% live on site for at least three months of the year,
- over 40% live on site at least nine months of the year,
- 43% don't return to another home elsewhere for part of the year,
- 39% consider their caravan or chalet to be their main home, and
- 39% are permanently registered with a GP at the caravan's address.

These findings may also be applicable to North Wales.

2.3.2 Tourists

North Wales is a prime tourist destination, predominantly for visitors from the North West of England/Merseyside (Liverpool and Manchester), who stay in coastal resorts such as Llandudno, Rhyl and Prestatyn. This large increase in the number of visitors, especially in the summer months, will lead to increased pressure on health care resources.

According to the 2024 Domestic Great Britain tourism statistics annual report, in 2024 there were 2.48 million overnight trips to North Wales by Great Britain residents. The number of nights spent away from home on these trips was approximately 8.19 million and the value of spending on these trips was £680 million[5]. It is to be noted that spend and visits remained behind pre-Covid levels.

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[4] Beatty, C., Fothergill, S., & Powell, R. (2012). Living in seaside caravans: new survey evidence and the implications for local authority funding. People, Place and Policy, 6(2), pp. 90-100

[5] Welsh Government – Domestic GB tourism statistics (overnight trips): annual report 2024

2.3.3 Second homes

The Council tax dwellings (CT1) data collection conducted by Welsh Government provides data on the number of dwellings eligible for council tax in each local authority[6]. Part of this return includes the number of chargeable second homes in each local authority area.

As can be seen from the figure below, in 2020/21 Gwynedd had the highest number of second homes (also the highest number in Wales), whereas Wrexham had the third lowest number of second homes in Wales after Blaenay Gwent (none) and Torfaen (sixteen).

Figure 2.4 – number of total chargeable second homes in North Wales, 2026/27

Local authority	Number of chargeable second homes
Conwy	1,508
Denbighshire	439
Flintshire	321
Gwynedd	5,004
Isle of Anglesey	2,297
Wrexham	63

2.4 Ethnicity

Most unitary authority areas across North Wales have a lower percentage of residents from ethnic minority backgrounds compared to the average for Wales (5.2%), with the exception of Denbighshire, also 5.2%.

Table 2.3 – ethnicity by ethnic group, Wales and North Wales unitary authorities, June 2023[7]

Area	All persons	White	Black, Asian and minority ethnic	Percentage of people who are Black, Asian and minority ethnic
Wales	3,149,100	2,982,400	165,200	5.2%
Betsi Cadwaladr University Health Board	703,300	676,300	26,600	3.8%
Conwy	115,500	113,300	2,200	1.9%
Denbighshire	95,900	90,900	5,000	5.2%
Flintshire	156,300	150,500	5,800	3.7%
Gwynedd	124,400	119,400	4,700	3.8%
Isle of Anglesey	70,100	67,600	2,400	3.5%
Wrexham	141,100	134,600	6,500	4.6%

[6] StatsWales, Council tax dwellings by authority and band
[7] Produced by Welsh Government using the Annual Population Survey

The proportion of people from ethnic minority backgrounds is higher for people aged under 65 at around 3.9%, so the number aged 65 and over may rise as these younger people age. However, around 19% of people from ethnic minority backgrounds aged 16 to 64 living in North Wales are full-time students (compared to 8% of white people). This is a highly mobile population who may move out of the area and be replaced by other students moving to the area rather than growing older in North Wales[8].

Table 2.4 – Population aged 65 years and over by broad ethnic group, North Wales and unitary authorities, 2021[9]

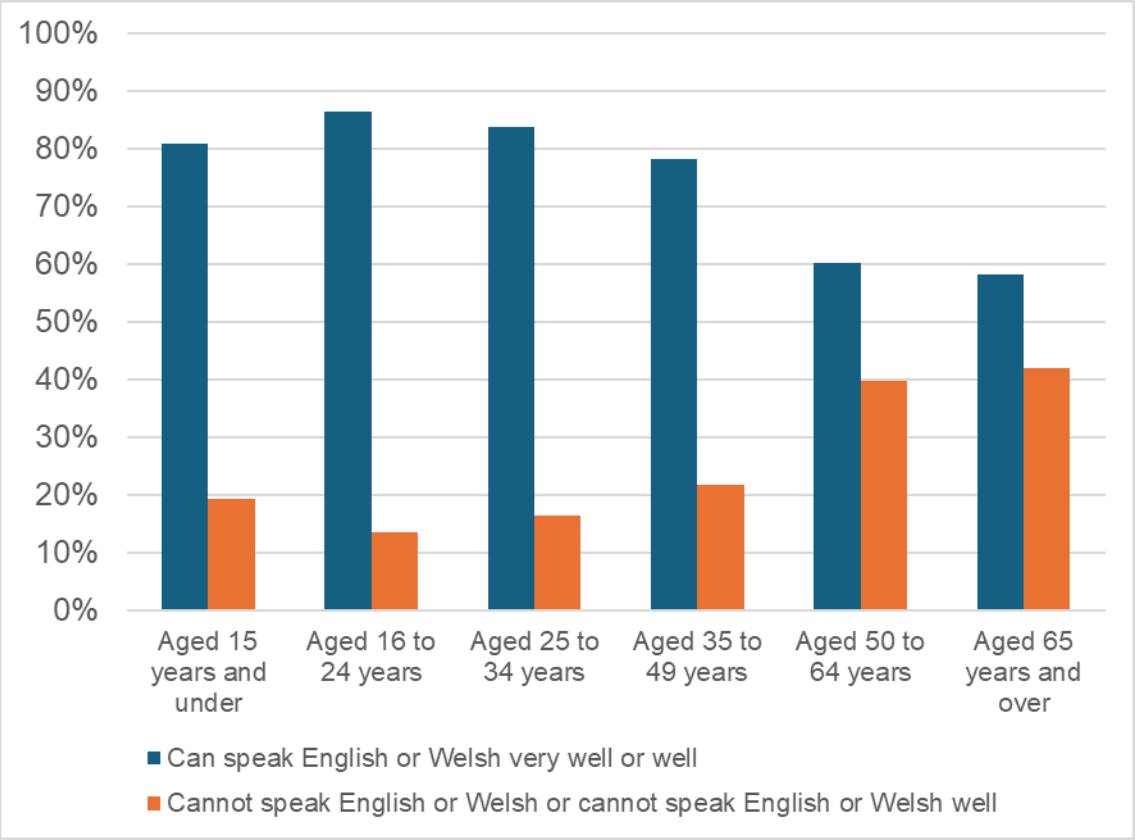
Area	All persons	White	Black, Asian and minority ethnic	Percentage of people who are Black, Asian and minority ethnic
Wales	3,149,100	2,982,400	165,200	5.2%
Betsi Cadwaladr University Health Board	703,300	676,300	26,600	3.8%
Conwy	115,500	113,300	2,200	1.9%
Denbighshire	95,900	90,900	5,000	5.2%
Flintshire	156,300	150,500	5,800	3.7%
Gwynedd	124,400	119,400	4,700	3.8%
Isle of Anglesey	70,100	67,600	2,400	3.5%
Wrexham	141,100	134,600	6,500	4.6%

2.5 Household language

The number of residents in the health board for whom English or Welsh is not their main language was 19,354 at the 2021 Census, with4,456 or 23.0% not able to speak English or Welsh or not able to speak either well[10]. As can be seen from the figure below the ability to speak English or Welsh very well or well reduces with age for those for whom English or Welsh is not their main language.

[8] North Wales Regional Innovation Coordination Hub, 2025
[9] Produced by North Wales Regional Innovation Co-ordination Hub using Census 2021 data
[10] Nomis 2021 Census RM111 – Proficiency in English by age

Figure 2.5 – Proficiency in English or Welsh by age



According to the 2021 Census, English or Welsh was the main language of the health board's residents based on the combination of adults and children aged three years of age and older (96.7%)[11]. The next eight most commonly spoken languages were:

- Polish - 0.7%
- Arabic – 0.3%
- Romanian – 0.2%
- Portuguese, Bengali (with Sylheti and Chatgaya), 'All other Chinese', Spanish and Bulgarian – 0.1% each

There is some variation at local authority level with fewer people who have English or Welsh as their main language in Wrexham (94.9%) compared to the other local authority areas (higher than 96% in each).

2.6 Welsh language skills[12]

For many Welsh speakers, being able to access services in Welsh significantly affects their overall experience as health and care service users.

[11] Nomis 2021 Census – TS024 – Main language
[12] StatsWales - percentage of adults who speak Welsh (including the percentage that cannot speak Welsh and have some Welsh speaking ability) by local authority

The proportion of adults aged 16 years and over in North Wales who can speak Welsh ranges from 12.4% in Flintshire to 64.0% in Gwynedd. The average for the whole of Wales is 18.0%.

The proportion of Welsh speakers is higher again in some communities in North Wales – in some electoral divisions (wards) in and around Caernarfon over 85% of the population are able to speak Welsh. Higher concentrations are generally found in rural areas and to the west of the region[13].

Table 2.5 - percentage of population (aged 16 years and over) able to speak Welsh, Wales and unitary authorities, 2022-23

	Speak Welsh	Cannot speak Welsh	Some Welsh speaking ability
Wales	18.0	66.0	15.9
Conwy	27.6	57.5	14.9
Denbighshire	20.9	56.3	22.7
Flintshire	12.4	65.4	22.2
Gwynedd	64.0	24.9	11.1
Isle of Anglesey	48.0	39.7	12.3
Wrexham	16.7	64.7	18.6

The Annual Population Survey 2025 in Wales records Welsh language ability and frequency. In 2025, almost 39% of residents in North Wales reported being able to speak Welsh. As can be seen from the table below, this ranges across the region from 15.5% in Flintshire to 72.7% in Gwynedd.

Table 2.6 – ability to speak Welsh, persons aged 3 years and over, Wales, health board and unitary authorities, March 2025[14]

Area	Population aged 3 years and over	Yes, can speak Welsh	No, cannot speak Welsh	People who say they can speak Welsh (%)
Wales				26.9
Betsi Cadwaladr University Health Board	694,900	269,500	425,300	38.8
Conwy	114,500	46,200	68,300	40.4
Denbighshire	94,600	30,500	64,000	32.3
Flintshire	154,300	23,900	130,400	15.5
Gwynedd	122,500	89,000	33,500	40.4
Isle of Anglesey	69,800	43,600	26,200	62.5
Wrexham	139,200	36,300	102,900	26.1

[13] North Wales Regional Innovation Coordination Hub, 2025
[14] StatsWales – Annual Population Survey Welsh language

2.7 Religion

In 2021, 51.6% of the North Wales population was made up of residents who stated that they followed one of the main six religions and 41.7% stated that they followed no religion.

The table below shows the variation between unitary authorities and compares these to the averages for Wales.

Table 2.7 – religion at unitary authority and Wales level[15]

Area	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other religion	No religion	Religion not stated
Conwy	50.8%	0.3%	0.2%	0.1%	0.7%	0.0%	0.5%	40.9%	6.4%
Denbighshire	49.3%	0.3%	0.2%	0.1%	0.8%	0.0%	0.5%	42.1%	6.7%
Flintshire	51.5%	0.3%	0.2%	0.0%	0.5%	0.0%	0.3%	40.7%	6.5%
Gwynedd	46.2%	0.4%	0.2%	0.1%	1.0%	0.0%	0.7%	44.2%	7.3%
Isle of Anglesey	51.5%	0.2%	0.1%	0.0%	0.5%	0.0%	0.4%	40.7%	6.5%
Wrexham	49.5%	0.3%	0.2%	0.0%	1.1%	0.1%	0.4%	41.8%	6.5%
Wales	43.6%	0.3%	0.4%	0.1%	2.2%	0.1%	0.5%	46.5%	6.3%

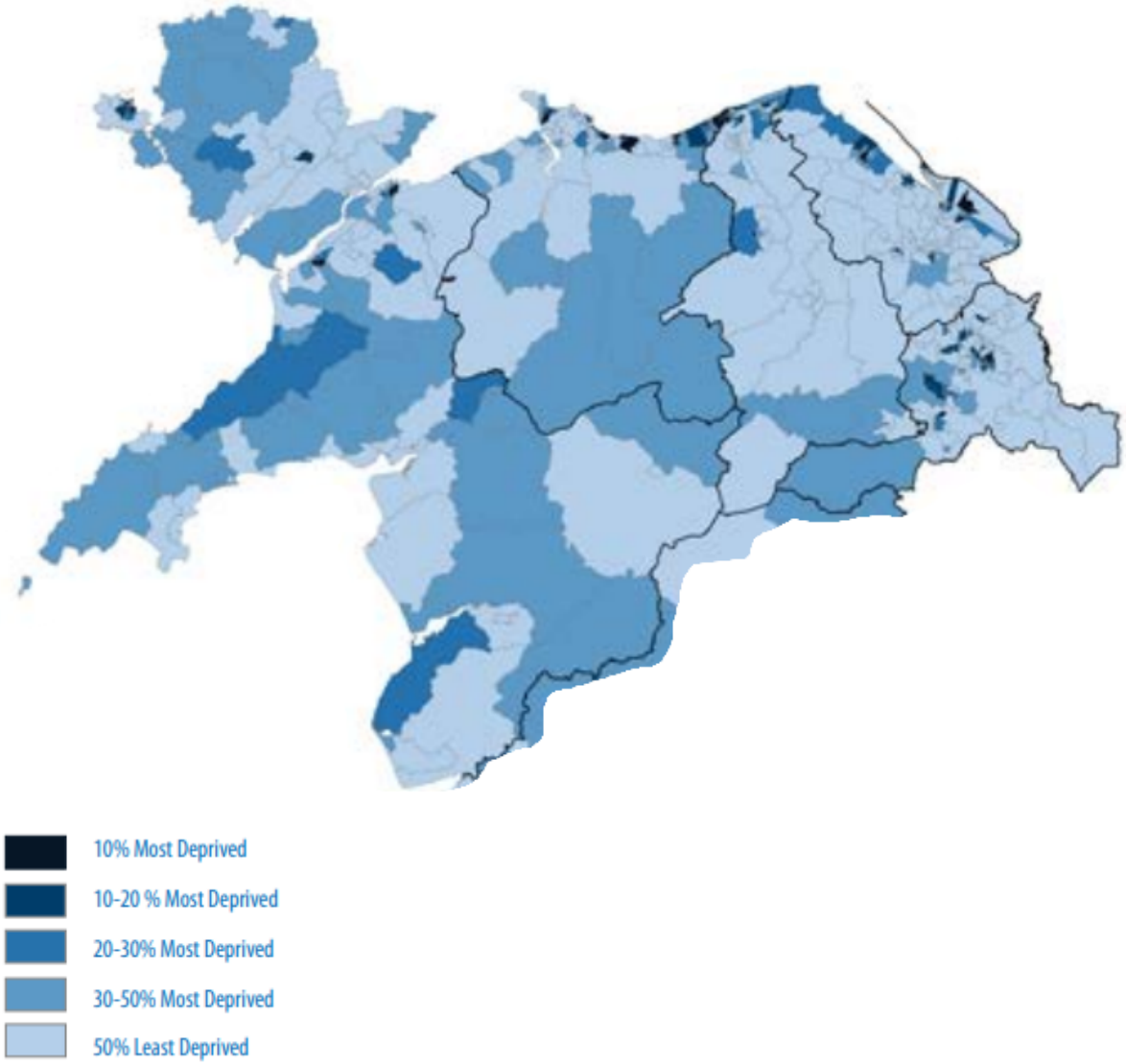
2.8 Welsh index of multiple deprivation[16]

The Welsh index of multiple deprivation is the official measure of deprivation for small areas in Wales. It is produced at lower super output area and is made up of eight domains: employment, income, education, health, community safety, access to services, housing, and physical environment. Each lower super output area is ranked from 1 (most deprived) to 1,917 (least deprived).

The map below shows the ranking of each lower super output area in North Wales.

[15] Nomis 2021 Census – TS030 - Religion
[16] Welsh Government - Welsh Index of Multiple Deprivation 2025

Map 2.3 – Welsh index of multiple deprivation, North Wales, lower super output areas, 2025



North Wales has some of the most deprived areas in Wales, particularly along the North Wales coastline. Rhyl West 2 is the most deprived lower super output area in Wales and Rhyl South West 2 is the fifth most deprived. The top ten most deprived lower super output areas in North Wales based on their overall ranking are shown in in the table below.

Table 2.8 – Welsh index of multiple deprivation ranks of ten most deprived lower super output areas in North Wales, 2025

Unitary authority	Lower super output area	Ranking
Denbighshire	Rhyl West 2	1
Denbighshire	Rhyl South West 2	5
Wrexham	Queensway 1	7
Denbighshire	Rhyl West 1	9
Denbighshire	Rhyl West 3	10
Denbighshire	Rhyl South West 1	21
Wrexham	Plas Madoc	22
Wrexham	Wynnstay	28
Conwy	Tudno 2	42
Wrexham	Queensway 2	54

The table below shows the percentage of living in the most deprived 20% lower super output areas by locality. Across the region, percentages range from 0% in Dwyfor and North Meirionnydd, and South Meirionnydd localities to 27.8% in North Denbighshire locality.

Table 2.9 – locality population in 20% most deprived lower super output areas, number and percentage, locality, 2025

Locality	Population	Percentage living in 20% most deprived areas	Locality deprivation quintile
Isle of Anglesey	65,980	14.8%	3
Arfon	67,340	11.3%	3
Dwyfor and North Meirionnydd	37,628	0.0%	5
South Meirionnydd	18,898	0.0%	5
Conwy East	52,247	21.3%	2
Conwy West	64,171	5.7%	4
North Denbighshire	61,847	27.8%	2
Central and South Denbighshire	42,795	3.5%	5
North East Flintshire	62,445	13.5%	3
North West Flintshire	40,671	18.9%	3
South Flintshire	52,774	2.8%	5
North and West Wrexham	36,303	8.4%	4
Central Wrexham	58.433	17.1%	3
South Wrexham	47,030	8.8%	4

2.9 Births

The total fertility rate is the average number of live children that a group of women would bear if they experienced the age-specific fertility rate in a particular year throughout their childbearing years. The rates in central and east areas of North Wales are slightly higher compared to Wales.

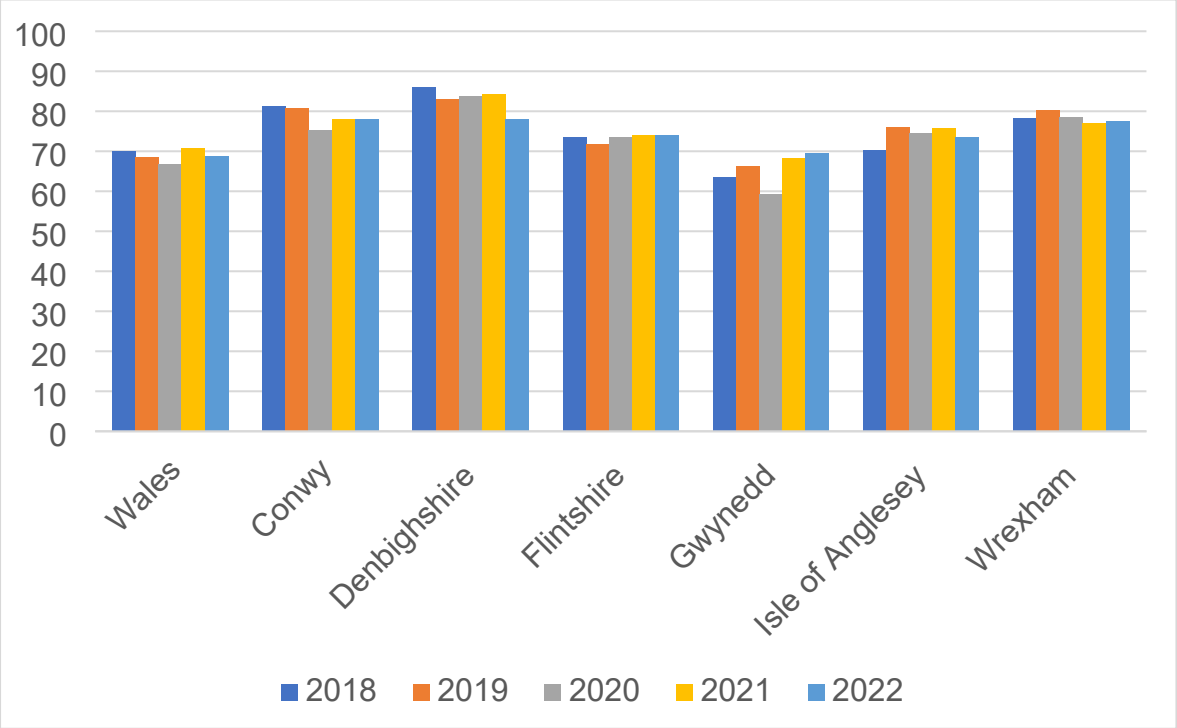
The general fertility rate is the total number of live births born to females aged between 15 and 44 years and provides a useful indicator when studying population growth and change. In 2024, the rates across North Wales were above the Wales average with the exception of Gwynedd.

Table 2.10 - live births and fertility rates, Wales and unitary authorities, 2024

Areas	Number of live births	Crude birth rate	General fertility rate	Total fertility rate
Wales	26,832	8.4	45.7	1.34
Conwy	503	7.3	48.6	1.5
Denbighshire	780	7.9	49.2	1.5
Flintshire	1,331	8.8	49.8	1.5
Gwynedd	945	7.8	42.7	1.3
Isle of Anglesey	503	7.3	48.6	1.5
Wrexham	1,222	8.8	49.8	1.5

Conception rates across North Wales are shown in the figure below. The data includes pregnancies that result in one or more live or still births and legal abortions; they do not include miscarriages or illegal abortions. In 2022, Conwy and Denbighshire had the highest rates at 78 per 1,000 females and Isle of Anglesey had the lowest, 73.6 per 1,000 females.

Figure 2.6 – conception rate per 1,000 females, Wales, and unitary authorities 2018 to 2022[17]



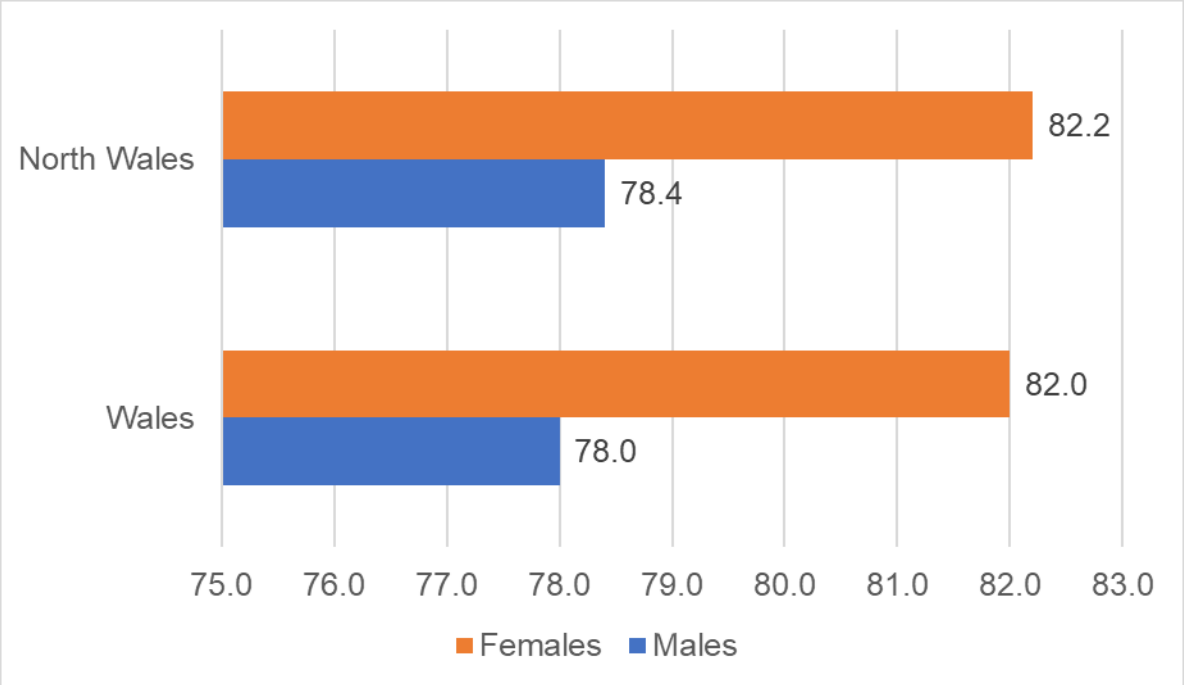
2.10 Life expectancy

Life expectancy at birth provides an estimate of the average number of years a new-born baby could expect to live, if the current mortality rates for the area are applied throughout their lives. As mortality rates are likely to change and people move areas, life expectancy provides a comparative population measure of mortality of those living in an area rather than an exact prediction of individual life expectancy for a new-born[18].

As can be seen from the figure below, the average life expectancy for males (78.4 years) and females (82.2 years) in North Wales is similar to Wales.

[17] Office for National Statistics
[18] Public Health Wales, 2020

Figure 2.7 – life expectancy at birth, years, males and females, Wales and North Wales, 2021-23[19]



At unitary authority level, life expectancy for females in Denbighshire is statistically significantly lower than Wales and in Gwynedd it is statistically significantly higher than Wales.

For males, life expectancy in Wrexham unitary authority is statistically significantly lower, whereas it is statistically significantly higher in Gwynedd compared to Wales.

There are inequalities in life expectancy between the most and least deprived members of the population. Males living in the most deprived communities across North Wales can expect to live around seven years less than males in the least deprived communities. The difference for females is around six years.

2.11 Mortality[20]

Indicators derived from mortality (death) rates provide a good picture of overall population health. However, small area mortality rates do not take into account unusual demography, such as high numbers of residents in nursing homes, which might alter the expected pattern of mortality.

2.11.1 Premature deaths from key non-communicable diseases

The North Wales rate for premature deaths from key non-communicable diseases is 311 per 100.000, similar to the Wales average of 310. The indicator includes the following diseases:

[19] Produced by Public Health Wales using data published by the Office for National Statistics
[20] Betsi Cadwaladr University Health Board – Health and wellbeing profile 2026

- Diseases of the circulatory system
- Malignant neoplasms (excluding other and unspecified malignant neoplasm of skin)
- Diabetes mellitus
- Diseases of the respiratory system except infections

Premature deaths from key non-communicable diseases in the most deprived communities in Wales are more than twice the rate in the least deprived communities. Wrexham has the highest rate at 337 per 100,000 persons aged 30 to 70 years, followed by Denbighshire at 335. Gwynedd has the lowest rate at 291.

2.11.2 Mortality by cause

All-cause mortality rates for all persons in North Wales are lower than the Wales average but not statistically significantly lower than Wales. At locality level, rates are statistically significantly higher than Wales in North Denbighshire and statistically significantly lower in Central and South Denbighshire, Conwy West, South Flintshire and South Meirionnydd.

The table below lists the mortality rates (by cause) that are statistically significantly different compared to Wales.

Table 2.11 – comparison of North Wales mortality rates with Wales averages, 2024

Cause of mortality	Localities where the mortality rate is statistically significantly higher	Localities where the mortality rate is statistically significantly lower
Diseases of the circulatory system	North Denbighshire	Central and South Denbighshire South Meirionnydd
Diseases of the respiratory system	(nil)	South Flintshire
Cancers	(nil)	(nil)
Mental and behavioural disorders	(nil)	Conwy West

2.11.3 Avoidable mortality

Avoidable mortality refers to deaths caused by certain conditions, for which effective medical and public health interventions are available, they should be rare and ideally should not occur. It can be split into preventable mortality and treatable mortality.

- Avoidable mortality – the total of preventable and treatable deaths.
- Preventable mortality – causes of death that can be mainly avoided through effective public health and primary interventions.

- Treatable mortality – causes of death than can be mainly avoided through timely and effective healthcare interventions, including secondary prevention and treatment.[21]

Around one in five deaths in 2023 were considered preventable or treatable in England (21.6%) and in Wales (22.7%). This is a similar proportion of avoidable deaths to the previous year and are still higher than pre-coronavirus (Covid-19) pandemic levels.

Avoidable mortality rates are higher in more deprived areas. In Wales, the most deprived quintile's avoidable mortality rate is 2.7 times higher than the least deprived quintile for both males and females.

The leading cause of avoidable mortality in Wales (and England) is cancer followed by diseases of the circulatory system. Avoidable mortality due to alcohol- and drug-related causes has been increasing since 2001 with the largest rises seen from 2019 onwards.

At unitary authority level, rates for avoidable and treatable mortality are statistically significantly higher in Wrexham compared to Wales.

At locality level, avoidable mortality rates in North Denbighshire are statistically significantly higher compared to Wales; in South Meirionnydd rates are statistically significantly lower compared to Wales. Rates in North Denbighshire are also statistically significantly higher compared to Wales for treatable mortality.

2.12 People with disabilities

2.12.1 People with learning disabilities

The main sources of routinely available data on the number of people with a learning disability are in primary care and local authorities. GP practices hold learning disability registers which are used as part of the Quality assurance and improvement framework reporting.

These registers can provide very rough estimates of the number of people with a learning disability; however, it should be noted that there are variations in the coding and recording of chronic conditions by practices.

In 2025, 3,946 patients were registered has having a learning disability by their GP. The highest numbers of people registered as having a learning disability are in North Denbighshire and Arfon.

Local authorities in Wales are required to record the number of placements for people with learning disabilities. Placements include:

- community, for example own home, family home and supported living,

[21] Public Health Wales - Public Health Outcomes Framework 2025

- health service accommodation,
- local authority accommodation, and
- private or voluntary accommodation.

Unitary authority registers, however, may underestimate the total number of people with learning disabilities as registration is voluntary. It is believed only one in four people with a learning disability in Wales are known to social services[22].

In 2021-22, there were almost 3,100 recorded placements for people with learning disabilities in North Wales. The highest number of placements were in Flintshire (around 1,000)[23].

2.12.2 People with physical disabilities

Data is also limited on the numbers of people with a physical disability. Local authority disability registers are also likely to underestimate the true numbers of people with a physical disability in North Wales.

Table 2.12 - numbers on unitary authority disability registers, 2021/22

Area	Total severely sight impaired	Total sight impaired	Total with hearing impairment	Physical disability only	Total without visual disability	Total disabled persons on register
Betsi Cadwaladr University Health Board	770	929	568	4,878	5,464	7,163
Conwy	61	36	38	1,579	1,617	1,714
Denbighshire	150	77	224	-	224	451
Flintshire	116	319	236	1,349	1,585	2,020
Isle of Anglesey	162	141	22	863	885	1,188
Wrexham	38	65	29	30	59	162

Across North Wales, 39 per 1,000 residents are living with sight loss compared to 35 per 1,000 across Wales. Conwy has the highest rate at 48 per 1,000.

The rate of residents who are registered blind in North Wales (429 per 100,000) is higher than the all-Wales rate (417 per 100,000). At unitary authority level, Conwy has the highest rate (586 per 100,000) and Denbighshire has the lowest (424 per 100,000). The number of people with sight loss in North Wales is predicted to increase by 17% from 2022 to 2032[24].

[22] Mencap – About learning disability
[23] StatsWales
[24] Royal National Institute of Blind People – sight loss data tool

Conwy also has the highest rates for moderate or severely hearing impaired and profoundly hearing impaired, as well as the estimated numbers and rates of people living with dual sensory loss.

2.13 Household composition[25]

With regard to the composition of the households in North Wales, as of the Census 2021:

- 32.2% were one person households (of which 49.1% are persons aged 66 and over),
- 63.4% were single families,
- 4.4% were other household types.

At unitary authority level, Gwynedd has the highest proportion of one-person households across North Wales at 34.6% with Flintshire having the lowest (29.1%). However, Conwy has the highest percentage of one person households occupied by someone aged 66 and over at 17.8%. Wrexham has the lowest proportion at 13.9%.

Table 2.13: Number and percentage of one person households, Wales and unitary authorities, 2021

Area	One-person households		One-person households: aged 66 years and over	
	Number	Percentage	Number	Percentage
Wales	429.559	31.9%	196,056	14.6%
Conwy	17,909	34.3%	9,318	17.8%
Denbighshire	14,107	33.3%	6,982	16.5%
Flintshire	19,471	29.1%	9,639	14.4%
Gwynedd	17,644	34.6%	8,472	16.6%
Isle of Anglesey	10,189	33.1%	5,223	16.9%
Wrexham	17,662	30.5%	8,042	13.9%

2.14 Car ownership[26]

According to the 2021 Census data:

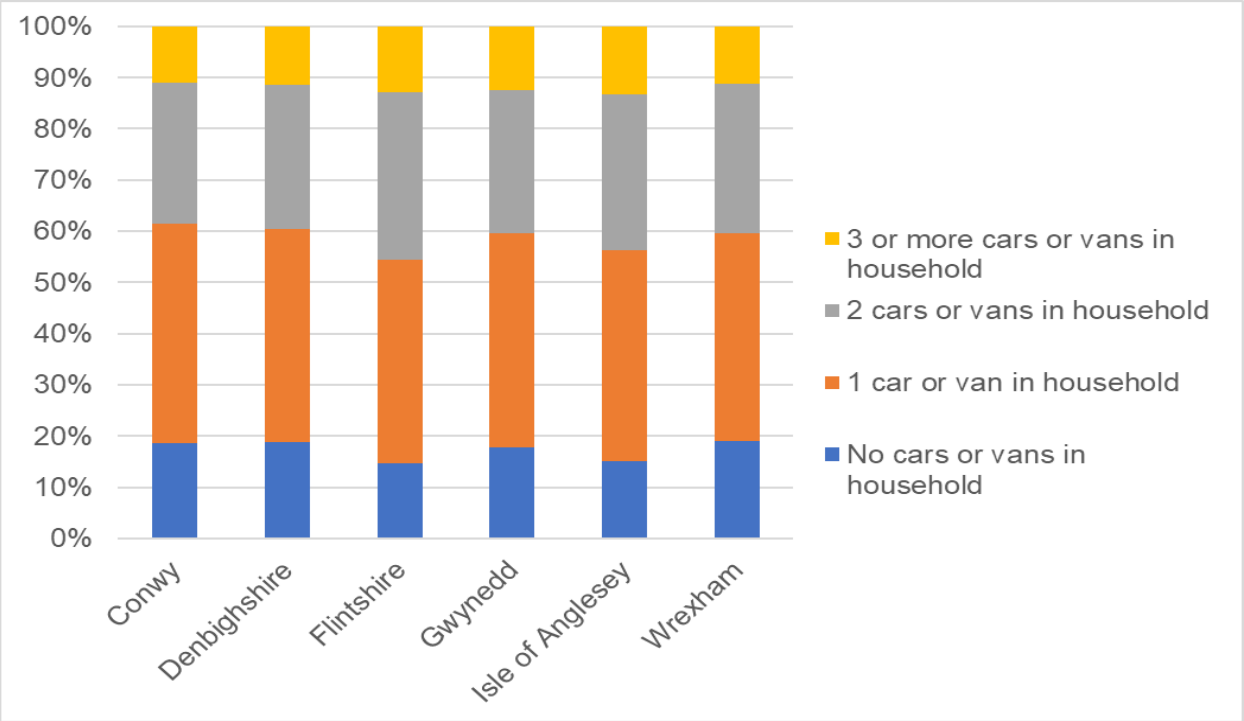
- 17.5% of the households in North Wales did not have a car or van,
- 41.3% had one car or van,
- 29.3% had two cars or vans, and
- 11.8% had three cars or vans.

The level of car ownership in North Wales has increased since the 2011 Census when 22.9% of households did not have a car or van.

[25] Nomis 2021 Census – TS003 – household composition
[26] Nomis 2021 Census – TS045 – car or van availability

The figure below shows the variation at local authority and Wales level. As can be seen, in general car ownership is higher in Flintshire than in the other unitary authority areas, with more households having two or more cars or vans (45.6%) compared to both the average for North Wales (41.4%) and Wales as a whole (38.8%). Wrexham has the highest proportion of households without a car or van (19.1%).

Figure 2.8 – car ownership at local authority level



2.15 Economic activity

According to the Census 2021[27], 54.9% of the population aged 16 years and over is economically active (excluding full-time students), 43.2% is economically inactive and 1.9% is economically active and a full-time student.

In relation to the population as a whole, rates of people who are:

- economically active are highest in Flintshire (58.9%) and lowest in Conwy (52.0%),
- economically active and a full-time student are highest in Gwynedd (2.7%) and lowest in Conwy and Isle of Anglesey (1.5% each),
- economically inactive are highest in Conwy (46.5%) and lowest in Flintshire (39.4%).

[27] Nomis 2021 Census – TS066 economic activity status

2.16 Sexual orientation

For the first time in its history, the Census 2021[28] included a voluntary question for those aged 16 and over and asked, “Which of the following best describes your sexual orientation?”.

Sexual orientation is an umbrella term covering sexual identity, attraction, and behaviour. For an individual respondent, these may not be the same. For example, someone in an opposite-sex relationship may also experience same-sex attraction, and vice versa. This means the statistics should be interpreted purely as showing how people responded to the question, rather than being about whom they are attracted to or their actual relationships.

- 89.4% stated that they are straight or heterosexual,
- 8.1% did not answer the question,
- 1.3% stated that they are gay or lesbian,
- 1.0% said bisexual,
- 0.1% said pansexual, and
- 0.1% said all other sexual orientations.

2.17 Unpaid carers

Over 66,600 residents of North Wales were identified as an ‘unpaid carer’ in the 2021 Census; this is 9.7% of the population, similar to the Wales average (Table 2.14).

Table 2.14 – number and percentage of residents providing unpaid care in Wales, health board and the unitary authorities, 2021[29]

Area	Number	Percentage
Wales	310,751	10.0%
Betsi Cadwaladr University Health Board	66,663	9.7%
Conwy	11,640	10.1%
Denbighshire	10,169	10.6%
Flintshire	15,262	9.8%
Gwynedd	9,988	8.5%
Isle of Anglesey	6,746	9.8%
Wrexham	12,858	9.5%

The 2021 Census also showed:

- The number of hours of care provided each week has increased since 2011,
- 59% of unpaid care is provided by women,
- unpaid carers are most likely to be aged 50 to 64 years,

[28] Nomis 2021 Census – TS079 – sexual orientation
[29] Nomis 2021 Census – TS039 – Provision of unpaid care

- unpaid carers are more likely to be economically inactive compared to non-carers, and
- unpaid carers are more likely to be in poor health themselves and to have a disability compared with the non-carer population.

At locality level, North Denbighshire has the highest proportion of unpaid carers (11.4%) and the highest numbers at just over 6,500 and Arfon has the lowest proportion at 8.1%.

2.18 Gypsy and Irish Traveller communities

The 2021 Census[30] showed the following numbers of people identified as White: Gypsy or Irish Traveller:

- Conwy - 75
- Denbighshire - 48
- Flintshire - 123
- Gwynedd – 100
- Isle of Anglesey - 54
- Wrexham – 109

These figures compare to a total of 3,370 across the whole of Wales or 15.1% of the total population.

However, it is likely that many households would not have completed the census – both because they were living on 'unauthorised sites' or encampments and as such did not appear on official records or because of a mistrust of the purpose of the census. In addition, potential lower than average literacy levels may have meant that some households would not have completed the Census, and where they were completed, some households would have chosen not to identify as Gypsy or Irish Travellers.

According to the Gypsy and Traveller caravan count in January 2025[31] there were 315 caravans in North Wales. The table below shows the number of caravans at unitary authority level. As can be seen, the highest number of caravans is in Flintshire and the lowest in Conwy and Denbighshire.

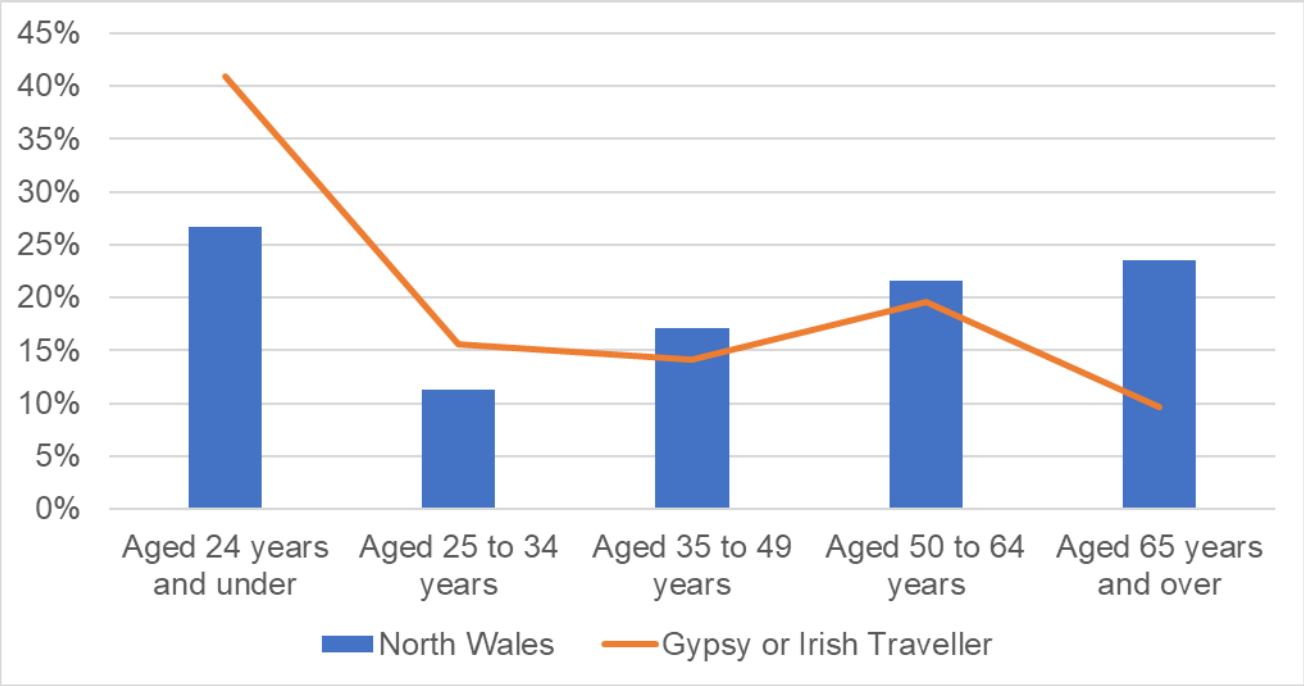
[30] Nomis 2021 Census – TS022 - ethnic group
[31] Welsh Government - Gypsy and traveller caravan count, January 2025

Table 2.15 - number of caravans by authorisation and local authority

Area	Number of caravans on authorised sites	Number of caravans on unauthorised sites	Total
Conwy	4	0	4
Denbighshire	4	0	4
Flintshire	167	64	231
Gwynedd	14	4	18
Isle of Anglesey	0	14	14
Wrexham	37	7	44

The age profile of the community in North Wales illustrates the extent of the life expectancy issue for travellers. In comparison to the general profile, the age structure is heavily concentrated at the lower age bands, generally running above proportional figures for North Wales until the age of 35, after which it drops below particularly from the age of 65 onwards. Whilst cultural factors play a considerable role in their poor health, part of this issue may also be engagement with services and the proximity of sites to healthcare services.

Figure 2.9 - Age profile for the health board's population and Gypsy or Irish Traveller community 2021[32]



2.19 Offenders

The population of those who are designated as offenders covers two specific groups.

[32] Nomis 2021 Census – TM032 - ethnic group by sex by age

The first is the population of HMP Berwyn the Category C (training prison) adult male prison in Wrexham, housing approximately 2,100 men

The second group of offenders are those no longer serving prison terms; this may include those serving suspended sentences, those on probation, and those living in secure accommodation.

“Approved premises” are hostel-type accommodation which has been approved for the temporary supervision and rehabilitation of offenders and for people on bail. There are two approved premises in North Wales for adult men – Plas Y Wem in Wrexham and Ty Newydd in Gwynedd. There are none for women.

Bail accommodation holds people on bail and on Home Detention Curfew – these are adults who need a suitable address, or some support, so that they can be released. There are two in North Wales, in Wrexham. One has three female places and the other has three male places.

There are no local secure provisions in North Wales for young people who are remanded into Youth Detention Accommodation or sentenced by the Courts to custodial sentences (Detention and Training Orders or Section 90-92 sentences from Crown Courts). This presents a significant issue, including around Welsh language, and it is not anticipated to change.

2.20 Homeless and rough sleepers

In 2024/25, across Wales, the main reasons for households being assessed as threatened with homelessness with 56 days were:

- “Loss of rented or tied accommodation” – 33% of cases,
- “Parent, or other relative or friends were no longer willing to accommodate” – 26%,
- “Breakdown of a relationship with a partner” – 13%, and
- “Rent or mortgage arrears” – around 9%[33].

The main reasons for a person becoming homeless in 2024/25 were:

- “Parent, or other relative or friends were no longer willing to accommodate” - 30%),
- “Breakdown of a relationship with a partner” - 20%,
- “Loss of rented accommodation” - 15%,
- “Prison leaver” – 12%, and
- “Other (including homeless in emergency, returned from abroad, sleeping rough or in hostel)” – 10%.

For those who were assessed as unintentionally homeless and in priority need the main reasons were:

- “Parents or other relatives or friends no longer willing to accommodate” - 29% of all cases,

[33] Welsh Government - Homelessness: April 2024 to March 2025

- “Breakdown of relationship with partner” - 20%,
- “Loss of rented or tied accommodation” - 18%,
- “Other (including homeless in emergency, returned from abroad, sleeping rough or in hostel)” - 10%, and
- “Prison Leaver” – 9%.

In 2024/25, 2,436 households in North Wales were assessed as eligible, homeless subject to duty to help to secure accommodation. Flintshire had the highest number of households at 633, followed by Conwy with 537. Isle of Anglesey had the lowest number of households at 240[34].

A count of rough sleepers is undertaken by unitary authorities and their partners to give a single night snapshot. The estimated count is based on data collected over a two-week period. For the purposes of the count a rough sleeper is defined as persons who are sleeping overnight in the open air (such as shop doorways, bus shelters or parks) or in buildings, vehicles or other places not designed for habitation (such as stairwells, barns, sheds, car parks, tents, cars/vans).

The figure below shows the number of rough sleepers on a one-night count on 28 February 2026.

Figure 2.10 – rough sleeper count, 2026[35]

Area	Total count of rough sleepers
Conwy	1
Denbighshire	1
Flintshire	8
Gwynedd	8
Isle of Anglesey	4
Wrexham	2

[34] StatsWales - Households found to be eligible, homeless subject to duty to help to secure during the year: Main reason for loss of last settled home by type of household (Section 73)
[35] Welsh Government - Rough sleepers by local authority

3 General health needs of North Wales

3.1 Cancer [36]

Cancer is a major cause of ill health and according to Cancer Research UK one in two people in the UK will get cancer in their lifetime. It is a group of 200 diseases which together impose a heavy burden of disease.

Cancer causes around one in four of all deaths of people living in Wales (2024). Lung cancer is the leading cause of cancer death in Wales and in 2024, it caused 1,759 deaths, almost twice as many as the next most common cause. Other cancers that caused more than 500 deaths in 2024 were colorectal cancer (987), cancer of unknown primary origin (659), prostate cancer (624), breast cancer (590, of which 589 were female breast), and pancreatic cancer (555).

In North Wales[37], as in Wales as a whole, prostate, breast, colorectal, and lung cancers are the most common types of cancer for all persons (2022-2022). For men, the top four cancers are prostate, colorectal, lung, and melanoma of the skin, whilst for women it is breast, lung, colorectal, and uterine.

In 2015, over 7,000 new cancer cases (around four in ten) in Wales each year, were linked to risk factors that can be changed[38]. Lung, colorectal, melanoma of the skin, and breast cancer together accounted for over three fifths of potentially preventable cancer cases. A range of factors influence a person's risk of developing cancer during their lifetime and some of the most important risk factors for cancer can be modified.

- Smoking,
- Living with overweight or obesity,
- Getting too much ultraviolet radiation (from the sun or sunbeds),
- Being exposed to harmful substances at work (like asbestos),
- Certain infections (like human papillomavirus),
- Drinking alcohol,
- Eating too little fibre,
- Being exposed to ionising radiation, and
- Eating processed meat.

However, some of these factors cannot be modified as they relate to things like age, sex, and genetic make-up.

Different cancers have different risk factors; some of these are only a risk factor for certain cancer types, while others are a risk factor for many different types of cancer.

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[36] NHS Wales Public Health Wales - Cancer in Wales – trends and projections (September 2025)
[37] NHS Wales Public Health Wales - Cancer reporting tool Wales (March 2026)
[38] Brown, K.F., Rumgay, H., Dunlop, C. *et al.* The fraction of cancer attributable to modifiable risk factors in England, Wales, Scotland, Northern Ireland, and the United Kingdom in 2015. Br J Cancer **118**, 1130–1141 (2018)

It has been estimated that approximately 40% of cancers are directly related to these modifiable lifestyle behaviours.

Across North Wales there is inequity in survival rates for certain cancers with those living in greater socioeconomic deprivation more likely to present with new cancers, but less likely to survive than those who are more affluent.

In relation to all malignancies (excluding non-melanoma skin cancers) for the period 2020 to 2022[39], Wrexham had the highest European age-standardised rate per 100,000 population for all persons (636.6) with Denbighshire the second highest (634.7). These figures compare to a Welsh average of 596.0. Gwynedd, at 587.8, had the lowest rate in North Wales.

3.2 Cardiovascular disease

Cardiovascular diseases affect the blood supply to the heart and other vital organs and include[40]:

- Congenital heart disease,
- Coronary heart disease,
- Cerebrovascular disease
- Deep vein thrombosis and pulmonary embolism
- Heart failure,
- Atrial fibrillation,
- Rheumatic heart disease,
- Stroke, and
- Peripheral vascular disease.

As with cancer, taking steps to modify lifestyle behaviours will help reduce the risk of cardiovascular disease. The main risk factors include:

- Alcohol,
- Diabetes,
- High blood pressure,
- High cholesterol levels,
- Physical inactivity,
- Unhealthy diet,
- Overweight and obesity, and
- Smoking.

Non-modifiable risk factors include age, male gender, ethnicity, and family history of premature cardiovascular disease.

[39] NHS Wales Public Health Wales - Cancer reporting tool Wales (March 2026)
[40] World Health Organization - Cardiovascular disease (31 July 2025)

3.3 Diabetes

There are two main types of diabetes, type 1 and type 2, with the latter being much more common. It can be preceded by a pre-diabetic state in which levels of sugar in the blood are raised but are not yet high enough to diagnose diabetes.

People with type 1 diabetes are at greater risk of developing other autoimmune conditions such as coeliac disease or thyroid disease. In addition, it can increase the risk of cancer of the liver, pancreas, kidney and stomach. However, there is some evidence that type 1 diabetes may reduce the risk of cancers of the prostrate or breast.

Those with type 2 diabetes have an increased risk of cancers of the bowel, liver, breast and pancreas, as well as thyroid disease.

Other complications of diabetes include kidney failure, eye disease and circulatory and neurological problems in the foot and leg. Diabetes is more common in socio-economically deprived communities and in Black and Asian people.

According to Diabetes UK[41], Wales has the highest prevalence of diabetes in the UK, with more than 207,000 people, or 8% of the population, living with diabetes. The numbers are rising each year, in part due to a growing rate of type 2 diabetes diagnoses. Estimates suggest that there are a further 65,000 people with type 2 who have not yet been diagnosed.

An updated cost-of-illness analysis estimated the direct cost of diabetes in the UK at £10.7 billion in 2021/22, with over 60% of this spending attributed to managing complications. Diabetes is now estimated to account for more than 6.0% of the UK health budget. Historic modelling had previously projected that diabetes would represent around 10% of total health expenditure, potentially rising to 17% by 2035 to 2036 if trends continued.

In Wales, projections indicate that an additional 48,000 people could be living with diabetes by 2035, bringing the total to around one in 11 adults. The financial burden is significant, with diabetes-related hospital admissions costing an average of £4,518 per spell in 2021/22 (excluding those involving amputations), and prescription costs for diabetes medications reaching £105 million in 2022 to 2023.

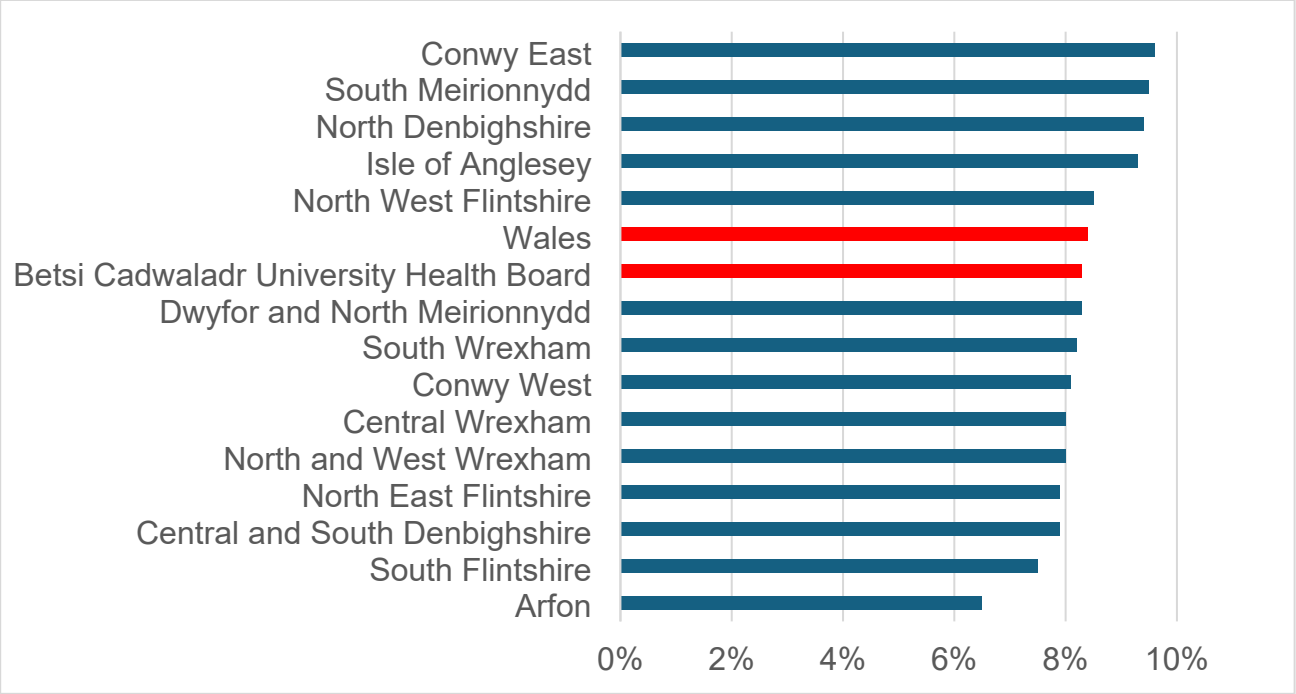
The modifiable risk factors include overweight and obesity, physical inactivity, unhealthy diet, high blood pressure[42].

Under the quality and outcomes framework, GP practices establish and maintain a register of all patients aged 17 or over with diabetes. Figures for 2025 show diabetes prevalence ranges from 6.5% (Arfon) to 9.6% (Conwy East) for the GP registered population in North Wales. The table below shows the variation in diabetes

[41] Diabetes UK, Diabetes in Wales
[42] NHS Wales Public Health Wales - Diabetes prevalence – trends, risk factors, and 10-year projection

prevalence at locality level based on the registers maintained by the GP practices in that locality compared to the average for the health board and Wales.

Figure 3.1: Estimated percentage prevalence of diabetes based on patients on GP practice registers by locality, health board and Wales 2025[43]



As can be seen the highest prevalence rate is in Conwy East locality (9.6%) and the lowest in the Arfon locality (6.5%). Nine of the 14 localities are lower or equal to the health board and Wales rates (8.3% and 8.4% respectively) and five localities are higher.

3.4 Mental wellbeing

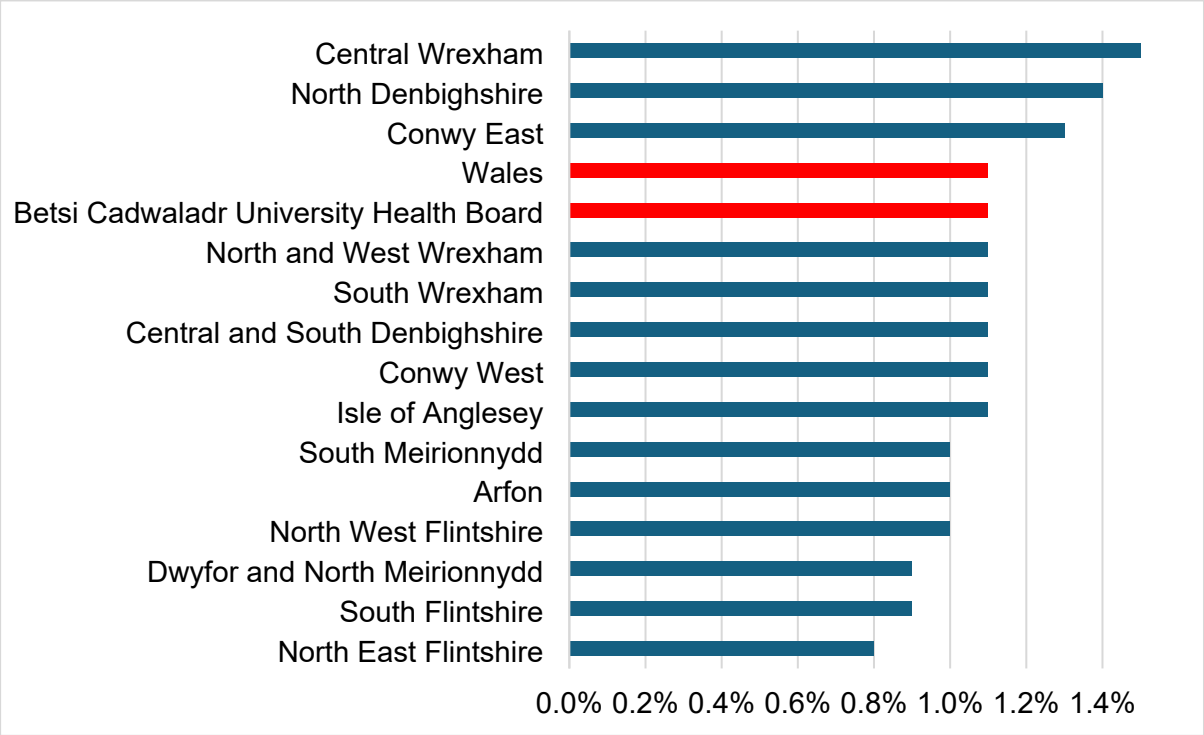
The key messages on the mental health of adults in North Wales in the North Wales population assessment 2022[44] are:

- People in North Wales reported slightly better mental health than in Wales as a whole.
- The number of people with mental health problems is likely to remain stable.
- The most common mental illnesses reported are anxiety and depression.
- Research suggests a high number of people with mental health problems are not seeking help.
- The number of admissions to mental health facilities is reducing.
- People with mental health problems are more likely to have poor physical health.

[43] Welsh Government StatsWales - Disease registers by local health board, cluster and GP practice
[44] North Wales Regional Partnership Board – North Wales Population Needs Assessment 2022

Under the GP quality and outcomes framework GP practices are required to maintain a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy. The figure below shows the percentage of people registered with a GP practice in North Wales and included in the practice's mental health register. However, it should be noted that the figures are likely to underestimate the true prevalence because it relies on the patient presenting to a GP for treatment, receiving a diagnosis, and being entered onto the disease register. There will be many patients in the community with symptoms of a psychological disorder who do not have an encounter with their GP, therefore it is important to interpret these estimates with caution.

Figure 3.2: Estimated percentage prevalence of mental health based on patients on GP practice registers by locality, health board and Wales 2025[45]



As can be seen the highest prevalence rate is in Central Wrexham locality (1.5%) and the lowest in North East Flintshire locality (0.8%). 11 of the 14 localities are lower or equal to the health board and Wales rate (1.1%) and three localities are higher.

In 2025, almost 27% of patients were registered in primary care as having any mental health condition; this is higher than the average for Wales (23.9%). Across the region, figures range from 22.2% in Arfon locality to 32.5% in North Denbighshire locality.

The causes of suicide are complex. A summary of evidence on suicide prevention cited a number of factors associated with an increased risk of suicide including:

[45] Welsh Government StatsWales - Disease registers by local health board, cluster and GP practice

- gender (male),
- age (15- to 44-year-olds),
- socio-economic deprivation,
- psychiatric illness including major depression,
- bipolar disorder,
- anxiety disorders,
- physical illness such as cancer,
- a history of self-harm, and
- family history of suicide.

It is important that recognition is given to the fact that suicides are an uncommon occurrence. Small area analyses should be interpreted with caution, as rates can vary dramatically due to a small number of cases. Suicide data is also subject to a number of caveats.

The suicide rate in the health board's area (11.9 per 100,000) is just below Wales (12.5 per 100,000). At unitary authority level, Flintshire is statistically significantly lower compared to Wales.

There is a stark difference in suicide rates between the most and least deprived communities across Wales. People living in the most deprived areas are almost twice as likely to die by suicide compared to those living in the least deprived areas.

3.5 Dementia

Dementia is an important mental health condition of old age, as it is a significant cause of morbidity, mortality and health care use. As people live longer, the prevalence of dementia is likely to increase.

Alzheimer's in the most common form of dementia. It is caused by a build-up of proteins on the brain which affect how brain cells transmit messages. Vascular dementia is the second most common type of dementia and is caused by reduced blood flow to the brain. Vascular dementia is often the result of a stroke or transient ischaemic attacks.

Other forms of dementia include dementia with Lewy bodies which is thought to account for 10-15% of all those with dementia. Lewy body dementia includes two subtypes: dementia with Lewy bodies and Parkinson's dementia. Frontotemporal dementia is a term used for a group of dementias that can affect personality, behaviour and language.

Young onset dementia is caused mostly by the same diseases that case dementia in older people, such as Alzheimer's or vascular disease. Genetics are an important factor in young onset dementia, as well as factors such as severe damage to the brain caused by an early stroke, traumatic brain injury or heavy alcohol use.

Dementia is a complex condition with multiple causes and risk factors which are summarised below.

There are several known risk factors for dementia[46]:

- older age,
- genes (inherited risk)
- other long-term health conditions,
- lifestyle, for example, smoking and excessive alcohol use,
- sex and gender, and
- cognitive reserve, the brain's ability to keep working despite having disease.

Dementia prevalence increases with age. Only about one in 100 people aged 60 to 64 (0.9%) is expected to experience dementia, but by age of 95 and over this is predicted to increase to about 41 in 100 people (41.1%)[47].

Dementia is one of the chronic conditions recorded in primary care and reported via the GP quality assurance and improvement framework.

In North Wales, 6,147 patients are registered with GP practices as having a diagnosis of dementia. The highest numbers of patients are in North Denbighshire (1.2% of registered patients), Central Wrexham and Conwy East (1.1% of registered patients each). The lowest are in Arfon and North East Flintshire (0.6% each).

However, it is estimated that around half of people with dementia in North Wales are undiagnosed.

The number of people predicted to be living with dementia is expected to increase by 27.2% between 2024 and 2034 with the highest increase in Wrexham (31.7%) and the lowest in Gwynedd (23.8%)[47].

Table 3.1 – number of people projected to be living with dementia in North Wales, 2034 and 2044

Unitary authority	2024 latest estimate	2034 projection	Percentage increase
Conwy	2,400	3,050	27.1%
Denbighshire	1,800	2,250	25.0%
Flintshire	2,450	3,100	26.5%
Gwynedd	2,100	2,600	23.8%
Isle of Anglesey	1,350	1,750	29.6%
Wrexham	2,050	2,700	31.7%

3.6 Respiratory disease

Respiratory diseases are diseases of the airways and other structures of the lung. Among the most common are chronic obstructive pulmonary disease, asthma,

[46] Alzheimer's Society – risk factors for dementia
[47] North Wales Regional Innovation Coordination Hub – Estimates of the prevalence of dementia in North Wales December 2025

occupational lung diseases such as coal miners' pneumoconiosis, pneumonia and pulmonary hypertension.

Over the last 10 years[48], chronic lower respiratory diseases and influenza and pneumonia were consistently two of the leading underlying causes of death in Wales. The numbers dying from chronic lower respiratory tract disease has been increasing each year since 2020, and in 2023 was the underlying cause for 2,132 deaths.

Deaths due to influenza and pneumonia have fluctuated and were the underlying cause for 1,534 deaths in 2023. Combined, these two respiratory disease groups accounted for 3,666 deaths, 10% of all deaths in Wales. This combined total was only slightly lower than the leading cause of death, 'dementia and Alzheimer's disease', which was the underlying cause for 3,796 deaths. These figures are based on the underlying cause of death, meaning the disease or injury that initiated the train of events leading directly to death.

Tobacco is the biggest cause of lung cancer in the UK, and people who smoke were first shown to be more likely to develop lung cancer relative to non-smokers in the 1950s. It also increases the risk for cancers elsewhere in the body for example the mouth, lips, nose and sinuses, oesophagus, stomach, liver, bladder and colon/rectum.

Although chronic obstructive pulmonary disease can be the result of exposure to occupational hazards and air pollution, it is predominantly caused by active and second-hand tobacco smoke exposure.

Pneumonia can be acquired in either the community of a hospital/healthcare environment and can affect people of any age. In the UK, pneumonia affects around 0.5 to 1% of adults each year and is more widespread in autumn and winter. Smoking and exposure to tobacco smoke are risk factors for community acquired pneumonia.

Asthma is the most common chronic disease of childhood and the leading cause of childhood morbidity from chronic disease as measured by school absences, emergency department visits and hospitalisation. It affects all ages, races and ethnicities. Exposure to cigarette smoke can trigger the development of the asthma and exacerbate symptoms.

Smoking cessation is one of the most effective ways to both prevent respiratory diseases and treat people with a respiratory disease.

3.7 Sexual health

Sexual health is the capacity and freedom to enjoy and express sexuality without exploitation, oppression or physical or emotional harm. Sexual health problems include:

[48] NHS Wales Public Health Wales - Respiratory disease prevalence – trends, risk factors, and 10-year projections (19 June 2025)

- Sexually transmitted infections including human immunodeficiency virus infection,
- Unintended pregnancy,
- Abortion,
- Fertility problems, and
- Sexual dysfunction.

The Royal College of Midwives published "Wales state of maternity service 2023[49]" and below are some of the findings.

- The demographic makeup of women using maternity service in Wales is changing, for example, the majority of women giving birth in Wales are now over 30 years. A significant shift over the past decade, where the proportion of births to women aged 30 or older has jumped from 42% (2011) to 53% (2021).
- There were just over 15,000 babies born to women agreed 30 years or older, with just over 13,500 births to younger women and girls.
- Nearly six in ten pregnant women in Wales in 2021 were overweight or obese. Higher body mass index during pregnancy is a significant risk factor, for both women and their babies, and can lead to conditions such as gestational diabetes.
- In 2021 the total number of "live" births in Wales was 28,879 of which 6,211 were in Betsi Cadwaladr University Health Board.
- In 2021, the most common age for mothers in Betsi Cadwaladr University Health Board was 30-34, followed by 25-29. The least common age was 19 years and under.

Teenage pregnancy is a possible cause and consequence of child poverty, which can increase the likelihood of health inequalities. Being a teenage mother or a child of a teenage mother increases the risk of health problems and other issues, for both mother and child. Higher teenage conception rates are associated with areas of higher deprivation and areas of higher unemployment.

As can be seen from the table below, Denbighshire has the highest rate of conception for women aged under 18 years (20.9), the second highest rate in Wales. [50].

Table 3.2 - Conception rates for women aged under 18 years, by local authority, Wales, 2022

Unitary Authority	Conception rate per 1,000 women in age group
Denbighshire	20.9
Flintshire	19.8
Wrexham	17.7
Isle of Anglesey	16.8
Conwy	15.1
Gwynedd	14.5

[49] Royal College of Midwives – Wales state of maternity services 2023
[50] Office of National Statistics - Conceptions in England and Wales

3.8 Alcohol[51, 52, 53]

In 2016, the UK Chief Medical Officer published new guidelines that advise drinking no more than 14 units of alcohol a week to keep health risks low[54]. Alcohol use remains a major public health challenge in Wales. It is associated with the development of many health conditions such as high blood pressure, heart disease, cirrhosis of the liver and cancers of the mouth, throat and breast cancer. It has also been identified as a causal factor (consuming alcohol is a direct or partial cause) in more than 200 medical conditions.

Alcohol misuse is also a cause of falls, accidents, and injuries as well as social problems such as assaults and crimes. In Wales, 49% of all violent crime is alcohol related, as well as contributing to public order and anti-social behaviour in communities, child neglect, domestic and intimate partner violence and the abuse of vulnerable individuals[55].

Growing up in families where alcohol or substance misuse is a problem and can have negative impacts which persist long into adulthood. 14% of adults have been exposed to alcohol misuse during childhood. Reducing adverse childhood experiences can reduce levels of harmful drinking by 35%.

Alcohol consumption does not have the same link with deprivation as other lifestyle behaviours. Drinking alcohol above recommended guidelines is higher among adults in the least deprived areas of Wales (21.3%) compared to the most deprived areas (14.6%).

In 2023, alcohol specific death (wholly caused by alcohol) in Wales increased to a new record high with 562 deaths recorded, marking a 16.0% increase from the previous year (486). Of the alcohol specific deaths in 2023, nearly two thirds (64.8%) involved males.

Alcohol-specific hospital admissions continue to rise with over 12,000 admissions involving more than 8,000 individuals. Older adults aged 50 years and over made up two thirds (67.0%) of those cases.

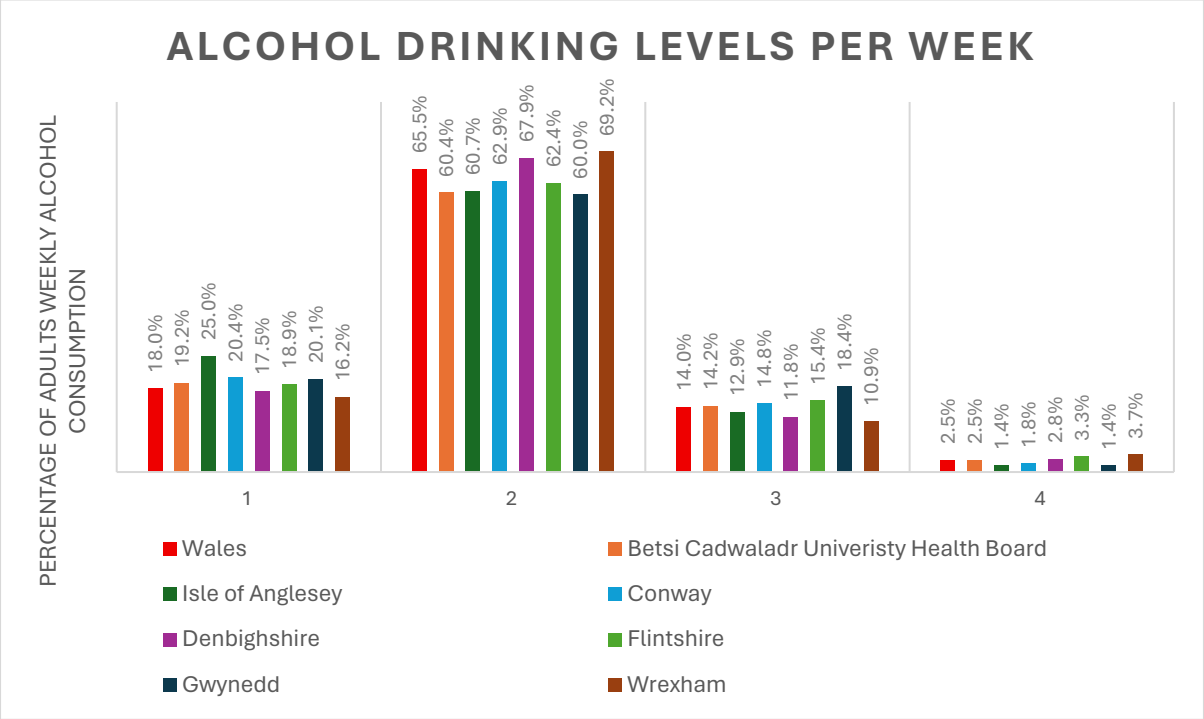
While overall alcohol-specific hospital admissions among those under 25 declined by 17.4% compared to the previous year, school exclusions related to drugs and alcohol reached a new record high of 939 cases in the 2022/23 academic year.

The figure below highlights the reported drinking patterns in Betsi Cadwaladr University Health Board, local authorities compared to the rate for Wales.

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[51] Public Health Wales Observatory, Alcohol in Wales
[52] NHS Wales Public Health Wales - Alcohol
[53] NHS Wales Public Health Wales - Record high alcohol related deaths in Wales highlight urgent public health concerns (March 2025)
[54] Department of Health and Social Care - UK Chief Medical Officers' Low Risk Drinking Guidelines (2016)
[55] Alcohol Change UK - Alcohol, crime and disorder

Figure 3.3: Adult weekly drinking levels by local authority, health board and Wales (2021-2023)[56]



Key

Alcohol drinking levels per week
1. Non-drinker (zero units)
2. Moderate drinker (up to and including 14 units)
3. Hazardous drinker (up to 35 units for females and 50 unit for males)
4. Harmful drinker (more than 35 units for females and 50 units for males)

- The percentage of non-drinkers was highest in Isle of Anglesey (25.0%) and lowest in Wrexham (16.2%),
- The percentage of moderate drinkers was highest in Wrexham (69.2%) and lowest in Gwynedd (60.0%),
- The percentage of hazardous drinkers (was highest in Gwynedd (18.4%) and lowest in Wrexham (10.9%), and
- The percentage of harmful drinkers was highest in Wrexham (3.7%) and lowest in Isle of Anglesey and Gwynedd (1.5%).

3.9 Obesity

Obesity prevalence is rising in Wales, (as it is globally). Being overweight or obese increases the risk of a wide range of chronic diseases, principally type 2 diabetes, hypertension, cardiovascular disease including stroke, as well as some types of

[56] Social Care Wales - National social care data portal for Wales - Drinking

cancer, kidney disease, obstructive sleep apnoea, gout, osteoarthritis, and liver disease, among others[57].

Obesity is complex and can be influenced by a number of factors including economic, commercial, social and environmental determinants, cutting across government departments.

Having a high body mass index (ie being overweight or obese) and physical inactivity are the third and fourth leading causes of ill health in the UK. Taken together they are arguably the most important contributor to poor wellbeing in communities today. Childhood obesity leads to and exacerbates adult obesity which in turn causes or exacerbates our most prevalent limiting long term ill health conditions. It is well accepted that adult obesity results in less healthy life expectancy and shorter life expectancy.

Over 89,600 of the health board's population are registered by their GP as having obesity; this is almost 15% of the population. At locality level, the highest proportions are in North and West Wrexham (17.4%) and South Wrexham (16.8%).

A healthy, balanced diet is an essential component of healthy living. A balanced diet combined with physical activity helps to regulate body weight and contributes to good health. Maintaining a healthy body weight also reduces the risk of health problems such as diabetes, coronary heart disease, stroke and some cancers. Regular physical activity is an essential part of healthy living. A lack of physical activity is among the leading causes of avoidable illness and premature death.

Government advice is that everyone should have at least five portions of a variety of fruit and vegetables every day. An adult portion of fruit or vegetables is 80g. According to the results for North Wales from the National Survey for Wales between 2021 and 2023[58]:

- Between 63.0% (Flintshire lowest) and 83.0% (Isle of Anglesey highest) of people had eaten between one and four portions of fruit and vegetables the previous day and
- Between 16.0% (Isle of Anglesey lowest) and 29.0% (Flintshire highest) had eaten five portions of fruit and vegetables the previous day.

Physical activity guidelines for adults aged 19 to 64 include at least 150 minutes of moderate intensity activity a week or 75 minutes of vigorous intensity activity a week. According to the National Survey for Wales, the percentage range at local authority level for those who self-reported being active for 150 minutes in the week was between 37.0% (Conwy lowest) to 56.0% (Denbighshire and Wrexham highest).

In Wales 62.0% of adults self-reported being overweight and 25.0% self-reported they were obese. According to the National Survey for Wales, the percentage range at local authority level for those who reported being overweight was between 54.0%

[57] NHS Wales Public Health Wales - Overweight and obesity
[58] InfoBaseCymru data for an intelligent Wales - Adults reporting lifestyle behaviours (2021 to 2023)

(Denbighshire lowest) to 63.0% (Conwy highest) and for those who reported being obese it was between 17.0% (Denbighshire lowest) to 30.0% (Gwynedd highest).

3.10 Smoking[59]

Smoking is extremely damaging to health. It is the cause of death for around half of all long-term smokers[60] and the World Health Organisation[61] estimates that tobacco kills more than eight million people each year worldwide.

Smoking remains a major cause of mortality and ill health in Wales and is a major cause of premature death and one in two long term smokers will die of smoking related diseases.

Over the period 2020 – 2022[62]:

- An estimated 3,845 deaths per year amongst those aged 35 and over in Wales were due to smoking. This means that on average 10.7% of all deaths in Wales amongst those aged 35 and over in these years were attributable to smoking.
- The number of deaths attributable to smoking varies considerably by deprivation. Amongst those aged 35 and over living in the most deprived fifth of areas, 14.5% of all deaths were attributable to smoking. The European age-standardised rate of smoking attributable mortality was 337 per 100,000 adults aged 35 and over in the most deprived fifth of areas, more than three times higher compared with the least deprived fifth of areas.
- An estimated 17,195 hospital admissions per year in Wales were due to smoking. This means that on average 3.4% of all hospital admissions in Wales amongst those aged 35 and over in these years were attributable to smoking.

Smoking prevalence is higher in adults living in the most deprived areas of Wales. The National Survey for Wales shows that in 2022-2023, 21.8% of adults in the most deprived areas of Wales reported smoking, which is almost three times higher than adults in the least deprived areas of (7.5%).

The table below shows smoking attributable mortality, by European age-standardised rate per 100,000, persons aged 35 years and over by health board and Wales, 2020-2022 for the seven health boards in Wales.

Ranking: First (one) equals the health board with the lowest smoking attributable mortality and seven is the health board with the highest.

[59] StatsWales, Adult lifestyles by local authority and health board
[60] Doll, R., et al. (2004). Mortality in relation to smoking: 50 years' observations on male British doctors
[61] World Health Organization 2022 - Tabacco: Fact sheet (June 2025)
[62] NHS Wales Public Health Wales - Smoking attributable mortality and hospital admissions for Wales, 2020-22 (new analysis)

Table 3.3: Smoking attributable mortality, European age-standardised rate per 100,000, persons aged 35 years and over by health board and Wales, 2020-2022[63]

Rank	Health board	Smoking attributable mortality per 100,000 persons, 25 years and over
1	Powys	152
2	Cardiff and Vale	165
3	Hywel Dda	172
4	Betsi Cadwaladr	188
5	Swansea Bay	200
6	Aneurin Bevan	206
7	Cwm Taf Morgannwg	220
	Wales	190

Smoking is also known to increase people's risk of developing a wide range of illnesses, which can be fatal or cause irreversible long-term damage to health[64]. These include cancers, respiratory diseases, and cardio-vascular diseases, including strokes, heart attacks and dementia.

Exposure to second-hand smoke has been shown to cause significant harm, increasing non-smokers risks of developing smoking related diseases including lung cancer and cardio-vascular disease[65]. Exposure to second-hand smoke is particularly harmful to children, leading to conditions including middle-ear disease, asthma and allergies[66].

Smoking in pregnancy is known to have a range of impacts on the pregnancy and child in later life, including increased risk of miscarriage, premature birth and sudden infant death syndrome[67].

The table below, shows the average percentage of current smokers (adults 18 years and over) across the five unitary authorities, 2020 to 2024. The averages presented are five-year averages, calculated using data from 2020 to 2024, where available. The rank column shows where each unitary authority sits when compared to the other 21 unitary authorities in Wales, where 1 is the lowest average percentage of smokers.

[63] NHS Wales Public Health Wales - Smoking attributable mortality and hospital admissions for Wales, 2020-22 (new analysis)
[64] NHS 2018 - What are the health risks of smoking?
[65] Department of Health Scientific Committee on Tobacco and Health (SCOTH) 2004. Secondhand Smoke: Review of the evidence since 1998
[66] Royal College of Physicians London - Passive smoking and children (March 2010)
[67] Royal College of Obstetricians and Gynaecologists - Smoking and pregnancy (2021)

Table 3.4: The average percentage of current smokers (adults 18 years and over) between 2020 to 2024[68]

Rank	Unitary authority	2020 to 2024 Current smoker percentage (average)
7	Flintshire	12.3
10	Isle of Anglesey	12.7
11	Conwy	12.7
13	Wrexham	13.4
14	Denbighshire	14
18	Gwynedd	14.4

The table below shows the percentage of adults aged 16 years and over, in the six unitary authorities who have self-reported engaging in smoking and e-cigarettes as recorded by the National Survey for Wales[69] between 2021 and 2023.

Table 3.5: Percentage of adults (aged 16 years and over) who self-reported engaging in smoking and e-cigarettes by local authority and Wales, 2021 to 2023

Unitary authority	Percentage of self-reported smokers	Percentage of self-reported e-cigarette users
Conwy	6.0%	4.0%
Denbighshire	14.0%	5.0%
Flintshire	11.0%	10.0%
Gwynedd	17.0%	6.0%
Isle of Anglesey	11.0%	1.0%
Wrexham	14.0%	10.0%

The numbers of young people vaping have risen substantially in Wales in recent years, even though it has been illegal to sell a vape to anyone under 18 years since 2015[70].

The evidence suggests that the availability of disposable devices and the ways in which vapes are marketed have strongly contributed to their appeal amongst young people.

The School Health Research Network Student Health and Well-being Survey in secondary schools, 2023 is based on 129,761 learners from year seven to 11 from 201 schools in Wales responding to the survey which was administered between September and December 2023. The key findings were:

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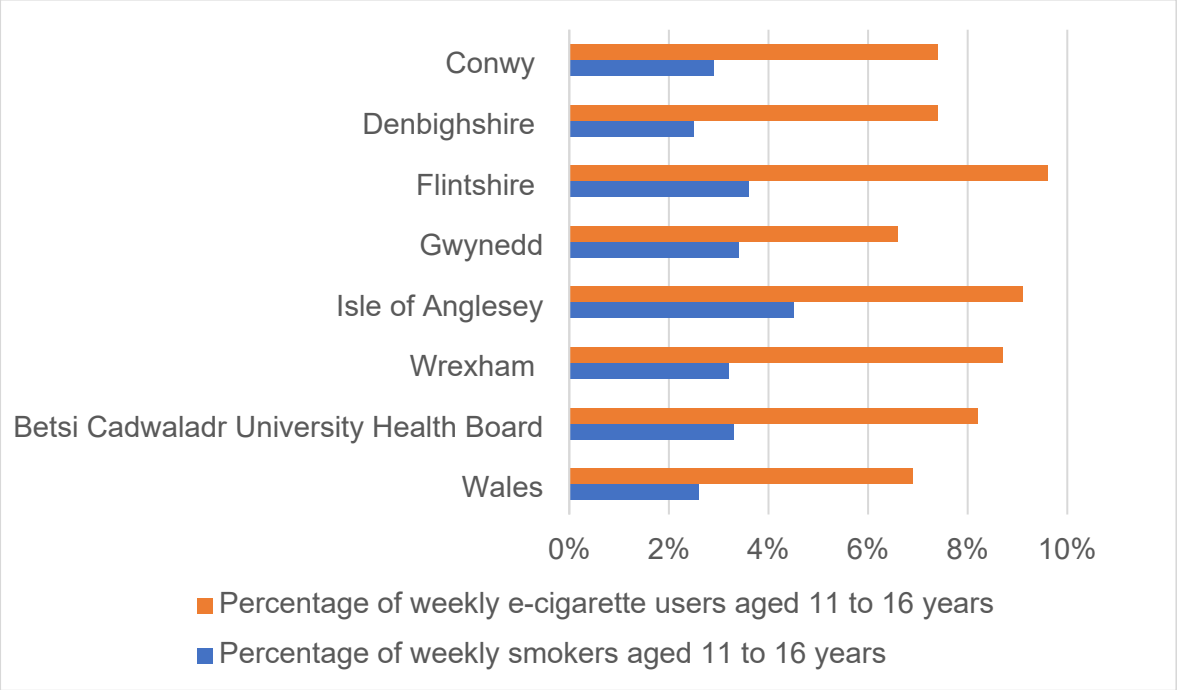
[68] Office of National Statistics - Adult smoking habits in the UK: 2024
[69] InfoBaseCymru data for an intelligent Wales - Adults reporting lifestyle behaviours (2021 to 2023)
[70] NHS Wales Public Health Wales and The School Health Research Network - Vaping and Smoking amongst Learners in Year seven to 11 in Wales - Analysis from The School Health Research Network Student Health and Well-being Survey in secondary schools, 2023

- The number of learners in year seven to 11 in Wales reporting vaping at least once a week is 7.0%, an increase from 5.4% (2021) and 2.7% (2019)
- Since 2021, vaping has increased amongst girls, year 11 learners and non-smokers, but weekly vaping increased between 2021 and 2023 in all year groups except year seven
- Girls (8.6%) are more likely to vape regularly than boys (5.1%). Those in year 11 (15.9%) are more likely to vape than those in younger year groups
- More than a quarter (25.7%) of all learners in year seven to 11 have tried a vape, an increase from 20.5% (2021). Amongst year 11 learners the figure was 45.4%
- Only 2.7% of learners in years seven to 11 now smoke regularly. The majority of these also vape
- The number of learners in year seven to 11 who only vape is 5.2%, higher than in 2021 (3.5%)
- The proportion of learners who only smoke and the proportion who smoke and vape regularly have both fallen since 2021
- Nicotine use by smoking or vaping at least weekly is currently 8.0% amongst learners in years seven to 11. This proportion has risen on every Survey since 2019 when it was 5.4%
- The data provides evidence that an increasing number of learners who have never and would never smoke regularly, are vaping regularly

The table below shows the percentage of 11 to 16 year-olds who were weekly smokers and e-cigarette users in 2023[71].

[71] NHS Wales Public Health Wales - Secondary School Children's Health and Well-being Dashboard: School Health Research Network Survey Data

Table 3.6: Percentage of adolescent weekly smokers and e-cigarette users by local authority, health board and Wales, 2023



4 Identified patient groups – particular health issues

The following patient groups have been identified as living within, or visiting, North Wales:

- Those sharing one or more of the following Equality Act 2010 protected characteristics,
  - Age
  - Disability, which is defined as a physical or mental impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities
  - Pregnancy and maternity
  - Race, which includes colour, nationality, ethnic or national origins
  - Religion (including a lack of religion) or belief (any religious or philosophical belief)
  - Sex
  - Sexual orientation
  - Gender re-assignment
  - Marriage and civil partnership.
- University students
- Offenders and those on probation
- Homeless and rough sleepers
- Gypsy and Traveller communities
- Refugees and asylum seekers
- Military veterans
- Visitors to sporting and leisure facilities and owners of second homes
- Socio-economic disadvantage
- Welsh speakers

Whilst some of these groups are referred to in other parts of the pharmaceutical needs assessment, this section focusses on their particular health issues.

4.1 Age

Health issues tend to be greater amongst the very young and the very old. However, whilst it is clear that the number and proportion of people aged 65 and over is set to rise and the prevalence of nearly all chronic and long-term conditions increases with age, it is important to recognise that the older population is very diverse in nature with many people remaining fit and active. While it is indeed the case that a growing older population will lead to an increasing number of people living with complex health and care needs, there will also be growing numbers across all older age groups living without any significant needs for support.

Furthermore, acquiring a health condition or disability does not necessarily equate to high levels of demand for health and care services. Many people aged 75 and over will have one or more health conditions but may not consider that their health condition has, or conditions have, a significant impact on their life.

In addition, older people also provide a significant amount of their time and energy caring for others.

For older people:

- Cigarette smoking is implicated in eight of the top fourteen causes of death for people 65 years of age or older. Smoking causes disabling and fatal disease, including lung and other cancers, heart and circulatory diseases, and respiratory diseases such as emphysema. It also accelerates the rate of decline of bone density during ageing. At age 70, smokers have less dense bones and a higher risk of fractures than non-smokers. Female smokers are at greater risk for post-menopausal osteoporosis. Half of long-term smokers die of tobacco related illnesses, most prematurely, and many suffer from a variety of chronic conditions related to smoking.
- Even modest alcohol use in old age may be potentially harmful as a contributor to falls, compromised memory, medicine mismanagement, inadequate diet and limitations on independent living.
- Falls are a major public health concern, particularly for older adults, with over one-third of people aged 65 years and over falling each year. Over 700 older people in Wales are expected to die from a fall each year, with 7,750 requiring hospital-based treatment, and more than 132,000 experiencing repeated falls in their home. Falls generate significant psychological and physical impact, often leading to isolation, anxiety, and reduced independence.[72] Feeling lonely or unconnected to friends can have a very negative effect on wellbeing and health. It is associated with poor mental health and conditions such as cardiovascular disease, hypertension and dementia. The lockdown restrictions imposed during the Covid-19 pandemic in 2020, are likely to have exacerbated these issues across all age groups. Loneliness also has a much wider public health impact, as it is associated with a number of negative health outcomes including mortality, morbidity, depression and suicide. Lonely people tend to make more use of health and social care services and are more likely to have early admission to residential or nursing care. Looking at different ways of making sure that older people stay in touch with the things that matter to them and that there are opportunities for older people to stay active and connected are important.
- Depression is the most common mental health need for older people and prevalence rises with age. Age Cymru hosted an event in April 2024, which highlighted the gap between the current levels of investment in older people's mental health and the pressing needs across Wales. The event spotlighted some key statistics regarding poor mental health among older demographics in Wales including 22% of men and 28% of women over 65 suffering from depression, with 30% of older carers experiencing depression at some point. It also highlighted that older individuals experiencing bereavement are four times more likely to suffer from depression.[73]

[72] Age Cymru - Falls amongst older people can have a devastating impact but they are not an inevitable part of ageing
[73] Age Cymru - Welsh Government consults on mental health and wellbeing, and suicide prevention strategies (2024)

- People with mental health needs can seek advice and support from their GP. However, two-thirds of older people with depression never discuss it with their GP, and of the third that do discuss it, only half are diagnosed and treated. This means of those with depression only 15 per cent, or one in seven, are diagnosed and receiving any kind of treatment. Even when they are diagnosed, older people are less likely to be offered treatment than those aged 16 to 64.
- Dementia is the leading cause of death in England and Wales. Welsh Government estimates there to be 42,000 people over the age of 65 living with dementia in Wales, but Alzheimer's Society Cymru[74] estimates suggest the total number could be as high as 51,000. This figure is set to rise by 37% to almost 70,000 people by 2040. Developing dementia supportive communities is crucial to the wellbeing of older people, especially the thousands of people living with dementia, regardless of official diagnosis, and the people around them that are also affected. The Welsh Government will be publishing a new Dementia Strategy (2026 – 2036) in 2026, replacing the Dementia Action Plan published in 2018[75], and subsequent Companion Document in 2021. The 2026 Dementia Strategy aims to improve dementia care and support across Wales. At the time of writing this pharmaceutical needs assessment the strategy was not published.
- Good physical health has a significant beneficial impact on health and wellbeing in older age; the ability to be physically active improves muscle strength and emotional health whilst reducing risk of falls and isolation.
- A Welsh study[76,77] funded by Health and Care Research Wales in collaboration with Cardiff University, explored how to improve lives of people living with vision impairment. In 2020, over 1,000 people in Wales were formally registered as sight impaired or severely sight impaired. Vision impairment is one of the most common disabling conditions in older people that affects every day lives, including relationships and social connections.
- Sight loss is a significant public health issue, particularly for older people, as it can affect physical and mental health and a person's independence, making people more likely to have a fall or become socially isolated. Age is the single biggest factor associated with having a long term condition and 60% of people aged 65 and over are affected, but lifestyle factors such as smoking, excessive alcohol consumption, unhealthy diets and physical inactivity are estimated to cause approximately 50% of long term conditions.

For children and young people:

- There is evidence that the first one thousand days of life[78] (this includes before the child is born, up until they are two years old) have a significant effect on the rest of the child's life. As Cymru Well Wales has explained it, "these years have a long-lasting impact on individuals and families. They

[74] Alzheimer's Society Cymru - A new dementia action plan for Wales (2025)
[75] Welsh Government - Dementia action plan 2018 - 2022
[76] Health and Care Research Wales - Research into pathway for older people with vision impairment to navigate support and services 18 September 2025
[77] Health and Care Research Wales - A preventative approach to ensuring access to a sustainable, whole system pathway for older people with vision impairment (ASSIST)
[78] Public Health Wales - The First 1000 Days programme October 2023

shape the destiny for children as they grow up: their educational achievements, their ability to secure an income, their influences on their own children, and their health in older age".

- Children born into poverty are more likely to be adults with poor health than those born into affluence.
- The importance of breastfeeding is well evidenced to provide health benefits for both mother and baby to promote attachment. Breastfeeding rates in more deprived areas are significantly lower than in the least deprived areas. Young mothers are amongst the groups least likely to breastfeed.
- A baby born to a mother who is obese and smokes throughout pregnancy, is at greater risk of developing unhealthy lifestyles in the future which render them at greater risk of serious chronic conditions which will impact on their quality of life and their life expectancy.
- Some children go through physical, emotional or sexual abuse or live in families where there is parental separation, substance misuse, domestic violence, or mental illness; these are called adverse childhood experiences. Adverse childhood experiences are stressful experiences occurring during childhood that directly harm a child or affect the environment in which the child lives in and can continue to harm the health of children throughout their life.
- In 2016, Public Health Wales published the first Welsh adverse childhood experiences study[79]. It revealed that 47% of adults in Wales experienced at least one adverse childhood experience in their childhood, and 14% suffered four or more. Adverse childhood experiences cause long lasting health harms which continue into adulthood and older age.
- People who have experienced four or more adverse childhood experiences are:
    - four times more likely to be a high-risk drinker
    - six times more likely to smoke
    - six times more likely to have had underage sex
    - six times more likely to have had or caused unintended teenage pregnancy
    - 11 times more likely to have smoked cannabis
    - 14 times more likely to have been a victim of violence in the previous 12 months
    - 15 times more likely to have committed violence against another person in the previous year
    - 16 times more likely to have used heroin or crack cocaine, and
    - 20 times more likely to be incarcerated during their lifetime.
- In Wales, a quarter (23%) of adults were exposed to verbal abuse as a child; a fifth (20%) to parental separation; 17% to physical abuse; 16% to domestic violence; 14% to mental illness; 14% to alcohol abuse; 10% to sexual abuse; and 5% each to drug use or incarceration of a parent. 'Trauma-informed' services can provide a supportive environment for people who have experienced adverse childhood experiences, encouraging engagement and improved management of conditions.
- Making sure that children are supported to take control of their own lives and wellbeing, will help them to live their best possible lives. Providing clear and

[79] Public Health Wales - Adverse Childhood Experiences

easily accessible information about how young people and their families can find out more about what early help is available in their area is important.

- Teenage years are also important. There is strong evidence that lifestyle behaviours that impact on future longer-term health and social care outcomes in adults are closely linked to lifestyle in the teenage years. With many children developing unhealthy behaviours in terms of physical activity and diet, influencing positive lifestyle choices in teenagers will impact on health outcomes for young people and on future demand for a wide range of services by adults.
- On average across Wales, one in four children is either overweight or obese (25.5%). As deprivation levels increase in Wales, so does the percentage of children at risk of becoming obese. For example, just over one in seven children living in the most deprived neighbourhoods are likely to be obese in the future (14.6%), compared to less than one in ten residing in areas of least deprivation (8.4%)[80]. Obesity Alliance Cymru in their 2025 response to the "Healthy Eating and drinking in maintained schools in Wales" advised studies shown that children and adolescents living with obesity are around five times more likely to live with obesity into adulthood, with 80% of adolescents living with obesity still measuring as having obesity in adulthood[81].
- Public Health Wales collected data across Wales during the 2026-2024 school year – the Child Measurement Programme 2022-2023.[82] The data for Betsi Cadwaladr University Health Board showed:
    - 0.7% of children aged 4 to 5 were underweight (highest in Flintshire at 1.0%)
    - 13.1% of children aged 4 to 5 were obese (highest in Anglesey at 13.6%)
    - 15.0% were overweight not obese (highest in Anglesey at 17.3%), and
    - 71.3% were a healthy weight (highest in Flintshire at 72.2%).
- 90% of people who smoke in the UK started before the age of 21[83]. Vaping has become the dominant nicotine behaviour among adolescents in Wales. 5% of children and young people aged 11–16 vape at least weekly (increasing from 3% in 2019).[84]
- Untreated sexually transmitted infections can have longer term health impact including infertility. Young people's sexual behaviour may also lead to unplanned pregnancy which has significant health risks and damages the longer-term health and life chances of both mothers and babies. Furthermore, it is known that low birth weight can be linked to teenage pregnancy and mothers who smoke while pregnant. To reduce the risk of babies being born early, with a low birth weight, and the risk of disabilities that this brings, it is important that help is available to those who may be at risk.
- Around 50% of lifetime mental illness starts by the age of 14[85]. Children and young people who are at greater risk of mental health problems include those

[80] Chemisy4u - Obesity Statistics Report 2025
[81] Obesity Alliance Cymru Response - Healthy eating and drinking in maintained schools in Wales (2025)
[82] Public Health Wales - Child Measurement Programme 2023-24
[83] Cancer Research UK - Around 350 young adults start smoking every day in the UK - Cancer News
[84] Public Health Network Cymru - Smoking and vaping
[85] The Children's Society - Children's mental health statistics

going through family breakdown; those in the Looked After System and those showing behavioural problems; and children who have experienced trauma.
- The Wales Centre for Evidence Based Care at Cardiff University (2023) produced the most recent national forecast of long-term conditions across age groups in Wales[86]. The burden of long-term conditions is expected to rise over the next ten years, driven by increases in multimorbidity, obesity, poor nutrition, and persistent health inequalities.

4.2 Disability

There are many different types of disabilities, and a disability may be present from birth or occur during a person's lifetime.

According to the World Health Organization[87], an estimated 1.3 billion people experience significant disability, and this number is growing due to demographic and epidemiological changes in the population (such as ageing and the global increase in chronic health conditions), and health emergencies (such as disease outbreaks, natural disasters, and conflicts).

- Some people with disabilities die up to 20 years earlier than those without disabilities.
- People with disabilities have twice the risk of developing conditions such as depression asthma, diabetes, stroke, obesity, or poor oral health.
- People with disabilities face many health inequities.
- People with disabilities find inaccessible and unaffordable transportation 15 times more difficult than for those without disabilities.
- Health inequities arise from unfair conditions faced by people with disabilities, including stigma, discrimination, poverty, exclusion from education and employment, and barriers faced in the health system itself.

People with disabilities are not a homogeneous group. They include people of different ages, genders and ethnicity which will influence their healthcare needs and access.

A 2010 study by the Improving Health and Lives Learning Disabilities Observatory noted that people with learning disabilities have poorer health than their non-disabled peers, differences in health status that are, to an extent, avoidable. It also noted that health inequalities faced by people with a learning disability began in childhood and that they were often caused as a result of lack of access to timely, appropriate and effective healthcare.

The outcomes for adults with disabilities compared to the wider population are poorer in almost every manner. People with learning disabilities have a shorter life expectancy and increased risk of early death when compared to the general

[86] Wales Centre for Evidence Based Care - Forecasted prevalence and incidence of long-term conditions in Wales (2023)
[87] World Health Organization - Disability factsheet 2023

population. Research has shown that people with a learning disability on average die 19.5 years earlier than people without a learning disability[88].

However, people with learning disabilities are living longer than in the past and as a result, the number of older people with a learning disability is increasing. According to the 2023 annual report by LeDeR on learning from lives and deaths of people with a learning disability and autistic people[89]:

- 54.7% of adults notified to LeDeR with a learning disability who died in 2023 were male
- 79.5% of autistic adults who died in 2021-2023 were male
- 7% of adults notified to LeDeR in 2023 were from an ethnic minority group
- In 2023, adults with a learning disability on average died 19.5 years younger than the general population.
- The median age at death of adults with a learning disability whose death was notified to LeDeR between 2018 and 2023 was 62.5.
- 38.6% of adults who died in 2023 lived in the most deprived areas (top three centiles).
- Nearly 60% of adults with a learning disability who had a LeDeR review died before the age of 65 years.
- Whilst avoidable deaths have declined since 2021, the rate for adults with a learning disability who died in 2023 is still nearly double the rate compared to the general population (data for 2022).
- In 2023, 15.1% of all deaths were preventable and 25.1% were treatable.
- The three most common causes of avoidable death were influenza and pneumonia (13.1%), ischaemic heart diseases (10.6%) and cerebrovascular diseases (7.5%).

The Joseph Rowntree Foundation Report Poverty in Wales 2020[90] found that 27.2% of disabled people in Wales are in poverty compared with 20% of non-disabled people.

In 2021, median pay for disabled employees living in Wales[91] was 11.6% less than non-disabled employees (although this was the narrowest gap of the four UK nations).

The disability employment gap (the difference between the percentage of disabled and non-disabled in employment) in in quarter 2 2025 was 29.7%[92]. For all disabled people, the disability employment gap is wider for males, older (aged 50 to 64) people, people with no qualifications, people living in social housing, people not living in a couple, and people living in Northern Ireland, Scotland, the North of

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[88] University of Bristol Norah Fry Centre for Disability Studies (2019) - The Learning Disabilities Mortality Review (LeDeR) Programme: *Annual Report* 2018. London: Healthcare Improvement Quality Partnership.
[89] LeDeR Autism and Learning Disability partnership, Kings College London - Learning from Lives and Deaths - People with a learning disability and autistic people (LeDeR) report for 2023 (updated January 2026)
[90] The Joseph Rowntree Foundation - Poverty in Wales 2020
[91] Office for National Statistics - Disability pay gaps in the UK: 2021
[92] Department for Work & Pensions - The employment of disabled people 2025

England, West Midlands and Wales. Disabled people were more likely to be economically inactive than non-disabled people and for those that were the majority gave long-term sickness as their main reason for being inactive. They were also more likely to want a job and less likely to have had a job between 2023 and 2025, with one in five having not worked for over ten years.

In the health board's area, GP practices hold learning disability registers which are used as part of the quality assurance and improvement framework reporting. These provide very rough estimates of the number of people with a learning disability; however, it should be noted that there are variations in the coding and recording of chronic conditions by practices. 3,946 people were on the learning disability register in April 2025.

4.3 Pregnancy and maternity

Pregnancy is a critical period during which the physical and mental wellbeing of the mother can have lifelong impacts on the child. Maternal stress, diet and alcohol or drug misuse can place a child's future development at risk. However, pregnancy is also a powerful motivator for change as it represents a time when women and partners are more susceptible to new information and are more likely to make positive lifestyle changes to provide optimal conditions to ensure the health and wellbeing of the unborn baby.

The periods before, during and after pregnancy also provide opportunities to give women practical, consistent advice to help them manage their weight and stop smoking to avoid associated complications.

4.3.1 Perinatal mental health[93,94]

Perinatal mental illnesses affect at least 10% of women and, if untreated, can have a devastating impact on them and their families. When mothers suffer from these illnesses it increases the likelihood that children will experience behavioural, social or learning difficulties and fail to fulfil their potential. If perinatal mental illnesses go untreated, they can have long term implications for the well-being of women, their babies and families (Jones et al., 2014).

Guidance issued by the National Institute for Health and Care Excellence states that depression and anxiety are the most common mental health problems experienced during pregnancy, with around 12% of pregnant women experiencing depression and 13% anxiety at some point, with many experiencing both. Both can continue to affect women for up to a year after their child's birth.

During pregnancy and the postnatal period, anxiety disorders, including panic disorder, generalised anxiety disorder, obsessive compulsive disorder, posttraumatic stress disorder and tokophobia (an extreme fear of childbirth), can occur on their own or can coexist with depression. Psychosis can reemerge or be exacerbated

[93] National Institute for Health and Care Excellence - Antenatal and postnatal mental health: clinical management and service guidance, 2020.
[94] Royal College of Midwives - Strengthening perinatal mental health, a roadmap to the right support at the right time

during pregnancy and the postnatal period. Postpartum psychosis affects between one and two in 1,000 women who have given birth. Women with bipolar I disorder are at particular risk, but postpartum psychosis can occur in women with no previous psychiatric history.

Changes to body shape, including weight gain, in pregnancy and after childbirth may be a concern for women with an eating disorder. Although the prevalence of anorexia nervosa and bulimia nervosa is lower in pregnant women, the prevalence of binge eating disorder is higher.

In Wales[95]:

- 32% of pregnant women reported a mental health condition at their initial assessment in 2023. This is an increase of 1.4% from the previous year, and an increase of 12.2% from 2016 (first year of comparable data)
- 38% of pregnant women aged 16 to 19 and 40% of those aged 20 to 24 reported a mental health condition in Wales in 2023. The proportion fell to 29% for those in age groups 30 to 34 and 35 to 39
- 38% of pregnant women from Mixed ethnic groups and 36% from White ethnic groups reported a mental health condition at their initial assessment in 2023. These were two ethnic groups with the highest proportion of pregnant women reporting a mental health condition and has followed an upward trend since data was first collected in 2016

NB The percentage of women who reported a mental health condition at their initial assessment does not include data for Betsi Cadwaladr University Health Board or Cwm Taf Morgannwg University Health Board.

4.3.2 Smoking

Smoking is the single biggest modifiable risk factor for poor outcomes in pregnancy. Encouraging pregnant women to stop smoking during pregnancy can help them kick the habit for good, provide health benefits for the mother and unborn child, and reduce children's exposure to second-hand smoke.

In Wales[96]:

- 20% of women who were smokers at the initial assessment were not smokers at birth. This is a decrease of 6.5% since the previous year, and an increase of 2.0% since data was first collected in 2016. The large increase since 2021 may be affected by nearly all data being self-reported, rather than being carbon monoxide monitored and the higher-than-usual amount of missing data in the past two years
- 14% of pregnant women were recorded as smokers at their initial assessment in 2023 and 12% of women who birthed in 2023 were recorded as being smokers at the time they gave birth. Both rates are similar to the previous two years

[95] Welsh Government - Wales maternity and birth statistics 2023
[96] Welsh Government - Wales maternity and birth statistics 2023

- 28% of pregnant women aged under 20 were recorded as a smoker at initial assessment, compared to 21% aged 20 to 24, and 12% aged 35 or over.
- 27% of pregnant women aged under 20 were recorded as smokers at birth, compared to 19% aged 20 to 24 and 10% aged 35 or older
- Smoking rates were highest among younger mothers and mothers from White and Mixed ethnic backgrounds
- The percentage of pregnant women recorded as a smoker differs widely by ethnic group. At initial assessment in 2023, smoking rates varied from 2% of pregnant women from Asian ethnic groups to 16% of pregnant women from White ethnic groups
- At birth in 2023, smoking rates varied between 1% of pregnant women from Black ethnic groups and 2% of pregnant women from Asian ethnic groups to 14% of pregnant women from both White and Mixed ethnic groups
- Over the past 5 years the smoking rates have decreased in the White and Mixed ethnic groups, while rates have been broadly similar (but at a much lower level) for pregnant women of Other, Black and Asian ethnic groups
- Large decrease in smoking rate at initial assessment since 2020 coincide with nearly all data being self-reported, rather than being carbon monoxide monitored. Suspended since the Covid-19 pandemic in 2020. This change in data collection method may explain the sharp falls from this point onwards

NB The percentages for smoking at birth does not include data from Hywel Dda University Health Board

4.3.3 Substance and alcohol use

Maternal misuse of drugs during pregnancy increases the risk of low birth weight, premature delivery, perinatal mortality, and sudden unexpected death in infancy (sometimes known as cot death).

A number of risks are associated with drinking alcohol during pregnancy[97], including:

- increased chances of miscarriage
- affect the way the baby develops in the uterus and, in particular, the way its brain develops
- affect the way the baby grows in the uterus by causing the placenta not to work as well as it should
- increase the risk of a stillbirth
- increase the risk of premature labour
- make the baby more prone to illness in infancy and in childhood, and also as an adult
- cause foetal alcohol spectrum disorder or foetal alcohol syndrome

Being drug-free in pregnancy reduces the risk of:

- early birth
- underweight birth

[97] Royal College of Obstetricians & Gynaecologists 2018 - Alcohol and pregnancy patient information

- feeding and breathing problems
- getting infections
- having problems with their development and growth
- miscarriage
- stillbirth
- sudden Unexplained Death in Infancy

4.3.4 Healthy weight and nutrition

Being overweight whilst pregnant increases the chances of complications for the mother for example miscarriage, gestational diabetes, high blood pressure and pre-eclampsia and blood clots. For the baby, being overweight can lead to the baby being born early (before 37 weeks) and an increased chance of stillbirth. There is also a higher chance of the baby having a health condition, such as a neural tube defect like spina bifida.

In Wales[98]:

- 32% of pregnant women were classed as obese by their body mass index score at initial assessment in 2023 this is an increase of 0.8% from the previous year continuing the upward trend since 2016 and has increased every year since data collection started in 2016. In 2023 it was 5.8% higher than in 2016
- 33% of pregnant women from Black and 33% of pregnant women from White ethnic groups had a body mass index of 30 or more. The percentage for both ethnic groups only changed marginally from the previous year. An upward trend since data was first collected in 2016
- 27% of pregnant women from Mixed ethnic groups had a body mass index of 30 or more. This was a small decrease on the previous year, but the percentage of this group had the steepest longer-term upward trend and was 8.7% higher in 2023 than in 2016
- Pregnant women in the Other and Asian ethnic groups had the lowest proportion of women with a BMI of 30 or more out of all five ethnic groups at 21% and 19% respectively
- 32% of pregnant women with no stated ethnic group had a BMI of 30 or more in 2023
- There was little variation in the percentage of pregnant women with a body mass index of 30 or more between most age groups. The percentage varied between 30% and 34% in all age groups between 20 to 24 and 40 to 44; while the percentage was markedly lower for the under 16 (5%), the 16 to 19 (21%), and the 45 or over (25%) age groups

NB A person with a body mass index of 30 or more is considered obese.

4.3.5 Breastfeeding[99]

Breastfeeding is important for the health and development of infants and their mothers and is linked to the prevention of major health inequalities. The provision of

[98] Welsh Government - Wales maternity and birth statistics 2023
[99] Welsh Government - Breastfeeding data: 2024 (Wales)

human milk is the most accessible and cost-effective activity available to public health which is known to prevent a range of infectious and non-communicable diseases (NCDs), specifically gastroenteritis, childhood obesity, diabetes type 2 and maternal breast cancer

Every child in Wales should receive the best start in life[100], and breastfeeding can enhance this start. However, breastfeeding may not be every woman's choice. Therefore, it is essential all families have access to sufficient evidence-based information to make an informed choice and subsequently supported in whatever choice they make.

Breastfeeding data for Wales for 2024[101] is based on a mother's intentions to breastfeed prior to birth, therefore data is based on mothers who delivered in 2024 rather than children born in 2024.

- 65% of all mothers in Wales intended to breastfeed prior to giving birth. This percentage has remained broadly stable, however in the latest year it had decreased by 1.0% when compared to the previous year but increased by 1.7% when compared to five years ago
- 61% of mothers who gave birth to multiple children (twins, triplets or quadruplets) intended to breastfeed in 2024. This is 1.9% lower than the previous year and 3.1% higher than the rate five years ago
- 64% of babies were breastfed at birth. The percentage has been on an upward trend and is 2.2% higher than five years. But also decreased in the latest year as it was 1.2% lower compared to 2023
- 57% of babies were breastfed at 10 days. The percentage has been on an upward trend and is 8.3% higher than five years ago and 1.9% higher than 2023.
- 44% of babies were breastfed at 6 weeks. The percentage has been on an upward trend and is also 9.8% higher than five years ago and 3.4% higher than 2023
- 32% of babies were breastfed at 6 months. The percentage has been on an upward trend and is also 10% higher than five years ago and 3.8% higher than 2023

Mothers in the most deprived areas were less likely to breastfeed than those in the least deprived areas. 52% of mothers in the most deprived areas in 2024 breastfed at birth compared with 75% of mothers in the least deprived areas in 2024. Breastfeeding rates at birth within each quintile of deprivation have remained relatively stable since 2019. However there has been an increase of over 3% in breastfeeding rates at birth in the most deprived areas from 49% in 2019 to 52% in 2024. There was an increase of 0.7% over the same time period for those in the least deprived areas.

NB Percentages do not include data for Aneurin Bevan University Health Board.

[100] Welsh Government - The Well-being of Future Generations
[101] Welsh Government - Breastfeeding data: 2024 (Wales)

4.3.6 General health needs

There are many common health problems that are associated with pregnancy. Some of the more common ones are:

- Frequent urination
- Pelvic pain
- Piles (haemorrhoids)
- Skin and hair changes
- Sleeplessness
- Stretch marks
- Swollen ankles, feet, fingers
- Swollen and sore gums, which may bleed
- Tiredness
- Vaginal discharge
- Vaginal bleeding
- Varicose veins.

4.4 Race

Public Health Wales has found that ethnicity is an important issue because, as well as having specific needs relating to language and culture, persons from ethnic minority backgrounds are more likely to come from low- income families, suffer poorer living conditions and gain lower levels of educational qualifications.

In addition, certain ethnic groups have higher rates of some health conditions. For example, South Asian and Caribbean-descended populations have a substantially higher risk of diabetes; Bangladeshi-descended populations are more likely to avoid alcohol but to smoke, and sickle cell anaemia is an inherited blood disorder, which mainly affects people of African or Caribbean origin.

4.5 Religion or belief

Beliefs about health, illness and healthcare can vary between religions and cultures and within any given religious or cultural group. Religious belief may affect the acceptability of aspects of medical care, for example diagnostic procedures and certain types of treatment, and of the potential impact of religious observances on health and treatment plans such as periods of fasting.

It should never be assumed that an individual belonging to a specific religious group will necessarily be compliant with or completely observant of all the views and practices of that group. Individual patients' reactions to a particular clinical situation can be influenced by a number of factors, including what branch of a particular religion or belief they belong to, and how strong their religious beliefs are (for example, orthodox or reformed, moderate or fundamentalist). For this reason, each person should be treated as an individual.

Beliefs, rites and rituals around pregnancy and birth, 'coming of age', menstruation, marriage, and death are highly variable between religions and cultures, and may all impact on health and health-seeking behaviours.

There is a possible link with 'honour based violence' which is a type of domestic violence motivated by the notion of honour and occurs in those communities where the honour concept is linked to the expected behaviours of families and individuals

Female genital mutilation is related to cultural, religious and social factors within families and communities although there is no direct link to any religion or faith. It is an illegal practice that raises serious health related concerns

There is a possibility of hate crime related to religion and belief.

4.6 Sex

The NHS Wales Women's Health Plan 2025-2035[102] highlights:

- Women tend to live fewer years free from disability compared to men – the average age of women in Wales is 82 years, but the healthy life expectancy has dropped to 60.3 years, with women from black and minority ethnic groups, disabled women and from areas of greater deprivation, affected most.
- Women often wait longer for pain relief than men.
- Women's symptoms particularly for conditions such as cardiac disorders, asthma, incontinence, and mental health issues, can differ significantly from men's.
- One in five women in the UK (19%) experience a common mental disorder (such as anxiety or depression), compared with one in eight (12%) men.
- Data within Wales shows that women and girls between the ages of 10-24 years, are three times as likely to self-harm compared to males.
- Women have a greater risk of developing dementia during their lifetime than men, with women twice as likely to develop Alzheimer's, the most common cause of dementia. This is mainly due to women living longer than men and old age is the biggest risk factor for this disease.
- Alzheimer's is the leading cause of all deaths in women in Wales.
- Over 212,000 people live with diabetes in Wales, affecting more men than women across all age groups.
- However, women are more severely impacted by the consequences of diabetes compared to men.
    - Women with diabetes have a greater risk of heart disease.
    - Women are more likely to be on lower incomes and lack time and ability to focus on caring for themselves on top of caring for others, so leading to poorer outcomes.
    - Women are more likely to have retinopathy and neuropathy, and hormonal fluctuations may exacerbate this further, such as in pregnancy.
    - Diabetes control is more difficult for women due to hormonal fluctuations.

[102] NHS Wales - NHS Wales Women's Health Plan 2025-2035 December 2024

    - Elderly women with type 2 Diabetes Mellitus and end stage renal disease are more likely to die than men with similar problems.
- Ischemic heart disease is the second leading cause of death for women in Wales, killing twice as many women as breast cancer. A study by the University of Leeds found that women had a 50% higher chance of receiving a wrong initial diagnosis following a heart attack, with a 70% increased risk of death after 30 days compared with those who had received a correct diagnosis. Evidence also shows that women are less likely to be prescribed medications that prevent further heart attacks.
- Musculoskeletal conditions are the most common cause of long-term pain and physical disability globally. They are the leading cause of life-limiting conditions in Wales, and are strongly linked to deprivation, ethnicity, gender and age. Women consistently demonstrate more prevalent and severe clinical presentations of Musculoskeletal disorders, and this disparity increases in magnitude with age.
- One in three women will have a fragility fracture over the age of 50 years, compared to one in five men.
- Rheumatoid arthritis is the most common inflammatory condition, affecting 1% of the population. It has a two to three times higher prevalence in women than in men, suggesting female hormonal factors play a role in the development of the disease.
- The percentage of girls with low mental wellbeing scores increases as they get older, with around twice as many 16 year-old girls having a low mental wellbeing score, compared with 16 year-old boys.
- Fewer adolescent girls, when compared with boys, achieve the recommended physical activity target of at least 60 minutes per day across the week.
- More girls than boys aged 11-16 years will drink alcohol or smoke.
- While the majority of syphilis diagnoses are in men, there has been a 26% increase in case amongst females between 2021 and 2022, with an overall upward trend noted since 2013.

Other examples of the gender health gap include the following.

- Men are more likely to die from coronary heart disease prematurely and are also more likely to die during a sudden cardiac event. Women's risk of cardiovascular disease in general increases later in life and women are more likely to die from stroke.
- Women are more likely to report, consult for, and be diagnosed with depression and anxiety, although it is possible that depression and anxiety are under-diagnosed in men. Suicide is more common in men, as are all forms of substance abuse.
- According to the Welsh Government's 2025 modelling update on alcohol consumption[103] 23% of adult drinkers in Wales drink above the UK low-risk weekly guidelines. This group consumes 70% of all alcohol sold in Wales, highlighting a concentration of consumption among heavier drinkers. Alcohol disorders are twice as common in men, although binge drinking is increasing

[103] Welsh Government - New modelling of alcohol pricing policies, alcohol consumption and harm in Wales

at a faster rate among young women. Among older people, the gap between men and women is less marked.
- Morbidity and mortality are consistently higher in men for virtually all cancers that are not sex specific. At the same time, cancer morbidity and mortality rates are reducing more quickly for men than women.

4.7 Sexual orientation

A report published by the LGBT Foundation in 2023[104] highlighted key statistics which it believes most clearly evidence the sequential and significant impact of experiencing inequality over the life course.

- In 2017, 21% lesbian, gay, bisexual, and transgender people reported that they had experienced a homophobic, biphobic, or transphobic hate crime in the previous 12 months, with this rising to 41% for trans people.
- 23% of lesbian, gay, bisexual, and transgender people have at one time witnessed anti-lesbian, gay, bisexual, and transgender remarks by healthcare staff.
- In 2017, one in six lesbian, gay, bisexual, and transgender people reported drinking almost every day in the last year; this compares to one in ten adults in the general population who report drinking alcohol on five or more days per week.
- 45% of trans young people (aged 11-19) and 22% of cis lesbian, gay, and bisexual young people have tried to take their own life. Among the general population the NHS estimates this figure to be 13% for girls and 5% for boys aged 16-24.
- 24% of homeless people aged 16-24 are lesbian, gay, bisexual, and transgender and 69% of these people believe parental rejection was a main factor in becoming homeless.
- 42.8% of lesbian, bisexual, transgender women said that they had experienced sexual violence compared to an estimated 20% of all women in the UK.
- 55% of gay, bisexual, and trans men were not active enough to maintain good health, compared to 33% of men in the general population.
- In 2017, 52% of lesbian, gay, bisexual, and transgender people reported experiencing depression in the previous year. This includes 67% of trans people and 70% of non-binary people.
- In 2017, 40% of trans people who had accessed or tried to access public healthcare services reported having experienced at least one negative experience because of their gender identity in the previous 12 months.
- 93% of lesbian, gay, bisexual, and transgender specialists and service users consider that more work needs to be done to improve end of life services for lesbian, gay, bisexual, and transgender people.
- LGB+ people are 2.2 times more likely to have self-harmed or attempt suicide than heterosexual people.
- Gay and bisexual men are 2.5 times more likely to attempt suicide.

[104] LGBT Foundation - Hidden Figures: LGBT Health Inequalities in the UK

- Nearly one in five (18.6%) lesbian, gay and bisexual young people (16–24) have attempted suicide.[105]

4.8 Gender re-assignment[106]

Gender reassignment refers to individuals, who either:

- have undergone, intend to undergo or are currently undergoing gender reassignment (medical and surgical treatment to alter the body), or
- do not intend to undergo medical treatment but wish to live permanently in a different gender from their gender at birth.

'Transition' refers to the process and/or the period of time during which gender reassignment occurs (with or without medical intervention). According to the Gender Identity Research and Education Society there are a number of health and wellbeing issues associate with gender re-assignment. These include:

- Drugs and alcohol are processed by the liver as are cross-sex hormones. Heavy use of alcohol and/or drugs whilst taking hormones may increase the risk of liver toxicity and liver damage.
- Alcohol, drugs and tobacco and the use of hormone therapy can all increase cardiovascular risk. Taken together, they can also increase the risk already posed by hormone therapy.
- Smoking can affect oestrogen levels, increasing the risk of osteoporosis and reducing the feminising effects of oestrogen medication.
- Transgender people face a number of barriers that can prevent them from engaging in regular exercise. Many transgender people struggle with body image and as a result can be reluctant to engage in physical activity.
- Gender dysphoria is the medical term used to describe this discomfort. Transgender people are likely to suffer from mental ill health as a reaction to the discomfort they feel. This is primarily driven by a sense of difference and not being accepted by society. If a transgender person wishes to transition and live in the gender role they identify with, they may also worry about damaging their relationships, losing their job, being a victim of hate crime and being discriminated against. The fear of such prejudice and discrimination, which can be real or imagined, can cause significant psychological distress.

4.9 Marriage and civil partnership

There are no specific health needs that are unique to this population.

4.10 University students

There are two universities in North Wales, Bangor University in Gwynedd (approximately 10,000 students) and Wrexham University in Wrexham (approximately 8,500 students).

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[105] UK wide data from ONS data reported ONS Data: LGB+ Community Facing Higher Mental Health Risks | LGBT HERO

[106] Gender Identity Research and Education Society - Trans Health Factsheets

Starting university is an exciting time. For many young people it will be their first time away from home so there is not only the pressure of becoming independent and self-reliant in a new environment. It is a time of transition, and the challenges of university life can impact on health care. Health needs[107] identified include:

- screening for, and treatment of, sexually transmitted diseases.
- smoking cessation,
- meningitis vaccination,
- alcohol and substance use support,
- contraception, including emergency hormonal contraception, provision,
- mental health support (stress, anxiety, and depression are common due to academic pressures and personal issues),
- social wellbeing support (feeling connected and supported within the university community. Loneliness and isolation can negatively impact both mental and physical health), and
- physical health concerns (poor nutrition, lack of exercise, and sleep disturbances).

A UK study undertaken by Transforming Access and Student Outcomes in Higher Education and The Policy Institute Kings College London examined British higher education in 2024[108],and found:

- Almost one fifth (18%) of students reported a mental health issue in 2024, triple the rate in 2017, when it was 6.0%.
- 17.9% of students report mental health challenges, indicating nearly one in five students, or around 300,000 UK students are now experiencing mental health difficulties.
- Anxiety and depression continue to be the primary mental health challenges among students, linked to:
    - cost of living pressures,
    - academic stress,
    - post pandemic effects, and
    - social isolation and loneliness.
- Mental health difficulties are higher amongst lesbian, gay, bisexual, queer and allies. In 2024 bisexual students had the highest rate (30%), followed by lesbian students (29%).
- More than half of non-binary students and queer-identifying students now experience mental health difficulties.
- Female students are twice as likely to report mental health difficulties (22%) compared to male students (11%), and the gap has increased compared to 2023. Death by suicide is more prevalent among young men than young women, suggesting a highly acute need for support among male students.
- Of 40,810 students asked if they had considered dropping out of university, 11,424 (27.9%) said they had with the most common reason stated as mental

[107] Education - Health and Wellbeing Services for Students in UK Universities 2024
[108] Transforming Access and Students outcomes in Higher Education - Report Student mental health in 2024: How the situation is changing for LGBTQ+ students

health difficulties. This reason was significantly greater than all other reasons, including financial difficulties.
- The 2024 data show the proportion of students who have considered dropping out has fallen after previous years of fairly consistent rates.

4.11 Offenders and those on probation

HMP Berwyn is a Category C (training prison) adult male prison in Wrexham, housing approximately 2,100 men and is the largest prison in the UK. There are no female prison facilities in Wales, and many women from North Wales serve their sentences in HMP Styal in Cheshire which is a closed category prison.

The health board commissioned an assessment of the health and social care needs of those in HMP Berwyn in 2021[109]. It identified the following characteristics of the population.

- The rate of men treated for asthma was higher than predicted and had increased since the needs assessment undertaken in 2015.
- The rate of identified and treated chronic obstructive pulmonary disease was below average among comparator prisons.
- The rate of identified and treated diabetes was below average among comparator prisons, although this may be explained by the fact white men are overrepresented in the prison.
- Whilst rates of epilepsy were higher than the predicted prevalence, it was lower than the average among comparators.
- The identification rate for hypertension was well below the expected prevalence based on the population age profile. It was also low among comparators, although identification at the comparators was also lower than predicted.
- Whilst identification for coronary heart disease was at the predicted rate, the rate was relatively low among comparators.
- Identification for cancer was similar to predicted rates.
- The rate of identified depression was likely lower than is typical, although the level of prescribing of antidepressant medications per year per 100 residents showed a 39% increase from 2019/20 to 2020/21. Whilst similar increases had been reported in other prisons in 2020/21, they were far lower in HMP Berwyn.
- The numbers of residents identified with anxiety and stress-related disorders are higher than expected.
- The rate of residents with severe and enduring mental health problems (including schizophrenia, bipolar affective disorder or other psychoses) was average compared to comparators but had decreased slightly since the 2015 assessment.
- The rate of residents with a recorded diagnosis of post-traumatic stress disorder was much higher than predicted.
- The rate of identified personality disorder was slightly below the average among comparators.

[109] Tamlyn Cairns Partnership - HMP Berwyn health and social care needs assessment, June 2021

- The identification rate of residents with a co-occurring mental health and/or substance misuse problems (dual diagnosis) had increased, mainly due to greater identification. Although the recorded prevalence of mental health problems overall (including substance misuse) is about average at HMP Berwyn compared to comparators, the profile of identified conditions seems to be more skewed towards dual diagnosis than most.
- The recorded identified rate of learning disability was well below the predicted rate based on literature. However, comparators also reported a lower proportion than predicted.
- The identified prevalence of autism spectrum disorders was similar to the UK average.
- Whilst the diagnosis rate for attention deficit hyperactivity disorder was low against predictions it was slightly higher than the average across comparators.
- The observed demand for drug treatment for substance misuse was lower than predicted.
- For alcohol treatment, the observed demand was also far lower than predicted (this is not unusual and attracting prisoners to alcohol treatment is notoriously challenging in any establishment).
- The substance use profile of those in treatment was more weighted towards non-opiate use compared to Category C prisons on average, with lower proportions of patients in treatment reporting alcohol use compared to an average Category C prison.
- A lower proportion of substance misuse treatment entrants currently injecting and a higher proportion of past injectors was reported compared to the national average for Category C prisons (though it was similar to the average for Welsh prisons).
- There was a high rate of sexually transmitted infection testing and the vast majority of positive results were for chlamydia.
- The number of patients recorded as receiving any of a wide range of vaccines had dropped dramatically during the Covid-19 pandemic.

An assessment of the health and social care needs of residents in approved premises in Wales was undertaken in 2023 by the health board with the HM Prison & Probation Service in Wales[110]. Whilst the health needs of the prison population are well documented, less is known about the needs of those who are under the supervision of the probation service.

“Approved premises” are hostel-type accommodation which has been approved for the temporary supervision and rehabilitation of offenders and for people on bail. They are staffed 24 hours a day and accommodate high-risk offenders, the majority of whom come straight from prison. Of the four approved premises in Wales, two are in North Wales – Bangor (Ty Newydd) and Wrexham (Plas Y Wern). They house men, 60% of whom have been convicted of sexual offences and the remainder violent or other offences. Female offenders from Wales who need the services of an approved premises are required to attend approved premises in England.

[110] Betsi Cadwaladr University Health Board - A Health and Social Care Needs Assessment for Residents in Approved Premises in Wales, September 2023

Stays in approved premises are generally between eight and 12 weeks but can be longer in some circumstances. Those staying in approved premises often have complex health and social care needs and their time in the approved premises affords an opportunity for each resident to be signposted to agencies that are able to offer support, for example GPs, substance misuse services, community mental health teams, and social workers.

The assessment found that mental health and neurodiverse conditions represent the biggest health need of approved premises residents, and also the largest mismatch between demand and provision of healthcare services. The gaps in service provision were identified as:

- the provision of medications on release from prison not being sufficient to cover the time until a prescription can be written and dispensed in the community. In addition, some GPs may not wish to re-prescribe some psychoactive medications necessitating referral to specialist services.
- those residents under the care of mental health services within prison feeling that they have to start again when back in the community.
- The waiting list for referral to mental health services is often longer than the whole duration of the stay within an approved premises.

Physical health conditions were found at a level equivalent to or lower than that seen in the general population. This may be a true finding or may be a reflection of the younger age of approved premises residents with relatively few being in the older age categories where most physical health conditions become more prevalent. The assessment did not conclude that access to primary and secondary medical care for physical health conditions was a problem for any condition apart from access to dental care.

The assessment found that there is an unmet need for dental treatment amongst approved premises residents. The majority will have moved area, and therefore have no relationship with local dental practices, thereby necessitating the need to join a waiting list to be able to register as a new patient.

The rates of smoking and vaping were found to be considerably higher than the general population. As smoking is not allowed in prisons, those residents who reported smoking had recently started or restarted the habit.

Residents were found to have relatively high historic levels of problematic alcohol use, gambling, and substance misuse. The survey undertaken to inform the needs assessment did not ask about current behaviours as licence conditions would preclude such activities.

4.12 Homeless and rough sleepers

Homelessness is a complex issue. Although it is commonly associated with people sleeping rough, a person can be classed as being homeless, or at risk of being homeless, in many different circumstances:

- Temporarily staying with friends or family (also known as sofa surfing).

- Staying in a hostel or bed and breakfast.
- Living in very overcrowded conditions.
- At risk of violence or abuse in their home.
- Living in poor conditions that affect your health, or your home is unfit to live in.
- Living somewhere that you have no legal right to stay in (squatting).
- Living somewhere that you cannot afford to pay for without depriving yourself of essentials.
- Forced to live apart from family, or from someone they would normally live with, because the accommodation isn't suitable or a relationship breakdown.

Sleeping rough is dangerous and is seriously detrimental to a person's physical and mental health. Research by the homeless charity Crisis[111], found that people who sleep rough are 17 times more likely to be victims of violence than the general public. More than one in three people sleeping rough have been deliberately hit or kicked or experienced some other form of violence whilst homeless. Homeless people are over nine times more likely to take their own life than the general population.

The average life expectancy for someone sleeping rough in Wales remains at 45 years for men and 43 years for women and has not improved since the 1990s. This is compared to the average life expectancy for the general population of 77.9 for males and 81.8 for females. The overall numbers of people who have died whilst homeless across the UK have increased by 9% with an average of four deaths every day of the year. 90 people died while homeless in Wales in 2024. The majority of homelessness deaths (55%) can now be classed as a 'death of despair' with more deaths by suicide being reported and evidence of a higher rate of drug related deaths. There are significant issues with psychoactive substances such as spice and synthetic opioids[112].

The monthly rough sleeper count is now published by Welsh Government[113]. In July 2025 there were:

- Five rough sleepers in Isle of Anglesey
- Nine in Gwynedd
- One in Conwy
- Three in Denbighshire
- One in Flintshire

Over the last three years, Gwynedd has consistently had the highest number of rough sleepers of the five local authorities, and Conwy the least.

The key findings of a report by Homeless Link in 2022[114] were as follows.

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[111] Crisis, Sanders, B. & Albanese, F. - "It's no life at all" - Rough sleepers' experiences of violence and abuse on the streets of England and Wales (2016)
[112] Museum of Homelessness – The Wallich homeless deaths (2025)
[113] StatsWales - Rough sleepers by local authority
[114] Homeless Link - The unhealthy state of homelessness 2024: Findings from the homeless health needs audit

- People experiencing homelessness suffer from worse physical and mental health than the general population.
- Between 2018 and 2021, 63% of respondents reported they had a long term illness, disability, or infirmity (22% in the general population).
- 80% of those with a physical health condition reported having at least one comorbidity, with 29% having between five and ten diagnoses.
- The most commonly reported condition was joint aches/problems with bones and muscles, followed by dental/teeth problems.
- The number of people with a mental health diagnosis has increased substantially from 45% in 2014 to 82% in the 2018 – 2021 cohort (12% of the general population).
- 81% of those with a mental health condition reported experiencing at least two mental health conditions, with 17% reporting five or more.
- 45% of respondents reported they are self-medicating with drugs or alcohol to help them cope with their mental health.
- Barriers in accessing needed support for physical and mental health means people experiencing homelessness are over reliant on emergency health care services, with 48% of respondents having used A&E services in the last year: three times more than the general population.
- Between 2018 and 2021 a total of 38% of respondents had been admitted to hospital in the 12 months before participating in a homeless health needs audit. The most common reason for hospital admission related to a physical health condition (37%), and 28% related to either a mental health condition or self-harm or attempted suicide.
- For those who had been admitted to hospital nearly a quarter (24%) had been discharged to the streets.
- 54% of respondents had used drugs in the 12 months prior to taking part in a homeless health needs assessment. 38% reported that they have, or are recovering from, a drug problem.
- 20% regularly exceeded the low risk drinking guidelines (24% in the general population). 29% reported they have, or are in recovery from, an alcohol problem.
- 76% of respondents reported that they smoke cigarettes, cigars, or a pipe (13.8% in the general population). Of these, 50% would like to give up.
- Nutrition presents as a big challenge with a third of respondents reporting that on average, they eat only one more meal a day. 66% ate one or fewer portions of fruit or vegetables per day, with just 4% eating the recommended five or more.

Groundswell's study Healthy Mouths[115] reveals that homeless people suffer extremely poor oral health compared to the general population.

- 90% have had issues with their mouth since becoming homeless. Particularly common were bleeding gums (56%), holes in teeth (46%) and dental abscesses (26%).

[115] Groundswell - Healthy Mouths

- Many participants had experienced considerable dental pain. 60% had experienced pain from their mouths since they had been homeless. 30% were currently experiencing dental pain.
- 70% reported having lost teeth since they had been homeless and 7% had no teeth at all 35% had teeth removed by a medical professional, 17% lost teeth following acts of violence and 15% of participants pulled out their own teeth.

The study identified some key factors underlying poor oral health in homeless people.

- The diet of participants is damaging to oral health – lack of access to health food and a need for a source of energy meant high levels of sugar consumption were present.
- High rates of drug and alcohol misuse and smoking tobacco were likely to be damaging oral health. 37% had alcohol misuse issues, 33% had drug misuse issues and 78% were current smokers.
- Poor mental health was common which had a significant impact on their ability to care for themselves and seek treatment.
- Whilst participants highly valued and understood the importance of taking care of their oral health, the ability to do so was impacted by homelessness.
- Rates of cleaning teeth were significantly lower than the advised minimum levels – 35% were cleaning their teeth twice or more a day compared to 75% of the general population. 29% were cleaning their teeth less than once a day or never.
- Alcohol and drugs were commonly used in an attempt to manage oral health issues. 27% of participants had used alcohol to help them deal with dental pain and 28% had used drugs.

According to report by Centrepoint[116], homeless young people are amongst the most socially disadvantaged in society. Previous research has shown that many have complex problems including substance misuse, mental and physical health problems, and have suffered abuse or experienced traumatic events. 42% of homeless young people have a diagnosed mental health problem or report symptoms of poor mental health, 18% have attempted suicide, 31% have a physical health problem (such as problems with their breathing, joints and muscles, or frequent headaches), 21% have a history of self-harm, 52% report problems with their sleep, 55% smoke, and 50% use illegal substances.

4.13 Gypsy and Traveller communities

Gypsies and Travellers are among the UK's longest established minority ethnic populations. Romani Gypsies and Irish Travellers are recognised racial groups under Equality Act 2010. In the 2021 Census 3,630 people identified as Gypsy or Irish Traveller in Wales, representing 5.1% of the total Gypsy/Irish Traveller population across England and Wales This is approximately 0.12% of the Welsh population and is an increase of 845 people from the 2011 Census[117].

[116] Centrepoint - Toxic Mix: The health needs of homeless young people 2014
[117] Census 2021 - Gypsy or Irish Traveller populations, England and Wales - Office for National Statistics

In Wales, Gypsies and Travellers are entitled to access GP treatment as a permanent or temporary resident. Studies have shown that Gypsies and Travellers face challenges in accessing services, which may be due to:

- Transient nature of being in the area.
- Location of sites.
- Transport – particularly related to women who often cannot drive.
- Low levels of health literacy of what services they are entitled to use or how to access them.

Being Gypsy, Roma or Traveller is usually an important part of someone's identity. Cultural beliefs include considering that health problems should be dealt with by household members or kept within the extended family unit. There is also a strong gender divide in Gypsy and Traveller culture and a value of privacy.

A presentation to the Doncaster Health and Wellbeing Board in November 2023[118] highlighted the following facts:

- Gypsy and Traveller people will live between ten and 25 less years than the general population.
- The average health of 60-year-olds from Gypsy or Irish Traveller communities is similar to those of an average white British 80 year old.
- Gypsy, Roma and Traveller men are over 12 times more likely to suffer with more than two physical health conditions than white British men.
- Roma people had the highest risk of not being able to access health and social care services.
- Gypsy and Traveller mothers are 20 times more likely to experience the death of a child.
- 29% of Gypsy Roma and Traveller parents are likely to experience one or more miscarriages (compared to 16% non-traveller group surveyed).
- Roma mothers experience higher rates of poor infant outcomes, such as preterm births and low birth weight.
- Whilst the evidence on mental health and suicide is limited due to poor data collection it shows:
    - high levels of unmet need,
    - people in the Gypsy, Roma and Traveller community are three times more likely to be anxious and twice as likely to suffer from depression,
    - mental health is a taboo subject,
    - men are more likely to "reach for the rope" than talk, and
    - Irish Traveller men are seven times more likely to die by suicide, with women six times more likely.
- The challenges faced in accessing health and care include:
    - hate crime, marginalisation, discrimination,
    - cultural beliefs,
    - low or no literacy,

[118] Doncaster Health and Wellbeing Board meeting (Item 11) - Health inequalities – a focus on Gypsy Roma Traveller communities

    - English not the first language,
    - digital exclusion,
    - lack of education,
    - poverty,
    - transport, and
    - unconscious bias/staff attitude.
- The Evidence for Equality National Survey[119] in 2023 revealed that more than a third of people from ethnic and religious minority groups had experienced some form of racist assault. The survey had the largest number of Gypsy, Roma and Traveller participants in any national survey to date and revealed:
    - 62% of Gypsies and Travellers had experienced racial abuse, which was the highest out of all minority ethnic groups surveyed,
    - 47% of Roma people had been racially assaulted, and
    - 37% of Roma people have been physically attacked.
- The wide effects of discrimination include:
    - poor housing, limited access amenities,
    - Gypsy, Roma and Traveller people experience the highest levels of social and economic deprivation,
    - more than half of Gypsy, Roma and Traveller people having no educational qualifications,
    - 85% of Gypsy or Traveller men and 65% of Roma men were in precarious employment, compared with 19% of white British men, and
    - the Gypsy Roma Traveller community accounts for 6% of the prison population.
- In relation to Gypsy Roma Traveller children and young children:
    - they are statistically the most vulnerable of any group in UK,
    - 86% reported bullying as their biggest challenge at school,
    - leave school early,
    - approximately 50% are persistent non-attenders at school,
    - they have the lowest educational attainment of all ethnic groups, and
    - make up 15% secure training units.

4.14 Refugees and asylum seekers

An asylum seeker is a person who is also seeking international protection from dangers in their home country, but whose claim for refugee status hasn't been determined legally. For example, a person has come to the UK to exercise his or her legal right to claim asylum under the 1951 UN Convention on the Status of Refugees often shorted to 1951 Refugee Convention. If their claim is successful, the person is granted refugee status.

A refugee is a person who has been forced to flee their home because of war, violence or persecution, often without warning, and is unable to return home unless and until conditions in their native lands are safe for them.

A migrant is an umbrella term which does not have a legal definition under international law. It usually describes a person who has left their home, either within

[119] Evidence for Equality National Survey, Centre on the Dynamics of Ethnicity - Racism and ethnic inequality in a time of crisis

their country or across borders. This can be temporary or permanent and be due to various reasons. For example, they may feel they have no choice but to leave their homes due to political unrest, poverty or other serious circumstances which may make returning unsafe. Others voluntarily leave for reasons such as education, seasonal work opportunities or to join their families.

Issues of immigration and asylum are not devolved powers to Wales; however, the Welsh Government has responsibilities over many areas of life that will affect asylum seekers based in Wales, one of which is their access to health services.

Asylum seekers are one of the most vulnerable groups within society, with often complex health and social care needs. These may be influenced by experiences prior to leaving their home country, during transit, or on arrival in the UK.

Many asylum seekers will have complex health and social care needs. Pregnant women, unaccompanied children, those with significant mental health problems, and those who have experienced traumatic events such as rape or torture, are likely to be particularly vulnerable. Although, many of their health requirements are the same as those of the local community, asylum seekers may also have different health and health related problems[120]. These may include:

- specific problems arising from their experiences and circumstances that may have led to their asylum application eg they have experienced or witnessed torture or abuse.
- health challenges such as:
    - incomplete immunisations,
    - communicable diseases such as tuberculosis, human immunodeficiency virus/acquired immune deficiency syndrome and other sexually transmitted diseases, and
    - vulnerability to specific conditions,
- chronic disease,
- mental health problems which may be related to past experiences or pre-existing problems and potentially exacerbated by current circumstances eg post-traumatic stress disorder, and
- poor oral health.

There is evidence that non-UK born individuals residing in the UK have poorer outcomes for physical and mental health than other residents, although this varies by migration history. Socioeconomic circumstances and immigration regulations affecting some migrant groups impact negatively on their access and use of health care. Rates of infectious diseases, including tuberculosis and human immunodeficiency virus, are higher than for non-migrants. A lack of awareness of eligibility for healthcare, language issues, and a fear of being reported to the UK Border Agency, can be barriers to accessing care.

There is evidence of higher levels of depression and anxiety among asylum seekers and refugees compared with the national population, and much research has focused on the physical and mental impact of conflict and war in countries of origin.

[120] Welsh Government - Health and wellbeing provision for refugees and asylum seekers (2018)

Particularly vulnerable groups are children, and women who have suffered sexual and physical abuse.

In January 2019, the Welsh Government launched Nation of Sanctuary Refugee and Asylum Seeker Plan[121], which seeks to address key issues of refugees and asylum seekers.

- Refugees and asylum seekers can access health services (including mental health services) which they require throughout the 'asylum journey'. This includes health assessments on arrival and during the dispersal and post-trauma phases.
- Refugees and asylum seekers are provided with the information and advice they need to begin to integrate into Welsh society from day one.
- Asylum seekers are not prevented from accessing appropriate Welsh Government schemes which would support their integration.
- New refugees and asylum seekers are less likely to fall into destitution.
- All refugees and asylum seekers (particularly unaccompanied asylum-seeking children) are properly safeguarded and can access advocacy support.
- Refugees and asylum seekers can access educational opportunities, including language skills, to help them rebuild their lives and fulfil their potential.

Good communication with migrants is essential. Determining the language and suitability of format (eg written, audio, face to face, telephone) and support available, such as advocacy and interpretation, are critical elements to ensure effective communication. In addition, other issues highlighted for both migrants and asylum seekers include the need for more advocacy and floating support for migrants, lack of a strategic approach to information and service provision for new migrants and lack of coordination between services for migrants, asylum seekers and refugees.

4.15 Military veterans

The 2021 Census was the first to ask people if they had previously served in the UK armed forces. People aged 16 years and over were asked whether they had previously served in the regular or reserve UK armed forces, or both. People currently serving in the UK armed forces and those who had never served were advised to tick "no".

For the purposes of the Census 2021, a veteran is defined as "people who have previously served in the UK armed forces". It includes those who have served for at least one day in the armed forces (regular or reserve), or Merchant Mariners who have seen duty on legally defined military operations[122].

The table below shows the number of veterans living in the area of the five local authorities in North Wales based on the Census 2021.

[121] Welsh Government - Nation of Sanctuary – Refugee and Asylum Seeker Plan (2019)
[122] Office for National Statistics - TS071 previously served in the UK armed forces Census 2021

Table 4.1 – number of veterans living in each local authority 2021

Local authority	Previously served in both regular and reserve UK armed forces	Previously served in the UK regular armed forces	Previously served in UK reserve armed forces	Total
Flintshire	286	5,249	1,237	**6,772**
Conwy	242	4,453	954	**5,649**
Wrexham	205	3,923	938	**5,066**
Denbighshire	219	3,344	746	**4,309**
Gwynedd	167	3,214	796	**4,177**
Isle of Anglesey	121	2,619	481	**3,221**

In September 2024, Kings Centre for Miliary Health Research published a report[123]", covering data collected from serving and ex-serving UK Armed Forces Personal. 4,104 current and ex-serving personnel of the Armed Forces responded to a detailed questionnaire exploring symptoms of common mental disorders, portable post-traumatic stress disorder, complex post-traumatic stress disorder and alcohol misuse. This data showed that:

- 28% of respondents reported symptoms of common mental disorders, up from 22% in 2014/16 and 20% in 2004/06.
- 9% of respondents reported probable post-traumatic stress disorder, up from 6% in 2014/16 and 4% in 2004/06.
- Ex-serving Regular personnel reported higher probable post-traumatic stress disorder rates than serving Regulars at 11% versus 7% respectively.

The data highlights the prevalence based on serving status with ex-serving regular personnel at 11% and serving regular personnel at 7%. This supports past findings that post-traumatic stress disorder often emerges or worsens after leaving service, particularly during the transition to civilian life.

Phase 4 is the first time complex post-traumatic stress disorder had been measured in this cohort providing essential new evidence. It is a subset condition of post-traumatic stress disorder that is often brought about by experiencing long term or recurring traumatic events while also experiencing additional symptoms such as difficulty controlling emotions. Researchers found that almost three quarters (72%) of respondents with probable post-traumatic stress disorder met the threshold for complex post-traumatic stress disorder.

Dr Marie-Louise Sharp, Senior Research Fellow at Kings Centre for Miliary Health Research and the report's lead author said, "post-traumatic stress disorder is a potentially life changing condition that can be difficult to treat. Providing effective treatment to individuals with complex post-traumatic stress disorder can be more complicated, as they can take more time to come forward and ask for help and are

[123] Office for Veterans' Affairs - Office for Veterans' Affairs Final Report. Health and Wellbeing Study of Serving and Ex-Serving UK Armed Forces Personnel: Phase 4

more likely to be managing a range of different mental illnesses. Services providing for ex-service personnel will need to assess how well they support and treat complex and comorbid health conditions.”.

Alcohol misuse had seen declines in previous phases but appears to have levelled off remaining at a high level compared to the general population.

Exposure to combat and post deployment mental health problems have been found to be risk factors for violence both inside and outside the family environment.

The first national data published on veteran suicide in England and Wales[124] showed that in 2021, 253 UK Armed Forces veterans died by suicide of which 93.7% were male and 6.3% were female. 5.9% of the 253 UK Armed Forces veterans' suicides in 2021 were in Wales.

Overall rates for UK veterans were not higher than the general population. However, suicide rates are two to four times higher among male and female veterans aged 16 to 24 compared with the same age group in the general population.

Suicide after leaving the UK Armed Forces 1996–2018: a cohort study[125,126] published in 2023 found UK Armed Forces veterans are at their highest risk of suicide in their first two years of leaving the Armed Forces. Factors associated with higher risk of suicide are:

- being male,
- serving in the Army,
- being discharged between the ages of 16 and 34 years,
- a length of service under 10 years, and
- being untrained on discharge.

A quarter of all veterans who died by suicide had been in contact with mental health services in the year before they died.

The United Kingdom Armed Forces Veteran's Health and Gambling Study was published in 2021[127], and found that veterans are significantly more likely to struggle with gambling problems than non-veterans in the UK. Veterans who responded to the survey were more than ten times more likely than non-veteran respondents to experience gambling harm. They were also four times more likely to have gambled recently, and on more activities than non-veteran respondents. Veterans' gambling was seven times more likely to be motivated by a need to escape or avoid distress and were also found to be at a much greater risk of poor mental health outcomes including depression, anxiety, post-traumatic stress disorder, and to have an alcohol and/or nicotine dependence.

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[124] Census 2021- Suicides in UK armed forces veterans, England and Wales - Office for National Statistics
[125] National Confidential Inquiry into Suicide and Safety in Mental Health, The University of Manchester - Suicide after leaving the UK Armed Forces 1996–2018: A cohort study
[126] Samaritans - Armed Forces and Veteran Suicide
[127] Swansea University - The United Kingdom Armed Forces Veterans' Health and Gambling Study

Other issues that studies have identified as being of importance to veterans include:

- accessing suitable housing and preventing homelessness,
- supporting veterans into employment,
- accessing appropriate financial advice and information about relevant benefits,
- accessing health and support services,
- supporting veterans who have been in the criminal justice system,
- loneliness and isolation, and
- supporting a veteran's wider family.

4.16 Visitors to sporting and leisure facilities and owners of second homes

It is not anticipated that the health needs of this patient group are likely to be very different to those of the general population of North Wales. As they may only be in the area for a short period, their health needs are likely to be:

- Treatment of an acute condition which requires the dispensing of a prescription
- The need for repeat medication
- Support for self-care, or
- Signposting to other health services such as a GP or dentist.

A review conducted by the National Public Health Service for Wales on the impact of tourism on health[128] found the following:

- There is little research done on the health impacts of tourism in the UK.
- Holidaymakers have different patterns of consulting in primary care than the resident population, consulting more often for respiratory, gastrointestinal, minor infections and skin complaints.
- Workload for GPs in popular holiday resorts can increase in summer months.
- Holidaymakers are often ill-prepared for their trip, forgetting vital medications and travelling after major illnesses and surgery. Comprehensive pre-trip counselling by health professionals in the 'donor' areas, especially for those with chronic conditions, could reduce burden on health services in the 'host' areas.
- Tourists often have little local knowledge of conditions, putting them at increased risk of accidents, especially in relation to the natural environment.
- Comprehensive data collection on tourist health episodes and good communication and information sharing between health services, tourist industry and local government can aid planning for the health impacts of tourism.
- Risky behaviour in terms of alcohol use, drug use and sexual behaviour increase when people are on holiday.

[128] National Public Health Service for Wales, 2005. Health Impacts of Seasonal Demographic changes in areas with high levels of tourism in the UK – Key findings from the literature.

- The hedonistic, ‘carnivalised’, transient atmosphere of UK seaside resorts, together with easy access to alcohol can contribute to risk taking in the sexual behaviour of young people. Young people are often drawn into the leisure and entertainment industry geared towards adults which can leave them open to exploitation.

4.17 Socio-economic disadvantage

The socio-economic duty came into force in Wales on 31 March 2021 and requires the health board to address how its decisions might help reduce the inequalities associated with socio-economic disadvantage.

In October 2021, Welsh Government published a report[129] which summarised the key evidence relating to how socio-economic deprivation affects the people of Wales. Despite the importance of health and its links to deprivation being well recognised, health inequity is evidence in Wales with adults in the most deprived areas of the country, for example some North Wales coastal and border towns, having lower life expectancies, and adults and children in poorer areas having worse health outcomes than those in the least deprived areas.

The report highlighted the following key health inequalities of outcome due to socio-economic disadvantage.

- Poorer physical health and lower life expectancies in more deprived areas.
- More likely to suffer from non-communicable disease in more deprived areas.
- People in areas of higher deprivation more likely to have poorer mental health, increased risk of suicide, and are less likely to request help for mental health.
- Reduced access to adequate healthcare for certain communities of interest and in rural areas.
- People from Black, Asian and Ethnic Minority communities are more likely to suffer health inequalities and experience barriers to accessing healthcare and exercise/sport.
- Women more likely to be unpaid carers.
- LGBTQ+ people more likely to suffer from psychological distress.
- Disabled people face more unmet needs in healthcare.

4.18 Welsh language speakers

Whilst the health needs of Welsh language speakers are unlikely to differ to those who do not speak Welsh, the ability for a person to receive services in Welsh, at a time when they are at their most vulnerable, should be an integral part of person-centred care.

[129] Welsh Government - Implementing the Socio-economic Duty. A review of evidence on socio-economic disadvantage and inequalities of outcome October 2021

The “More than just words: Welsh language plan in health and social care”[130] was launched by the then minister for health and social services in August 2022. It stated that professional standards in health and social care services note that effective communication is a key requirement, highlighting the need to maintain dignity and respect. Adoption and delivery of “More than just words” should therefore help improve the quality of care for individuals living in a bilingual country. In the ministerial foreward the then Minister for Health and Social Services illustrated this by describing a scenario where an elderly woman who has lived in a close-knit Welsh language community all of her life, suffers increasingly with dementia and is admitted to a hospital or a care home where the predominant language is English. If she is unable to understand fully what is happening to her as her carers cannot speak her language – she is likely to become more frustrated which is likely to impact negatively on her wellbeing clinical outcomes.

A core element of “More than just words” is the “active offer” – providing a service in Welsh without someone having to ask for it.

[130] Welsh Government - More than just words: Welsh language plan in health and social care August 2022

5 Provision of pharmaceutical services

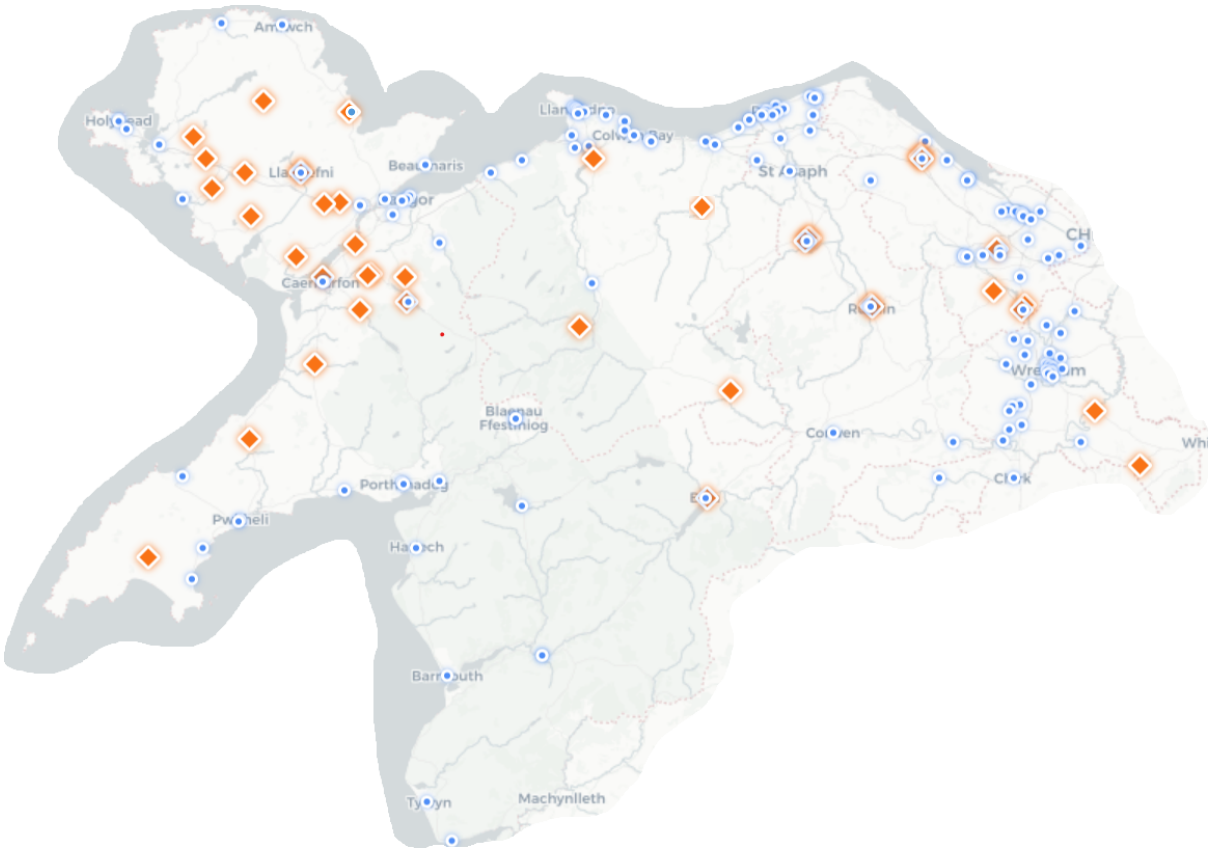
5.1 Current provision within Betsi Cadwaladr University Health Board area

There are 143 pharmacies included in the pharmaceutical list for the area of the health board as of March 2025, operated by 44 different contractors. This is a reduction from 152 pharmacies in the 2021 pharmaceutical needs assessment.

Six pharmacies operate under the ‘essential small pharmacies scheme’, one in each of Anglesey, Central and South Denbighshire, South Meirionydd, and South Wrexham, and two in Dwyfor and North Meirionydd. Being an ‘essential small pharmacy’ means that the pharmacy receives an additional payment to ensure it receives a minimum level of income for the provision of essential services and is therefore viable.

Of the 96 GP practices in the health board area, 34 dispense to eligible patients from 42 sites within the health board’s area. The map below shows the location of these premises.

Map 5.1 – location of pharmacies and dispensing practice premises



© OpenStreetMap © CARTO

Dispensing practice premises

Pharmacy

As can be seen there is a greater density of pharmacies along the north coast and in the east of the health board's area where population density will be greatest. Dispensing practice premises are more likely to be found in areas of lower population density.

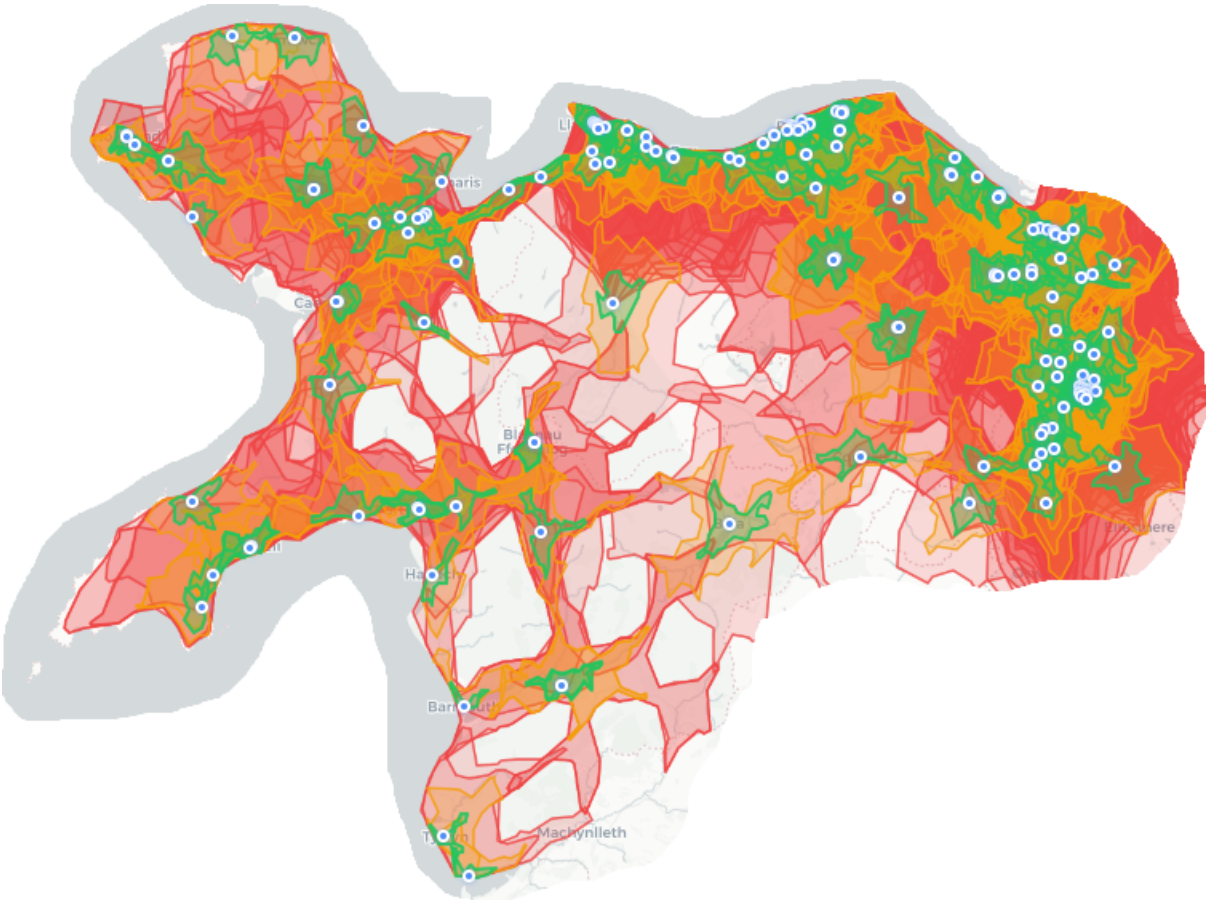
In 2024/25, 84.3% of items prescribed by GP practices in the health board's area were dispensed by pharmacies within the health board's area and 13.1% were dispensed or personally administered by the dispensing GP practices. In the first nine months of 2025/26, 84.8% were dispensed by pharmacies and 13.2% were dispensed or personally administered by the dispensing GP practices.

5.1.1 Access to premises

The health board has chosen a travel time of 20 minutes by car as an appropriate access standard. In order to assess whether residents are able to access a pharmacy in line with this standard travel times were analysed using Claude.ai.

Those areas bounded in green are within a five-minute drive of a pharmacy, the areas bounded in yellow are within a ten-minute drive of a pharmacy, and the areas bounded in red are within a 20- minute drive of a pharmacy. An analysis of the areas that are not within a 20-minute drive of a pharmacy can be found in the respective locality chapters.

Map 5.2 – Time taken to access a pharmacy by car



© OpenStreetMap © CARTO

Responses to the public engagement questionnaire provide the following insights into accessing pharmacies.

- 67.2% of respondents drive to a pharmacy.
- 24.6% walk.
- 4.1% go by bus.
- For 95.0% of respondents their journey time is less than 20 minutes. For 89.3% their journey time is 15 minutes or less.

5.1.2 Access to essential services

Whilst the majority of people will visit a pharmacy during the 08.30 to 18.30 period, Monday to Friday, following a visit to their GP or another healthcare professional, there will be times when people will need, or choose, to access a pharmacy outside of those times. This may be to have a prescription dispensed after being seen by the out of hours GP service, or to collect dispensed items on their way to or from work, or it may be to access one of the other services provided by a pharmacy outside of a person's normal working day.

Responses to the public engagement questionnaire showed that:

- 32.2% of respondents didn't have a preferred time to visit a pharmacy,
- 25.6% preferred 9.00 to 12 noon,
- 15.7% 15.00 to 18.00,
- 12.4% 18.00 to 21.00, and
- 11.6% 12 noon to 15.00.

In relation to the preferred day to access a pharmacy:

- 45.1% didn't have a preferred day,
- 28.7% said weekdays in general, and
- 13.1% said weekends in general.

Appendix L provides information on the pharmacies opening hours in January 2026 and at that point in time there were:

- 15 pharmacies open seven days a week
- 40 pharmacies open Monday to Saturday
- 60 pharmacies open Monday to Friday, and Saturday up to 14.00
- 28 pharmacies that open Monday to Friday.

A weekday evening service operates which provides for:

- Four pharmacies in Anglesey stay open for an additional 30 minutes, Mondays to Fridays between 17.30 and 18.00.

- One pharmacy in Arfon stays open for an additional hour Mondays to Wednesdays and Fridays, 17.30 to 18.30.
- Two pharmacies in Central and South Denbighshire stay open on alternate weeks on Mondays to Wednesdays and Fridays, one for an additional hour 17.30 to 18.30) and the other for an additional 30 minutes (17.30 to 18.00).
- One pharmacy in Conwy West stays open for an additional hour, 17.30 to 18.30 Mondays to Fridays.

Three pharmacies in Dwyfor and North Meirionnydd stay open for an additional 30 minutes, Mondays to Fridays (17.30 to 18.00), and two stay open for an additional hour (17.30 to 18.30) on alternate weeks, Mondays to Fridays.

GP practices are contracted to provide services between 08.00 and 18.30, Monday to Friday, excluding bank and public holidays. GP dispensaries will generally be open at the same time as the GP practice and dispense prescriptions issued as part of a consultation during this time as well as dispensing repeat prescriptions.

5.1.3 Access to the clinical community pharmacy service

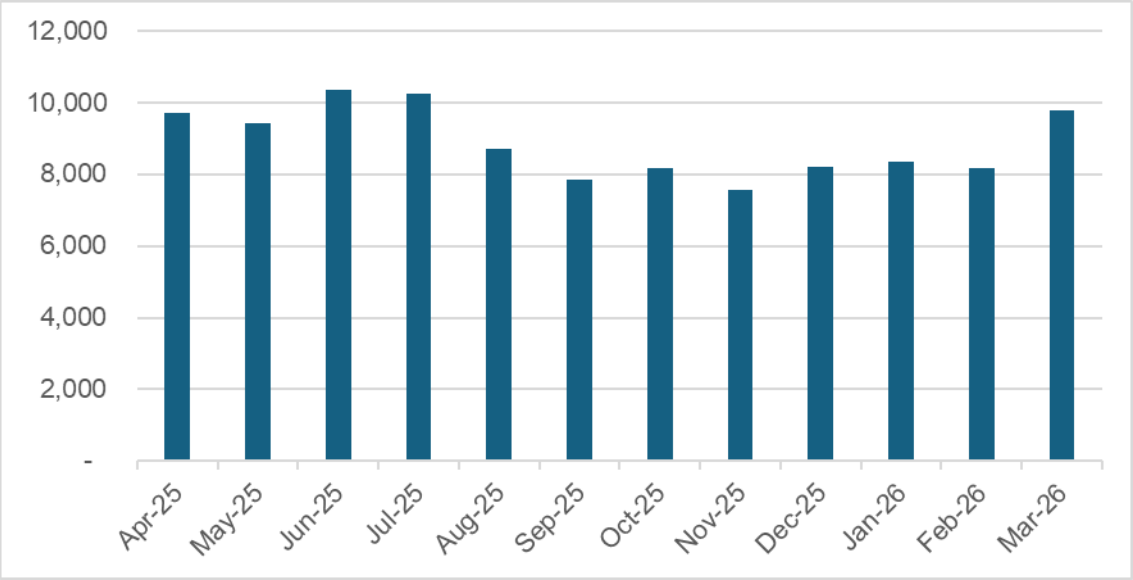
There are three components of this service:

- common ailments service,
- contraception service (emergency, Bridging and Quickstart contraception), and
- emergency medicines supply service.

All but one of the pharmacies was commissioned to provide this service in 2025/26.

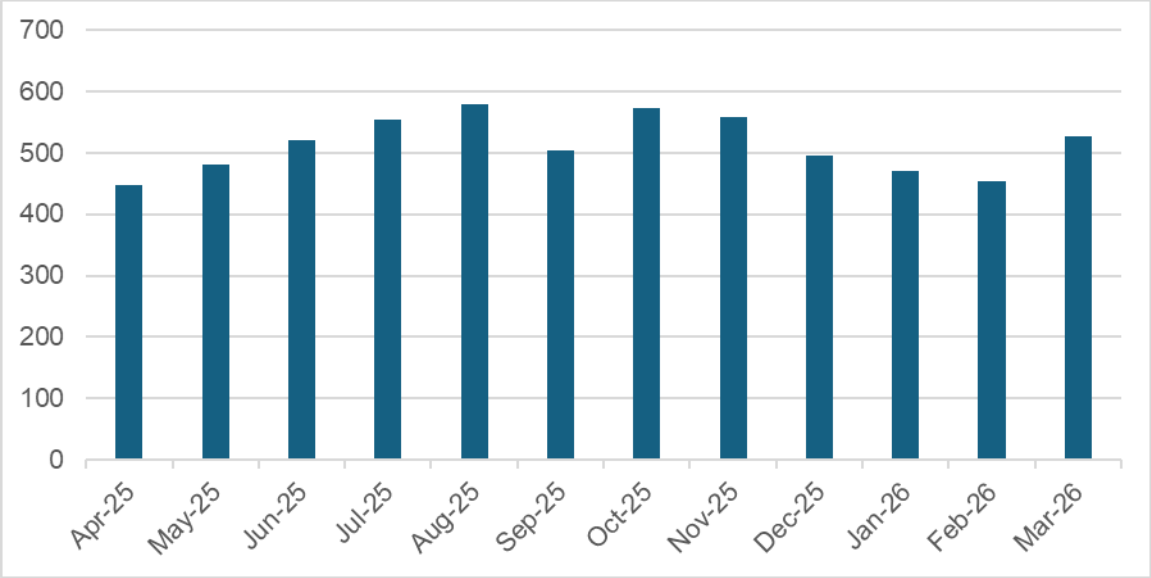
In 2025/26, a total of 106,498 common ailments service consultations were provided and the figure below shows the number provided each month.

Figure 5.1 – number of common ailments service consultations in 2025/26



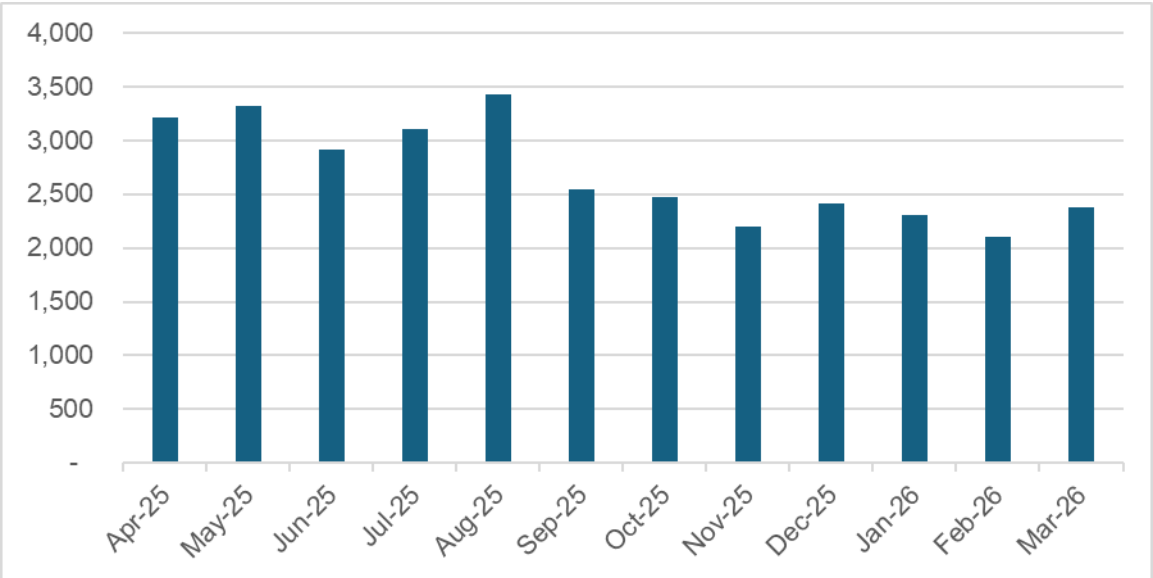
In 2025/26, a total of 6,161 contraception service consultations were provided and the figure below shows the number provided each month.

Figure 5.2 – number of contraception service consultations in 2025/26



In 2025/26, a total of 32,374 emergency medicines supply service consultations were provided and the figure below shows the number provided each month.

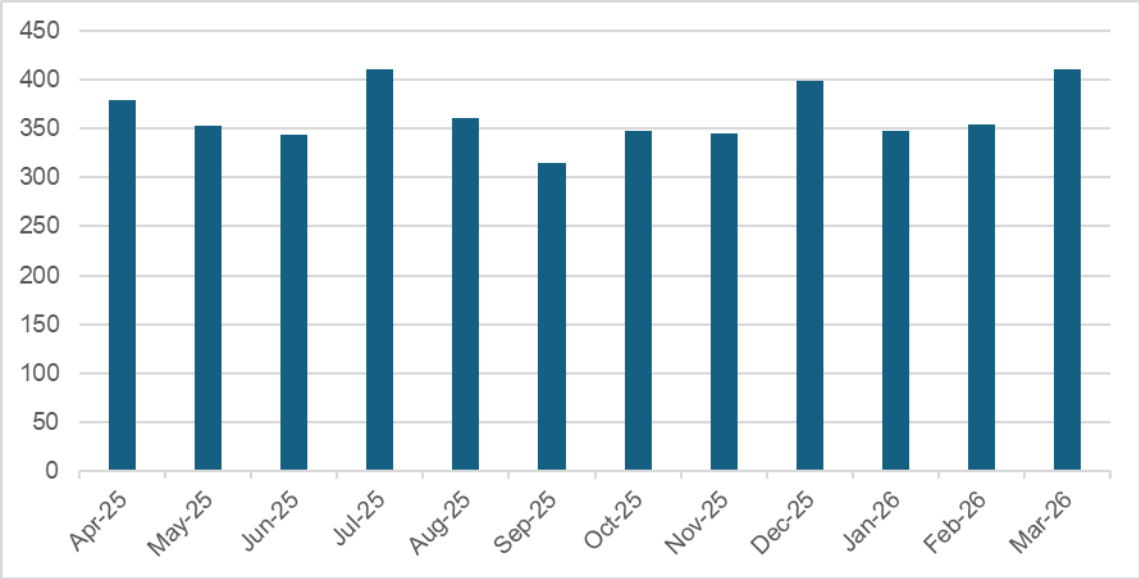
Figure 5.3 – number of emergency medicines supply service consultations in 2025/26



5.1.4 Access to the discharge medicines review service

In 2025/26, 122 pharmacies provided the service and claimed a total of 4,365 reviews. The figure below shows the number of reviews claimed each month.

Figure 5.4 – number of discharge medicines reviews claimed in 2025/26

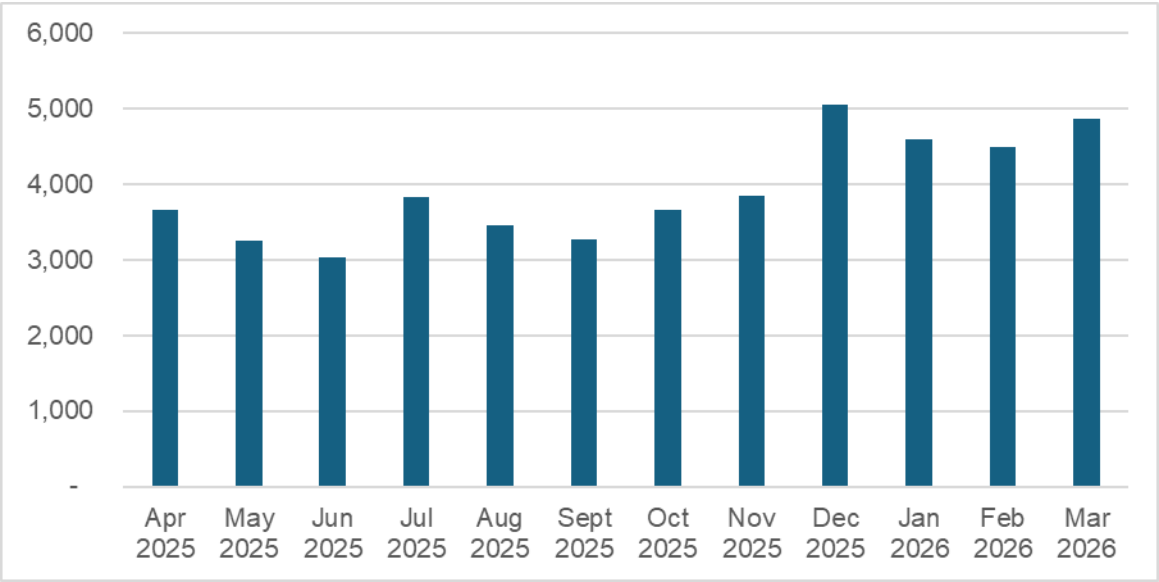


5.1.5 Access to the pharmacist independent prescribing service

62 pharmacies were commissioned to provide this service in 2025/26.

In 2025/26, a total of 96,954 consultations were provided and the figure below shows the number provided each month.

Figure 5.5 – number of consultations provided by pharmacist independent prescribers in 2025/26



5.1.6 Access to the seasonal influenza vaccination service

140 pharmacies were commissioned to provide this service in 2025/26 and provided a total of 23,216 vaccinations predominantly in October and November.

5.1.7 Access to stoma appliance customisations

No pharmacies provided this service in 2025/26 despite at least 82 pharmacies dispensing prescriptions for all types of appliances.

5.1.8 Access to appliance use reviews

No pharmacies provided this service in 2025/26 despite at least 82 pharmacies dispensing prescriptions for all types of appliances.

5.1.9 Access to lateral flow test supply service

127 pharmacies were commissioned to provide this service in 2025/26.

5.1.10 Access to the blood borne virus testing service

This service aims to improve access to blood borne virus screening and associated treatment and health advice thereby reducing the personal and public health risks associated with infection by Hepatitis B, Hepatitis C, and human immunodeficiency virus.

20 pharmacies were commissioned to provide this service in 2025/26.

5.1.11 Access to the Covid-19 vaccination service

Under this service, pharmacies provide Covid-19 vaccinations to eligible patients under a nationally agreed patient group direction.

Thirteen pharmacies were commissioned to provide Covid-19 vaccinations to eligible people under this service in 2025/26.

5.1.12 Access to the Help me quit @ pharmacy service

This service is designed to provide patients with a comprehensive support and treatment service to help them stop smoking over a 12-week programme, involving eight consultations. It will also include the provision of Varenicline under a patient group direction.

119 pharmacies were commissioned to provide this service in 2025/26.

5.1.13 Access to the Naloxone supply service

Under this service, pharmacies can provide Naloxone to those who are at risk of opioid overdose, and those who might witness an opioid overdose.

Ten pharmacies were commissioned to provide this service in 2025/26.

5.1.14 Access to the national care home support service

Under this service pharmacies support care homes to ensure the overall safer use of medicines by:

- reviewing systems and policies,
- providing education on administration, storage, and disposal of medication,
- reviewing ordering procedures to reduce waste, and
- reviewing the care home's processes for dealing with medication related errors.

42 pharmacies were commissioned to provide this service in 2025/26.

5.1.15 Access to the return of patients sharps boxes service

People who self-administer injections at home, such as people with diabetes or rheumatoid arthritis, have sharps waste which needs to be safely disposed of.

In 2025/26, 139 pharmacies were commissioned to provide the sharps service, providing convenient access to this important health protection service.

5.1.16 Access to the smoking cessation level 2 service

The smoking cessation level 2 service links pharmacies with the intensive behavioural support service provided by Help me quit. Under this arrangement, pharmacy contractors supply nicotine replacement therapy to smokers who are receiving smoking cessation behavioural support from Help me quit, in response to a referral letter or appointment card that indicates the client's dependence on nicotine. The Help me quit service provides a six-week programme of support, during which a referral letter will be issued for each pharmacy supply of nicotine replacement therapy. Following successful completion of the programme, Help me quit will issue a discharge referral letter to a pharmacy for a further six-week supply of nicotine replacement therapy to be supplied at fortnightly intervals.

140 contractors were commissioned to provide this service in 2025/26.

5.1.17 Access to the supervised administration service

Under this service, in addition to supplying the medicine, the pharmacist observes the client consuming the medicine to ensure that they take the full dose, reducing the risk of diversion and, through the daily/frequent contact with a healthcare professional, improving retention in the service. Pharmacies supplying oral substitution therapy and, particularly those undertaking supervision, have the most frequent contact with people who are receiving treatment for their opioid addiction, and this provides an opportunity to improve the wider health of the service user

In 2025/26, 128 pharmacies were commissioned to provide the service.

5.1.18 Access to the needle and syringe programmes

Needle and syringe programmes provide people who inject drugs with clean, sterile, injecting equipment, appropriate to the drugs they use, and accept used equipment for safe disposal. This is an important harm reduction service that reduces sharing of injecting equipment, which is associated with the spread of human immunodeficiency virus and hepatitis, as well as minimise the risk of injection associated injury through use of old or inappropriate equipment. These risks are present across all groups of people who inject drugs, including opioids, stimulants and performance and image enhancing drugs such as androgenic anabolic steroid

In 2025/26, 56 pharmacies were commissioned to provide the service.

5.1.19 Access to the urgent medicines service

The urgent medicines supply service supports the timely “in-hours” access to medicines which might otherwise not routinely be immediately available, in sufficient quantities, at a pharmacy. Pharmacies are commissioned to hold minimum levels of stock of medicines specified on an agreed list and to make emergency supplies in accordance with the Human Medicines Regulations 2012 where, in the opinion of the pharmacist, there is an immediate need, and it is not practical to obtain a prescription without undue delay.

In 2025/26, ten pharmacies were commissioned to provide this service.

5.1.20 Dispensing service provided by some GP practices

Dispensing GP practices will provide the dispensing service during their core hours which are 8.00 to 18.30 from Monday to Friday excluding public and bank holidays. The service may also be provided during any extended opening hours provided by the practices. Of the 96 practices in the health board’s area 34 dispense to their eligible patients from 42 premises.

Normally when a patient requires medication their GP will give them a prescription which is then dispensed by a pharmacy or dispensing appliance contractor. However, in certain circumstances practices can instead dispense the medication at the practice premises. The regulations around the provision of this service are complicated but in summary a GP may dispense medication to a patient where:

- the patient lives in an area that has been determined to be a “controlled locality” ie an area that is rural in character,
- the patient lives more than 1.6km (measured in a straight line) from a pharmacy,
- the practice has been given consent to dispense to the area in which the patient lives, and
- the practice has “premises approval” for the premises at which the dispensing is undertaken.

As of November 2025, the GP practices dispensed to 90,372 of their registered patients (41.8% of the total list size for all the dispensing practices). The percentage of dispensing patients at practice level varied between 7.0 to 96.0% of registered patients.

For those who responded to the public engagement questionnaire and are dispensed to by their GP practice:

- 70% do not have a preferred time to use the dispensary, 20% said 14.30 to 18.30 and 10% said 12.00 to 14.30.
- 40% do not have a preferred day to use the dispensary, 20% said weekdays in general, 20% said Thursday, and 10% said Wednesday.
- All said they drive to their GP practice.
- 20% said it takes them less than five minutes to drive to their GP practice, 50% said between five and 15 minutes, 10% more than 15 minutes but less than 20 minutes, and 20% said it takes them more than 20 minutes.

5.1.21 Access to pharmaceutical services on public and bank holidays

The health board has a duty to ensure that residents of its area are able to access pharmaceutical services every day. Pharmacies and dispensing appliance contractors are not required to open on public and bank holidays, or Easter Sunday, although some choose to do so. In advance of these days the health board asks the pharmacies to confirm if and when they will be open. The information is then collated and if there are any gaps in coverage pharmacies are commissioned to open.

5.2 Current provision outside Betsi Cadwaladr University Health Board's area

5.2.1 Access to essential services and dispensing appliance contractor equivalent services

Patients have a choice of where they access pharmaceutical services; this may be close to their GP practice, their home, their place of work or where they go for shopping, recreational or other reasons. Consequently, not all the prescriptions written for residents of the health board's area are dispensed within the same area although as noted in the previous section, the vast majority of items are. In 2024/25, 1.7% of items prescribed by the GP practices were dispensed outside of the health board's area in England (1.4%) and Cardiff and Vale University Health Board's area (0.9%, 99.4% of which were dispensed by the four dispensing appliance contractors).

In the first nine months of 2025/26, 1.6% of prescriptions were dispensed outside of the health board's area again predominantly in England (1.4%) and Cardiff and Vale University Health Board's area (0.2%, of which 99.6% were dispensed by the four dispensing appliance contractors).

5.2.2 Access to national community pharmacy and appliance contractor services

Information on the type of national community pharmacy and appliance contractor services provided by pharmacies outside the health board's area to its residents is not available. When claiming for these services contractors merely claim for the total number provided for each service. The exception to this is the stoma appliance customisation service where payment is made based on the information contained on the prescription. However, even with this service just the total number of relevant appliance items is noted for payment purposes.

It can be assumed however that residents of the health board's area will access these services from contractors outside of the area.

5.2.3 Access to additional clinical services

As with national community pharmacy and appliance contractor services information on the provision of additional clinical services by pharmacies outside the health board's area to its residents is not available. It can be assumed however that residents of the health board's area will access these services from contractors outside of the area.

5.2.4 Dispensing service provided by some GP practices

Some residents of the health board's area will choose to register with a GP practice outside of the area and will access the dispensing service offered by their practice.

5.3 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 5.1 and 5.2, the residents of the health board's area currently exercise their choice of where to access pharmaceutical services to a considerable degree. Within the health board's area, they have a choice of 143 pharmacies, operated by 44 different contractors. Outside of the health board's area residents chose to access a further 209 pharmacies elsewhere in Wales in 2024/25, although many are not used on a regular basis. In the first nine months of 2025/26, residents chose to access 193 pharmacies elsewhere in Wales. In addition, contractors in England dispensed prescriptions written by GP practices in both years.

When asked what influences their choice of pharmacy the four most common responses in the public engagement questionnaire were:

- Close to home,
- Close to GP practice,
- The location is easy to get to, and
- There is a private area if there is a need to speak to the pharmacist.

6 Other NHS services

This chapter describes the NHS services that are deemed, by the health board, to affect the need for pharmaceutical services within its area.

6.1 Hospital pharmacies or departments

The following hospitals in North Wales have dispensaries which dispenses in-patient medication:

- Ysbyty Gwynedd, Bangor,
- Glan Clwyd Hospital, Bodelwyddan,
- Wrexham Maelor Hospital, and
- Llandudno General Hospital.

Prescriptions issued to out-patients are either dispensed by the hospital or under pharmaceutical services by pharmacies.

There are also 16 community hospitals and prescriptions written in them are dispensed under pharmaceutical services by pharmacies.

The hospitals therefore both reduce (by dispensing in-patient medicines) and increase (by issuing prescriptions to be dispensed by pharmacies) the demand for pharmaceutical services.

6.2 Provision of drugs, medicines and appliances for immediate treatment or personal administration by GPs

Under their primary medical services contract with the health board there will be occasion where a GP or other healthcare profession at the practice:

- must provide a drug, medicine or appliance to a patient where such provision is needed for the immediate treatment of the patient before they provision can otherwise be obtained, or
- may provide a drug, medicine or appliance to a patient which the GP or healthcare professional administers or applies to the patient.

Generally, when a patient requires a medicine or appliance their GP will give them a prescription which is dispensed by their preferred pharmacy or dispensing appliance contractor. In some instances, however, the GP or practice nurse will supply the item against a prescription, and this is referred to as personal administration as the item that is supplied will then be administered to the patient by the GP or the nurse. This is different to the dispensing of prescriptions and only applies to certain specified items for example vaccines, anaesthetics, injections, intra-uterine contraceptive devices and sutures.

For these items the practice will produce a prescription however the patient is not required to take it to a pharmacy, have it dispensed and then return to the practice for it to be administered. Instead, the practice will retain the prescription and submit it

for reimbursement to the NHS Wales Shared Services Partnership at the end of the month.

Separately, a GP practice may provide a drug, medicine or appliance for the immediate treatment of a patient because the patient is unable to access the item from a pharmacy within the required timescale. The health board has developed a policy that underpins this provision within the primary medical services contracts and monitors compliance with it.

It is not possible to quantify the total number of items that were personally administered or provided for immediate treatment by GP practices in Wales as the published figures include items which have been either personally administered, provided for immediate treatment or dispensed by dispensing practices. However, as a minimum in 2024/25 170,665 items were personally administered or provided for immediate treatment by practices that do not also dispense. In the first nine months of 2025/26 at least 43,654 items were personally administered.

This service therefore reduces the demand for the dispensing essential service as certain items will be personally administered or provided to the patient for immediate treatment.

6.3 GP out of hours service

The North Wales GP Out of Hours service provides health care for urgent medical problems outside normal surgery hours (ie between 18.30 and 08.00 Monday to Friday and 18.30 Friday to 08.00 Monday, and on public and bank holidays). The national 111 service handles all calls to the service. Those needing further clinical assessment are sent to the service with a 111 clinical prioritisation. Callers will get a call back from a nurse practitioner, doctor or pharmacist during the out of hours period.

The service operates from bases at:

- Deeside Community Hospital,
- Wrexham Maelor Hospital,
- Glan Clwyd Hospital,
- Ysbyty Gwynedd, and
- Ysbyty Alltwen.

46,424 items were prescribed by the service in 2024/25, of which 99.2% were dispensed by pharmacies in North Wales, 0.7% by contractors in England and the remaining 0.1% elsewhere in Wales, predominantly by pharmacies in Hywel Dda University Health Board. 28,441 items were prescribed in the first nine months of 2025/26 of which 99.3% were dispensed by pharmacies in North Wales, 0.6% in England, with the remainder dispensed elsewhere in Wales.

This service increases the need for pharmaceutical services, in particular the essential service of dispensing.

6.4 Minor injury units

Minor injury units are staffed by experienced emergency practitioners who are supported by health care assistants; there are no doctors in the units. Patients that attend one of the units will be assessed and treated as quickly as possible. If their condition cannot be dealt with at the minor injury unit, then the patient will be referred to their GP, the nearest emergency department or to another appropriate service.

Injuries treated include:

- Minor injuries in adults
- Minor injuries in children
- Human/animal bites
- Minor burns
- Minor head injuries/scalp laceration
- Ear/nose foreign bodies
- Limb injuries
- Minor eye injuries, and
- Insect stings.

There are nine minor injury units across North Wales:

- Ysbyty Penrhos Stanley, Holyhead
- Ysbyty Dolgellau
- Bryn Beryl Hospital, Pwllheli
- Ysbyty Alltwen, Tremadog
- Tywyn Hospital
- Llandudno Hospital
- Denbigh Hospital
- Holywell Hospital, and
- Mold Community Hospital.

The minor injury units do not issue prescriptions but may reduce the need for the support for self-care essential service and the common ailments service element of the clinical community pharmacy service.

6.5 Urgent primary care centres

Patients may be referred to an urgent primary care centre by their GP practice. Urgent primary care centres treat patients with urgent primary care needs on the same day, creating capacity to support GP surgeries and reducing unnecessary emergency department attendances.

A team including advanced nurse practitioners, GPs and physiotherapists work together to provide care to people who have sought care from their GP or the one of the emergency departments.

Patients referred to the service will receive a telephone consultation with a centre clinician. If appropriate patients may be invited to attend a face to face appointment at one of the centre locations.

Conditions seen at the urgent primary care centres include:

- abdominal pain*
- acute sinusitis
- constipation
- ear pain/foreign body in ear
- emergency contraception*
- insect bites/ stings
- new acute limb/joint pain/back pain*
- post operation wound infection
- rashes/skin infections/cellulitis*
- respiratory tract infections
- shingles
- soft tissue injury*
- tonsillitis/sore throats
- urinary tract infections*

* Some exceptions excluded.

There are five urgent primary care centres in North Wales.

- Ysbyty Gwynedd, LL57 2PW
- Ysbyty Penrhos Stanley, LL65 2QA
- Ysbyty Alltwen, LL49 9AQ
- Mold Community Hospital Minor Injuries Unit, CH7 1XG
- Wrexham Maelor Hospital Outpatient Department, LL13 7TD

In 2024/25 the urgent primary care centres issued prescriptions for 649 items, of which 94.5% were dispensed by a pharmacy in North Wales and the remainder were dispensed by contractors in England.

466 items were prescribed in the first nine months of 2025/26 or which 77.3% were dispensed by a pharmacy in North Wales and the remainder by contractors in England.

These centres therefore increase the demand for the dispensing essential service and may reduce the demand for the clinical community pharmacy service.

6.6 Prescribing by dentists and optometrists

Unlike GP practices, prescriptions written by dentists are not aligned to the dentist's practice. It is therefore not possible to identify how many items were prescribed by the dental practices in North Wales. However, it is possible to identify the number of dental prescriptions dispensed by the pharmacies in North Wales.

In 2024/25, a total of 28,647 items were dispensed by the pharmacies and 20,394 items were dispensed in the first nine months of 2025/26.

The position is the same for prescriptions written by optometrists. In 2024/25, a total of 3,293 items were dispensed by the pharmacies and in the first nine months of 2025/26 3,636 items were dispensed.

For both services the highest level of dispensing was in Wrexham, and the lowest in Conwy.

These services therefore increase the demand for the dispensing essential service.

6.7 HMP Berwyn

The onsite pharmacy dispenses medicines required by those at the prison. This service therefore reduces the need for pharmaceutical services as it means that no prescriptions are dispensed by pharmacies in primary care.

6.8 Substance misuse service

The substance misuse service provides confidential, non-judgemental, professional and accessible support which aims to reduce the harm caused by drugs and alcohol to individuals, families and the local community. Six community clinics operate across North Wales, one in each unitary authority area.

In 2024/25, 9,974 items were prescribed by the service, 99.5% of which were dispensed by pharmacies in North Wales with 0.2% dispensed by contractors in England, and 0.1% in each of Hywel Dda University Health Board and Powys Teaching Health Board. 8,056 items were prescribed in the first nine months of 2025/26, with 995% dispensed by pharmacies North Wales, 0.2% by pharmacies in Powys Teaching Health Board and 0.1% by contractors in England or pharmacies in Hywel Dda University Health Board.

A ‘click and deliver’ service provides access to naloxone to anyone living in North Wales who uses opioids such as heroin, methadone or buprenorphine or opioid analgesic such as tramadol, oxycodone, codeine etc outside of prescription. It is also available for friends or family members of those who use opioids or opioid analgesics.

This service increases the demand for the dispensing essential service as prescriptions written under the service are dispensed by pharmacies and the supervised administration service. However, it reduces the demand for the naloxone supply additional clinical service as it provides a ‘click and deliver’ service.

6.9 Help Me Quit

Help Me Quit is the national NHS stop smoking brand for Wales, providing free, evidence-based support to help individuals quit smoking for good. Support may be provided via telephone support, one-to-one support, group sessions and/or stop smoking medication.

Services are provided at a number of locations across North Wales, including GP practices, community hospitals, district general hospitals, and other locations such as libraries and family centres, in addition to pharmacies.

This service provided in locations other than pharmacies will increase the need for the smoking cessation level 2 service.

6.10 Services provided by GPs under their General medical services contract

The GP practices in North Wales provide the following services which reduce the need for pharmaceutical services:

- Provision of advice and issuing prescriptions in relation to emergency hormonal contraception
- Influenza and Covid-19 vaccinations
- Advice and treatment for common ailments
- Disposal of sharps, just in case packs, and rescue packs
- Inhaler reviews.

Provision of general medical services increases the need for the dispensing essential service as prescriptions are issued. However, it will also reduce the need for the provision of some of the national community pharmacy and appliance contractor services and additional clinical services.

6.11 Alternative treatment scheme

This service provides primary medical services to patients who have been removed from their GP practice's patient list.

The service increases the demand for the dispensing essential service as prescriptions written under this service are dispensed under pharmaceutical services.

6.12 Hospices

There are four hospices in North Wales, one of which issues prescriptions which are then dispensed by pharmacies.

In 2024/25, 195 items were prescribed by the service and dispensed as follows:

- 57.9% by pharmacies in Central Wrexham,
- 13.3% in North and West Wrexham,
- 10.3% by pharmacies in Swansea Bay University Health Board,
- 7.2% in South Wrexham,
- 6.2% in North East Flintshire,
- 4.1% in South Flintshire,

- 0.5% in each of Central and South Denbighshire and North and West Wrexham.

72 items were prescribed in the first nine months of 2025/26 and dispensed as follows:

- 81.9% by pharmacies in Central Wrexham,
- 5.6% in each of North and West Wrexham and South Wrexham,
- 4.2% in South Flintshire, and
- 1.4% in each of North East Flintshire and England.

This service increases the demand for the dispensing essential service as prescriptions written under this service are dispensed under pharmaceutical services.

6.13 Sexual health services

Sexual health clinics operate from a range of hospital and community locations across North Wales and offer a range of free and confidential services including:

- testing for sexually transmitted infections,
- Human immunodeficiency virus testing,
- contraception including emergency contraception,
- free condoms,
- pregnancy tests,
- screening for blood borne viruses (hepatitis B and C),
- vaccination for hepatitis B and human papillomavirus,
- pre and post exposure prophylaxis, and sexual health promotion, and
- sexual health promotion.

They reduce demand for the contraception element of the clinical community pharmacy service provided by the pharmacies.

Under this service pharmacies provide Chlamydia and Gonorrhoea ‘test at home’ kits. This service is not provided as part of pharmaceutical services, and it reduces the need for the blood borne virus screening additional clinical service.

6.14 Other services provided within a community setting

There is a range of other community services that issue prescriptions which are then dispensed by pharmacies. These include community nurses and community dentistry.

7 Health needs that can be met by pharmaceutical services

Each health related visit to a pharmacy provides a valuable opportunity to support behaviour change through making every one of these contacts count. Making healthy choices such as stopping smoking, improving diet and nutrition, increasing physical activity, losing weight and reducing alcohol consumption could make a significant contribution to reducing the risk of disease, improving health outcomes for those with long-term conditions, reducing premature death and improving mental wellbeing. Pharmacies are ideally placed to encourage and support people to make these healthy choices as part of the provision of pharmaceutical services. In Wales, over 11,000 advice consultations occur every day across the pharmacy network[131].

7.1 Need for drugs and appliances

Everyone will at some stage require prescriptions to be dispensed irrespective of whether or not they are in one of the groups identified in section four, as prescribed medicines are one of the most common interventions in health care. This may be for a one-off course of antibiotics or for medication that they will need to take, or an appliance that they will need to use, for the rest of their life in order to manage a long-term condition. This health need can only be met within primary care by the provision of pharmaceutical services be that by pharmacies, dispensing appliance contractors or dispensing doctors.

Coupled with this is the safe collection and disposal of unwanted or out of date dispensed drugs. Both the health board and pharmacies have a duty to ensure that people living at home or in a residential care home (ie an establishment that exists wholly or mainly for the provision of residential accommodation together with board and personal care, but no nursing care) can return unwanted or out of date dispensed drugs for their safe disposal.

It should be noted that collection and delivery services are not contractual services and are therefore provided privately by pharmacies at their discretion. The only exception to that is where delivery is commissioned under a national community pharmacy and appliance contractor service, or an additional clinical service.

The discharges medicines review service will provide support to patients recently discharged between care settings by ensuring that changes to patients' medicines made in one care setting (eg during a hospital admission) are enacted as intended in the community helping to reduce the risk of preventable medicines related problems and supporting adherence with newly prescribed medication.

A medication administration record provision service can support domiciliary care providers, carers, friends and families to manage and safely administer medicines to those they care for, thereby ensuring the maximum benefit from prescribed medicines.

[131] Community Pharmacy Wales (2020) Pharmacy advice audit (full report) Richard Brown PhD, FRPharmS

There may be occasions where a person runs out of their regular medication and the pharmacist believes that it would not be practicable for the person to obtain the previously prescribed medicines they require in a clinically appropriate timeframe via the usual route without undue delay. Under the clinical community pharmacy service, a person may be able to access a supply of their urgently needed medicines.

In addition, an additional clinical service could be commissioned to ensure the timely “in-hours” access to medicines which might otherwise not routinely be immediately available, in sufficient quantities, at a pharmacy. Pharmacies could then make emergency supplies in accordance with the Human Medicines Regulations 2012 where, in the opinion of the pharmacist, there is an immediate need, and it is not practical to obtain a prescription without undue delay.

For those who have an appliance, the appliance use review service will help improve their knowledge and use of it. The service aims to ensure people get the maximum benefit from the use of their appliance and improve their experience of its usage.

For those with a stoma appliance that requires customisation, the stoma appliance customisation service will ensure the proper use and comfortable fitting of the appliance and improve the duration of its usage thereby reducing waste.

Access to specialist palliative care medicines is critical to support end of life care provided in a person’s home, however due to the specialist nature of the medicines they may not always be stocked by a pharmacy. An additional clinical service can ensure participating pharmacies stock an agreed range of specialist medicines and make a commitment to ensure users have prompt access to those medicines during core and supplementary opening hours.

Provision of nicotine replacement therapy to people who are receiving behavioural support through a smoking cessation service will help improve access to this therapy for those who wish to stop smoking, and also contribute to improving success rates.

There may be occasion when someone runs out of their regular medicines, and they are unable to access a prescription for a further supply or are not able to access a prescription before they need to take their medicines. As an alternative to the person phoning the GP out of hours service or going without their medicines, a service could be commissioned that would allow pharmacies to provide an emergency supply of a person’s regular prescribed medication under the NHS, rather than on a private basis under the Human Medicines Regulations 2012.

Treatment of certain conditions will require people to self-inject and as a result they will have sharps that require safe disposal. An additional clinical service whereby people can return sharps boxes to a pharmacy will ensure such safe disposal and reduce the risk of them being disposed of via household refuse collection services.

Concerns have been identified around the handling of medicines in care homes. A care home additional clinical service can link pharmacies and care homes in order to assess their procedures around the ordering, storing and administration of medicines, with a view to identifying areas of improvement. Reviews of the

medicines being taken by care home residents can also lead to improvements in prescribing.

7.2 Substance use

The provision of a supervised consumption additional clinical service by pharmacists can:

- assist prescribing clinicians in the provision of community based prescribing,
- ensure that the patient takes the correct doses of medication as prescribed,
- prevent prescribed medication being diverted to the illegal market,
- reduce the possibility of accidental poisoning, particularly of children, and
- reduce incidents of accidental death through overdose.

A needle and syringe exchange additional clinical service will assist in the reduction of the sharing of needles (and equipment) which can consequently result in blood-borne viruses and other infections (such as human immunodeficiency virus, hepatitis B and C) being transmitted. In turn this could lead to a reduction in the prevalence of blood-borne viruses, therefore also benefiting wider society.

An additional clinical service to provide “take-home” Naloxone from pharmacies could help to temporarily reverse the effects of opioids such as Heroin, Methadone or Buprenorphine and thereby avoiding opioid overdose and saving lives.

Access to a blood borne virus testing service can help to improve access to screening and associated treatment and health advice thereby reducing the personal and public health risks associated with infection by Hepatitis B, Hepatitis C, and human immunodeficiency virus.

There are also elements of essential service provision which will help address this health need.

- Pharmacies are required to participate in up to four public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by the health board and could include drug and alcohol abuse. Public health campaigns could include raising awareness about the risks of alcohol consumption through discussing the risks of alcohol consumption over the recommended amounts, displaying posters and distributing leaflets, scratch cards and other relevant materials.
- Where the pharmacy does not provide the additional clinical services of needle and syringe exchange and the supervised administration of substance misuse medicines, signposting people using the pharmacy to other providers of the services.
- Signposting people who are potentially dependent on alcohol to local specialist alcohol treatment providers.
- Providing healthy living advice during consultations and engagement with people attending the pharmacy.

7.3 Cancer

In addition to dispensing prescriptions, pharmacies can contribute to many of the public health issues relating to cancer care as part of the essential services they provide.

- Disposal of unwanted drugs, including controlled drugs.
- Pharmacies are required to participate in up to four public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by the health board and could include cancer awareness and/or screening.
- Providing appropriate advice to people who use the pharmacy and appear to smoke or are overweight with the aim of increasing that person's knowledge and understanding of the health issues which are relevant to their personal circumstances.
- Signposting people using the pharmacy to other providers of services or support.

Support for people who wish to stop smoking, whether that is under the level 2 or level 3 services, will also help reduce the incidence of some cancers.

7.4 Long-term conditions

In addition to dispensing prescriptions, pharmacies can contribute to many of the public health issues relating to long-term conditions as part of the essential services they provide.

- Where a person presents a prescription and appears to the pharmacist that they are suffering from or at risk of developing an adverse health issue, the pharmacist must provide advice to that person with the aim of increasing their knowledge and understanding of the health issues which are relevant to their personal circumstances.
- Pharmacies are required to participate in up to four public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by the health board and could include long-term conditions.
- Signposting people using the pharmacy to other providers of services or support.
- Where it appears to pharmacy staff that a person would benefit from advice to help them manage a medical condition, the provision of advice including advice on treatment options and changes to their lifestyle. This could include providing advice to a carer to help them manage another person's medical condition.
- Providing healthy living advice during consultations and engagement with people attending the pharmacy.

Provision of the appliance use reviews, stoma appliance customisation, discharge medicines reviews, influenza and Covid vaccination, return and supply of sharps bins, provision of lateral flow tests to those who are eligible due to a health condition,

and the urgent supply of medicines services will also assist people to manage their long-term conditions in order to maximise their quality of life.

Support for people who wish to stop smoking, whether that is under the level 2 or level 3 services, will also help reduce the incidence of circulatory diseases and cardiovascular diseases.

Regulations allow pharmacists to prescribe independently for any condition within their clinical competence. They therefore allow pharmacists to assist in the provision of unscheduled and urgent care, thereby helping reduce the demand on other services. Independent prescriber services most often cover respiratory disorders (for example chronic obstructive pulmonary disease and asthma exacerbation), bacterial and fungal infections of the skin, and suspected urinary tract infections.

7.5 Obesity

Four elements of the essential services will address this health need.

- Pharmacies are required to participate in up to four public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by the health board and could include obesity.
- Signposting people using the pharmacy to other providers of services or support for weight management services.
- Where it appears to pharmacy staff that a person would benefit from advice to help them manage a medical condition, the provision of advice including advice on treatment options and changes to their lifestyle. This could include providing advice to a carer to help them manage another person's medical condition.
- Providing healthy living advice during consultations and engagement with people attending the pharmacy.

7.6 Sexual health

Alongside the clinical community pharmacy service which includes the provision of a contraception service there are elements of essential service provision which will help address this health need.

- Pharmacies are required to participate in up to four public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by the health board and could include sexually transmitted infections and human immunodeficiency virus.
- Where it appears to pharmacy staff that a person would benefit from advice to help them manage a medical condition, the provision of advice including advice on treatment options and changes to their lifestyle. This could include providing advice to a carer to help them manage another person's medical condition.
- Signposting people using the pharmacy to providers of sexually transmitted infections screening services.

- Providing healthy living advice during consultations and engagement with people attending the pharmacy.

Independent prescribers would be able to provide a full contraception service to further expand the service provided by GP practices and sexual health clinics.

7.7 Teenage pregnancy

The clinical community pharmacy service which includes the provision of a contraception service coupled with elements of essential service provision will help address this health need.

- Pharmacies are required to participate in up to four public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by the health board and could include teenage pregnancy.
- Where the pharmacy does not provide the clinical community pharmacy service, signposting people using the pharmacy to other providers of the service.

7.8 Smoking

In addition to the smoking cessation additional clinical services there are elements of essential service provision which will help address this health need.

- Pharmacies are required to participate in up to four public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by the health board and could include smoking.
- Where the pharmacy does not provide the smoking cessation additional clinical services, signposting people using the pharmacy to other providers of these services.
- Routinely discussing stopping smoking when selling relevant over the counter medicines.
- Providing healthy living advice during consultations and engagement with people attending the pharmacy.

7.9 Support for self-care

Support for self-care is an essential service. As part of their essential services pharmacies must provide advice on self-care to patients in terms of treatment options and lifestyle changes.

7.10 Common ailments

After the need for medicines, support for the treatment of common ailments is probably the second most common reason for visiting a pharmacy.

The pharmacy independent prescribing service differs from the common ailments service under the clinical community pharmacy service in that appropriately trained pharmacists are required to prescribe medications for NHS supply where appropriate, often replacing the need for a GP appointment. Unlike the common ailments service, which typically focuses on minor health issues and supplies over-the-counter treatments, the independent prescribing service empowers pharmacists to manage a wider range of conditions independently. This advanced role supports patients with timely access to healthcare, reducing pressure on general practice and enhancing the provision of care within the community.

Any pharmacy contractor wishing to provide the pharmacy independent prescribing service must also provide the clinical community pharmacy service which includes three elements; common ailments service, emergency, Bridging and QuickStart contraception service and emergency medicine supply service.

7.11 Vaccinations

Pharmacies have provided flu vaccinations for a number of years, enhancing the service provided by GP practices by increasing the number of locations at, and the times and days on, which vaccines can be given. They could be commissioned to provide other vaccinations for example Covid-19 vaccinations which, due to their often longer opening hours, would improve access for patients.

8 Anglesey locality

8.1 Key facts[132]

- Smallest population of the six unitary authorities at 66,021.
- The population density is 0.9 persons per hectare, compared to 1.1 for North Wales and 1.5 for Wales[133].
- 27.4% of the population is aged 65 or over which is the second highest across the health board area and is higher than the Wales average of 21.7%.
- 3.6% of the locality's population is aged 85+ years, higher than the health board's average of 3.1% and higher than the Wales average of 2.7%. The resident population aged 85 years and over in the health board is expected to increase by almost 98%. Across the region, the largest percentage increases are expected in Wrexham (114.6%) and on the Isle of Anglesey (109.4%).
- 98.3% of the population is White.
- 15.0% of households have no car or van (second lowest percentage across North Wales).
- 14.8% of the population live in the most deprived 20% of the Welsh Index of Multiple Deprivation[134].
- Life expectancy in Anglesey is 78.6 for males and 82.4 for females[135]
- Healthy life expectancy in Anglesey is 63.1 years for males and 63.0 years for females and the inequality gap for healthy life expectancy in Anglesey is 8.4 years for males and 7.4 years for females
- 31.9% of four and five year olds have overweight and obesity. Healthy lifestyles and behaviour data for adults in Anglesey show:

Area	Physically active for at least 60 minutes per day	Eat at least one portion of fruit or vegetable daily	Smoke tobacco at least weekly	Tried e-cigarettes at least weekly	Reporting drinking alcohol
Anglesey	18.3%	44.3%	4.5%	9.1%	36.6%
Betsi Cadwaladr University Health Board	18.3%	45.7%	3.3%	8.2%	36.8%
Wales	18.3%	46.5%	2.6%	6.9%	35.6%

- 48% of adults (aged 16 year and over) reported being able to speak Welsh with a further 12.3% having some Welsh speaking ability. The proportion of adults aged 16 years and over in the health board's area who can speak Welsh ranges from 12.4% in Flintshire to 64.0% in Gwynedd. The average for the whole of Wales is 18.0%.
- Numbers of patients with chronic conditions as reported on the Digital Health and Care Wales disease registers, April 2025, are shown below.

[132] Public Health Profiles - North West Collaborative profiles 2025
[133] North Wales Regional Partnership Board - Anglesey primary care cluster statistical profile 2025
[134] Public Health Wales - Primary care clusters dashboard
[135] InfoBaseCymru data for an intelligent Wales - Life expectancy in males and females (2020 to 2022)

Disease register	Anglesey	Betsi Cadwaladr University Health Board	Wales
Asthma	8.7%	7.6%	7.1%
Atrial fibrillation	3.1%	2.8%	2.7%
Cancer	4.8%	4.3%	3.7%
Chronic obstructive pulmonary disease	3.1%	2.7%	2.3%
Diabetes	9.3%	8.3%	8.4%
Epilepsy	0.9%	0.9%	1.0%
Heart failure	1.3%	1.4%	1.4%
Hypertension	18.8%	17.9%	16.3%
Stroke transient ischaemic attack	2.7%	2.3%	2.2%
Secondary prevention of coronary heart disease	3.8%	3.6%	3.4%

The Anglesey and Gwynedd Joint Local Development Plan 2011 – 2026[136] identifies that 761 additional housing units will be built in:

- Amlwch – 373 units
- Holyhead – 147 units
- Llangefni – 241 units

Isle of Anglesey County Council is monitoring 38 large scale housing developments in its area. Information provided by the council in May 2026 confirms 758 units are still to be built.

The seventh annual monitoring report[137] on the local development plan for the period 1 April 2024 to 31 March 2025 notes that the number of units completed between 2011/12 and 2024/25 was 2,697 units, lower than the predicted figure of 3,231 units. 249 units were completed in 2024/25 which exceeded the indicative average annual requirement of 232 units. A new local development plan for Anglesey is being developed.

Development of a new permanent Gypsy and Traveller site for ten spaces at Star Crossroads, Star was approved in October 2018. In December 2025 the council's planning and orders committee approved an application for a lawful development certificate and variation of two conditions on the original application.

A nuclear power station is due to be built at Wylfa, with small modular nuclear reactors anticipated to be on stream in the 2030s[138].

[136] Anglesey and Gwynedd Joint Local Development Plan 2011 – 2026
[137] Isle of Anglesey County Council, Anglesey and Gwynedd Joint Local Development Plan 2011-2026 7th Annual Monitoring Report 2024/25
[138] Welsh Parliament research article – New nuclear at Wylfa: what happens next? December 2025

Further development is expected in the north of the locality as a result of the development of Anglesey Freeport. It will consist of sites at Prosperity Park and Parc Prosperity Park and Parc Cybi in Holyhead, M-Sparc near Gaerwen and two brownfield sites on Llangefni Industrial Estate.

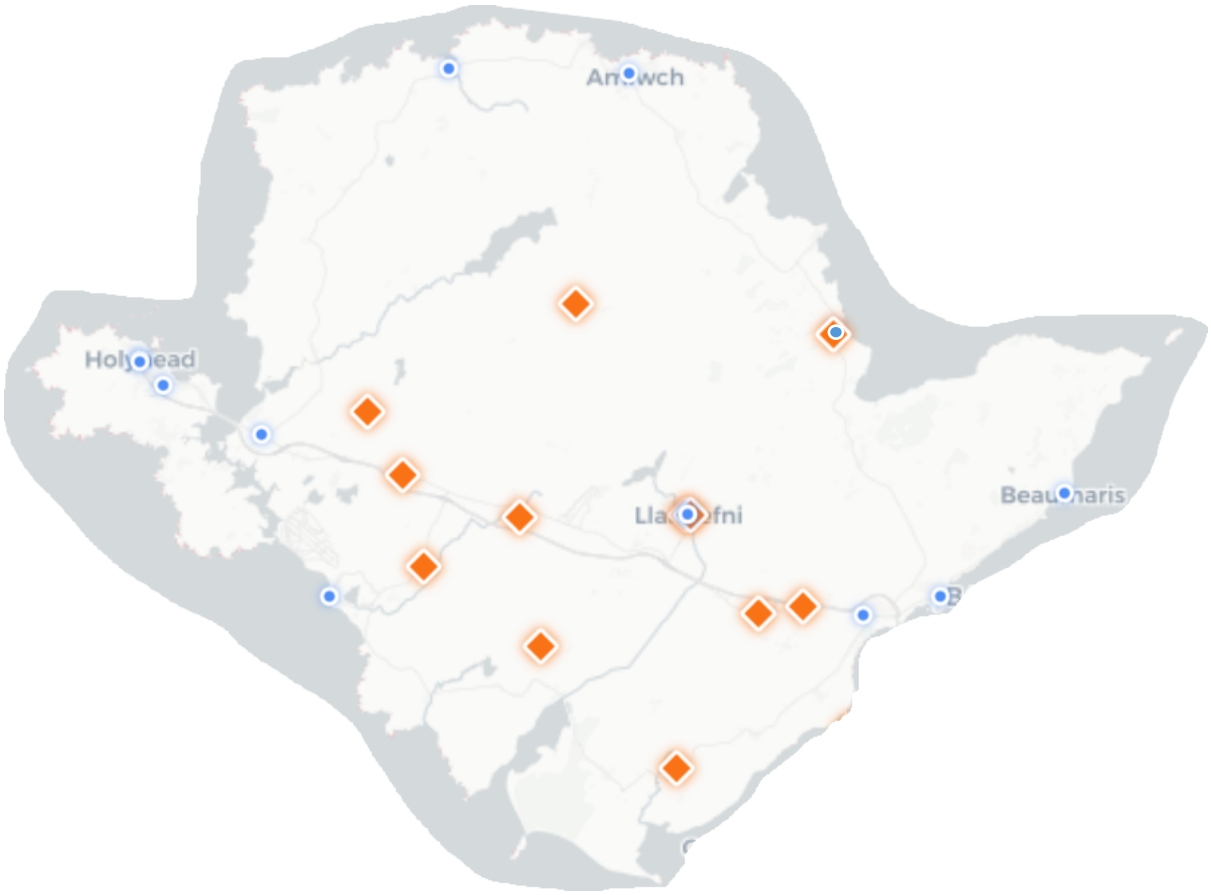
The Freeport aims to attract £6.5 billion in investment and create around 17,000 jobs.

8.2 Current provision of pharmaceutical services within the locality's area

There are 13 pharmacies in the locality operated by five different contractors. One pharmacy is covered by the essential small pharmacy scheme. Of the 10 GP practices, seven dispense from a total of 12 premises. The level of dispensing ranges from 20.1% to 83.5% of the practices' registered populations.

The map below shows the location of the pharmacies and dispensing practice premises. It should be noted that where premises are close to each other the symbols will overlap.

Map 8.1 – location of pharmacies and dispensing doctor premises



© OpenStreetMap © CARTO Dispensing doctor premises Pharmacy

In 2024/25, 70.4% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practices dispensed or personally administered 27.4 of the prescribed items. Whilst the data available doesn't show the percentage split between dispensed and personally administered items, based on the level of personal administration elsewhere in Wales it can be assumed that less than 2% of items were personally administered.

In the first nine months of 2025/26 71.5% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practices dispensed or personally administered 27.4% of the prescribed items.

The map in chapter 5 indicates that some areas along the coastline are not within a 20-minute drive of a pharmacy. Further analysis reveals they contain:

- North Wales Wildlife Trust Reserve in the north of the island,
- The Range Nature Reserve, and
- Newborough National Nature Reserve and Forest.

Google maps reveals that there is little or no resident population in these areas.

With regard to when the pharmacies are open:

- two open Monday to Friday,
- three open Monday to Friday, and part of Saturday, and
- eight open Monday to Saturday.

There are no pharmacies open on a Sunday on Anglesey.

With regard to the times at which these pharmacies are open between Monday and Friday:

- All 13 pharmacies open at 09.00
- Closing times vary between 17.30 and 18.00 with one pharmacy in Holyhead open until 19.00. One pharmacy closes at 13.00 on Wednesday and another at 14.00 on Thursday.

Four pharmacies were commissioned to open for an additional 30 minutes (17.30 to 18.00) during the week in 2025/26.

12 pharmacies close for lunch at varying times between 12.30 and 14.00. The remaining pharmacy is open all day.

On Saturday, the 11 pharmacies that open do so at 09.00. Of the eight pharmacies that open all day, three don't close for lunch, and the remaining five close for lunch at varying times between 12.30 and 14.00. 11 pharmacies have core opening hours on Saturday.

The health board asks the pharmacies whether they will be open on public and bank holidays and Easter Sunday. The responses are collated, and the health board

establishes whether or not there are any geographic gaps in provision. Where a gap exists, a pharmacy is either commissioned or directed to open.

Ten pharmacies responded to the pharmacy contractor questionnaire and the following information is taken from those responses.

These ten pharmacies are accessible by wheelchair and nine have a consultation area that is accessible by wheelchair. Ten consultation areas are:

- closed rooms,
- a designated area where the patient and pharmacist can sit down together, and
- clearly designated as an area for confidential consultations distinct from the general public areas of the pharmacy.

However, only nine area areas where the patient and pharmacists can talk at normal volumes without being overheard.

The ten pharmacies confirmed they have Welsh speakers. Three pharmacies reported other languages spoken by staff.:

- Polish
- French
- German, Hindi, Punjabi and sign language.

All ten pharmacies dispense prescriptions for all types of appliances.

All ten pharmacies collect prescriptions from GP practices and offer a private delivery service. Eight limit the service to elderly and vulnerable housebound patients. One pharmacy provides a free, private delivery service which is limited to selected patient groups,

None of the pharmacies stated that there is a requirement for an existing additional clinical service that is not currently provided, and none were of the opinion that there is a requirement for a new service that is not currently available.

All pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide. Two said they have sufficient staffing capacity to manage an increase in demand, and the other eight said they don’t but could make adjustments to manage an increase in demand.

Four pharmacies have plans to develop or expand their service provision.

- Three intend to start providing the pharmacist independent prescribing service, with two starting in May 2026.
- One intends to start providing a smoking cessation service. As it currently provides the level 2 smoking cessation service it is assumed this is reference to the help me quit @ pharmacy service.

None of the dispensing practices responded to the dispensing doctor questionnaire.

8.2.1 Clinical community pharmacy service

All the pharmacies had signed up to provide this service and in 2025/26 provided:

- 10,396 consultations for common ailments
- 469 consultations for contraception
- 2,274 emergency medicines supplies

8.2.2 Discharge medicines review

In 2025/26, all the pharmacies provided this service and completed 251 reviews.

8.2.3 Pharmacist independent prescribing service

Four pharmacies were commissioned to provide this service in 2025/26 and provided a total of 1,395 consultations over the year.

8.2.4 Seasonal influenza vaccination service

All the pharmacies were commissioned to provide this service in 2025/26 and provided a total of 1,584 vaccinations.

8.2.5 Stoma appliance customisation

None of the pharmacies provide this service despite dispensing prescriptions for appliances.

8.2.6 Appliance use reviews

None of the pharmacies provide this service despite dispensing prescriptions for appliances.

8.2.7 Lateral flow test supply service

All the pharmacies were commissioned to provide this service in 2025/26.

8.2.8 Blood borne virus testing service

No pharmacies were commissioned to provide this service in 2025/26.

8.2.9 Covid-19 vaccination service

Two pharmacies were commissioned to provide this service in 2025/26.

8.2.10 Help me quit @ pharmacy

11 pharmacies were commissioned to provide this service in 2025/26.

8.2.11 Inhaler review service

11 pharmacies were commissioned to provide this service in 2025/26.

8.2.12 Naloxone supply service

One pharmacy was commissioned to provide this service in 2025/26.

8.2.13 National care home support service

Five pharmacies were commissioned to provide this service in 2025/.

8.2.14 Return of patients sharps boxes

12 pharmacies were commissioned to provide this service in 2025/26.

8.2.15 Smoking cessation service level 2 service

All the pharmacies were commissioned to provide this service in 2025/26.

8.2.16 Supervised administration service

12 pharmacies were commissioned to provide this service in 2025/26.

8.2.17 Needle and syringe programmes

Seven pharmacies were commissioned to provide this service in 2025/26

8.2.18 Urgent medicines service

One pharmacy was commissioned to provide this service in 2025/26.

8.3 Current provision of pharmaceutical services outside the locality's area

Some residents choose to access contractors outside both the locality and the health board's area in order to access services:

- Offered by dispensing appliance contractors
- Which are located near to where they work, shop, or visit for leisure or other purposes.

Whilst the majority of prescriptions written by the GP practices in 2024/25 were dispensed by either the pharmacies in the locality or the dispensing practices, 1.6% was dispensed outside the locality.

- 0.6% by pharmacies in Arfon
- 0.5% by contractors in England, and
- 0.4% elsewhere in Wales.

In the first nine months of 2025/26, 1.6% was dispensed outside the locality.

- 0.7% by pharmacies in Arfon
- 0.5% by contractors in England, and
- 0.3% elsewhere in Wales.

In addition, residents may have accessed one or more pharmaceutical services provided by another pharmacy outside of both the locality and the health board's area; however, it is not possible to quantify this activity from the recorded data.

8.4 Other NHS services

Details of the NHS services which affect the need for pharmaceutical services can be found in chapter six.

8.5 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 8.2 and 8.3, those living within the locality and registered with one of the GP practices generally choose to access one of the pharmacies in the locality in order to have their prescriptions dispensed or, if eligible, to be dispensed to by their practice. Those that look outside the locality usually do so either to access a neighbouring pharmacy or a dispensing appliance contractor outside of the health board's area.

In 2024/25, over 114 contractors dispensed items written by one of the GP practices in this locality, of which:

- 13 were located within the locality,
- 77 were located elsewhere within the health board's area,
- 24 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

In the first nine months of 2025/26, 107 contractors dispensed items written by one of the GP practices in this locality, of which:

- 13 were located within this locality,
- 76 were located elsewhere within the health board's area,
- 18 were located elsewhere in Wales, and
- A number of prescriptions were dispensed in England.

8.6 Gaps in provision

When considering if there are any gaps in the provision of pharmaceutical services the health board has noted that ten pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide. Two said they have sufficient staffing capacity to manage an increase in demand, and eight said they don't but could make adjustments to manage an increase in demand.

8.6.1 Essential services

The health board has noted:

- The pharmacies are spread across the locality and are located in areas of greater population density and higher deprivation. The dispensing practices are generally located in areas of lower population density.
- Some parts of the locality are not within a 20-minute drive time of a pharmacy however there is either no resident population or a few scattered properties in those areas.
- The large scale housing developments and allocations in the local development plan.
- The population of the locality increases during the holiday season due to an influx of visitors and tourists.
- There are no pharmacies open on Sundays.

The health board has not identified any current needs in relation to the provision of essential services in this locality.

The health board has identified that should there be a loss of essential services due to the withdrawal of a pharmacy from the pharmaceutical list there will be a future need for either:

- a new pharmacy in the same town/village providing essential services, the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services for 40 core opening hours per week, or
- the GP dispensing service if the town/village is in a controlled locality,

unless there is another pharmacy in that town/village and then this future need will not arise.

The health board has identified that should there be a loss of supplementary opening hours on Saturdays from 1 October 2026 which results in less than three hours of provision of pharmaceutical services within a town/village there will be a future need for the provision of essential services for three core opening hours on Saturdays in the town/village or towns/villages where the reduction in supplementary opening hours has occurred, between 09.00 and 17.00, unless there is another pharmacy in that town/village and then the future need will not arise.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and

- the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

8.6.2 Clinical community pharmacy service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

8.6.3 Discharge medicines review

The health board has noted all the pharmacies provided this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

8.6.4 Pharmacist independent prescribing service

The health board has noted:

- Four pharmacies were commissioned to provide this service in 2025/26.
- Three pharmacies plan to commence providing this service in 2026/27.
- The aspiration set out in Pharmacy: Delivering a Healthier Wales is for each pharmacy to have an independent prescriber by 2030 and has set interim targets of 50% of pharmacies to be providing this service in each locality by April 2027 and 70% by April 2029.
- From 2026 it is anticipated that all newly qualified pharmacists will also qualify as independent prescribers on completion of their undergraduate

Based on the above, the health board has not identified any current needs for this service within the locality.

Should the interim targets not be met there will be a future need for the provision of this service by sufficient pharmacies in the locality to meet the two targets.

8.6.5 Seasonal influenza vaccination service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

8.6.6 Stoma appliance customisation

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

It is therefore anticipated that these contractors will be customising stoma appliances as required before dispatching or delivering them to patients.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.7 Appliance use reviews

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

Individuals requiring the appliance use review service are likely to access this service from the contractor that dispenses their prescriptions for appliances or may access it from other healthcare providers such as stoma nurses.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.8 Lateral flow tests supply service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

8.6.9 Blood borne virus testing service

The health board has noted no pharmacies were commissioned to provide this service in 2025/26. However, there are other providers of the service, for example the health board's harm reduction team.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.10 Covid-19 vaccination service

The health board has noted two pharmacies were commissioned to provide this service in 2025/26. It has also noted that GP practices and the health board's vaccination team provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.11 Help me quit @ pharmacy

The health board has noted:

- 11 pharmacies were commissioned to provide this service in 2025/26.
- One pharmacy intends to commence providing the service.
- Demand for the service is dictated by people wishing to stop smoking.

- There are other providers of the service for example Help me quit for baby, Help me quit in hospital, and the general Help me quit service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.12 Inhaler review service

The health board has noted:

- 11 pharmacies were commissioned to provide this service in 2025/26.
- GP practices also provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.13 Naloxone supply service

The health board has noted:

- One pharmacy was commissioned to provide this service in 2025/26.
- There are other providers of the service such as the health board's harm reduction team and the 'click and deliver' service provided by DAN24/7.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.14 National care home support service

The health board has noted:

- Five pharmacies were commissioned to provide this service in 2025/26.
- The service is provided by pharmacies to the care homes that they provide services to, or where a care home has requested the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.15 Return of patients sharps boxes

The health board has noted that 12 pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

8.6.16 Smoking cessation level 2

The health board has noted:

- All the pharmacies were commissioned to provide this service in 2025/26.
- Demand for the service is dictated by people wishing to stop smoking.

Based on the above, the health board has therefore not identified any current or future needs for this service within the locality.

8.6.17 Supervised administration service

The health board has noted 12 pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

8.6.18 Needle and syringe programmes

The health board has noted:

- Seven pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service, and a postal service is being established for those who are unable to use a pharmacy.
- If a pharmacy is asked to provide the service, they can approach the health board and asked to be commissioned to provide it.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.19 Urgent medicines service

The health board has noted one pharmacy was commissioned to provide this service in 2025/26. Due to the nature of the service, it is commissioned to ensure a good geographical spread of pharmacies providing it across the health board's geography.

The health board has therefore not identified any current or future needs for this service within the locality.

8.6.20 GP dispensing service

The health board has not identified any current needs in relation to this service.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and
    - the clinical community pharmacy service, patient sharps, smoking cessation level 2, and help me quit @ pharmacy services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

9 Arfon locality

9.1 Key facts[139]

- Gwynedd has a population of 120,813, which is the second highest population of the six unitary authorities in North Wales.
- The population density is 1.7 persons per hectare, compared to 1.1 for North Wales and 1.5 for Wales[140].
- 23.4% of the population is aged 65 or over. This is higher than the Wales average of 21.7% but slightly lower than the health board's average of 24.0%.
- 15.3% of the locality's population are aged between 66-84 years, lower than the Wales average of 17.7% and the health board's average of 19.6%.
- 2.2% of the locality's population is aged 85+ years, lower than the health board's average of 3.1% and lower than the Wales average of 2.7%.
- 22.5% of the locality's population is aged between 16-29, higher than the Wales average of 16.7% and the health board's average of 14.7%. This is probably due to the Bangor student population.
- The overall population of the health board is expected to increase by just over 50,000 residents (6.8%) between 2022 and 2047. At unitary authority level, the largest increases are expected in Gwynedd (10.8%) and Denbighshire (10.4%). The smallest increase is predicted to be in Wrexham (2.4%).
- Gwynedd has the highest percentage of adults who can speak Welsh at 64.0% This is compared to Flintshire at 12.4% and the Wales average of 18.0%.
- Gwynedd has the highest proportion of one-person households across the health board's area (34.6%) although the figure for Arfon is lower at 32.8%. 14.2% of one-person households in Arfon are occupied by a single occupant aged 66 years and over.
- 19.5% of households have no car or van.
- For the cluster population of Arfon 11.3% of the population live in the most deprived 20% of the Welsh Index of Multiple deprivation[141]
- Life expectancy in Gwynedd is 79.2 for males and 83.1 for females[142]
- Healthy life expectancy in Gwynedd is 64.9 years for males and 65.0 years for females and the inequality gap for healthy life expectancy in Gwynedd is 3.0 years for males and 2.8 years for females.
- 31.1% of four and five year olds in Arfon have overweight or obesity.
- Almost 37% of 11 to 16-year-olds report drinking alcohol in North Wales compared to 35.6% across Wales. The highest reported levels of alcohol drinking across the region are in Flintshire (39.3%) and Gwynedd (38.2%)
- Healthy lifestyles and behaviour data for adults in Gwynedd are shown below.

[139] Public Health Profiles - North West Collaborative profiles 2025
[140] North Wales Regional Partnership Board - Arfon primary care cluster statistical profile 2025
[141] Public Health Wales - Primary care clusters dashboard
[142] InfoBaseCymru data for an intelligent Wales - Life expectancy in males and females (2020 to 2022)

Area	Physically active for at least 60 minutes per day	Eat at least one portion of fruit or vegetable daily	Smoke tobacco at least weekly	Tried e-cigarettes at least weekly	Reporting drinking alcohol
Gwynedd	18.3%	50.2%	3.4%	6.6%	38.2%
Betsi Cadwaladr University Health Board	18.3%	45.7%	3.3%	8.2%	36.8%
Wales	18.3%	46.5%	2.6%	6.9%	35.6%

- Numbers of patients with chronic conditions as reported on the Digital Health and Care Wales disease registers, April 2025, are shown below.

Disease register	Arfon	Betsi Cadwaladr University Health Board	Wales
Asthma	6.6%	7.6%	7.1%
Atrial fibrillation	2.0%	2.8%	2.7%
Cancer	3.6%	4.3%	3.7%
Chronic obstructive pulmonary disease	2.5%	2.7%	2.3%
Diabetes	6.5%	8.3%	8.4%
Epilepsy	0.9%	0.9%	1.0%
Heart failure	0.8%	1.4%	1.4%
Hypertension	14.0%	17.9%	16.3%
Stroke transient ischaemic attack	1.7%	2.3%	2.2%
Secondary prevention of coronary heart disease	2.5%	3.6%	3.4%

- Arfon has the lowest rate of diabetes prevalence compared to the rest of North Wales.

The Anglesey and Gwynedd Joint Local Development Plan 2011 – 2026[143] identifies that 393 additional housing units will be built in Bangor. It is noted that the seventh annual monitoring report on the local development plan for the period 1 April 2024 to 31 March 2025 confirmed the number of units completed in 2024/25 was 212, lower than the average annual requirement of 479 units. The report also confirmed that 2,687 units have been completed between 2011/12 and 2024/25, whilst the trajectory anticipated a figure of 3,487 units.

[143] Gwynedd Council, Gwynedd Anglesey and Gwynedd Joint Local Development Plan 2011 – 2026

9.2 Current provision of pharmaceutical services within the locality's area

There are nine pharmacies in the locality operated by six different contractors. Of the eight GP practices, five dispense from a total of eight premises. The level of dispensing ranges from 19.9% to 84.8% of the practices' registered populations.

The map below shows the location of the pharmacies and dispensing practice premises. It should be noted that where premises are close to each other the symbols will overlap.

Map 9.1 – location of pharmacies and dispensing doctor premises



© OpenStreetMap © CARTO Dispensing doctor premises Pharmacy

In 2024/25, 58.1% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practices dispensed or personally administered 33.4% of the prescribed items. Whilst the data available doesn't show the percentage split between dispensed and personally administered

items, based on the level of personal administration elsewhere in Wales it can be assumed that less than 2% of items were personally administered.

In the first nine months of 2025/26 58.5% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practices dispensed or personally administered 33.2% of the prescribed items.

The map in chapter 5 indicates some parts of the locality are not within a 20-minute drive of a pharmacy. Further analysis reveals they contain:

- Caernarfon airport and RAF Llandwrog,
- Yr Wyddfa, and
- Parts of Eryri National Park.

Google maps reveals that there is little or no resident population in these areas.

With regard to when the pharmacies are open:

- one opens Monday to Friday,
- two open Monday to Friday, and part of Saturday,
- four open Monday to Saturday, and
- two open Monday to Sunday in Bangor.

With regard to the times at which these pharmacies are open between Monday and Friday:

- One opens at 08.45 and the remainder open at 09.00,
- Closing times vary between 17.30 and 18.30 (although one closes at 16.30 on Thursdays) with one pharmacy in Bangor open until 20.00.

One pharmacy in Penygroes is commissioned to open for 30 minutes on Mondays, Tuesdays, Wednesdays and Fridays (17.30 to 18.00) in 2025/26.

Six pharmacies close for lunch at varying times between 12.30 and 14.00. The remaining pharmacies open all day.

On Saturday, one pharmacy opens at 09:30, with the remainder opening at 09:00. Seven pharmacies have core opening hours on Saturday.

Of the four pharmacies that open all day, two close for lunch between 12:30 and 14:00. They close between 16:00 and 18:00.

The two pharmacies that open on Sunday are in Bangor and between them cover the hours 10.00 to 16.30. These are supplementary opening hours.

The health board asks the pharmacies whether they will be open on public and bank holidays and Easter Sunday. The responses are collated, and the health board establishes whether or not there are any geographic gaps in provision. Where a gap exists, a pharmacy is either commissioned or directed to open.

Five pharmacies responded to the pharmacy contractor questionnaire and the following information is taken from those responses.

These five pharmacies are accessible by wheelchair, and all have a consultation area that is accessible by wheelchair. The five consultation areas are:

- closed rooms,
- a designated area where the patient and pharmacist can sit down together and talk at normal volumes without being overheard, and
- clearly designated as an area for confidential consultations distinct from the general public areas of the pharmacy.

All five pharmacies confirmed they have Welsh speakers. One pharmacy confirmed that Ghanaian, Arabic, and are also spoken by staff, and another confirmed that Malay and Romanian are spoken.

The five pharmacies dispense prescriptions for all types of appliances.

All five pharmacies collect prescriptions from GP practices. In relation to the delivery of dispensed items, three pharmacies provide a delivery service to selected patient groups.

There was one suggestion for an existing service that is not currently provided in the area, namely the sore throat test and treat service.

None of the pharmacies were of the opinion that there is a requirement for a new additional clinical service which is not currently available, or that there is a requirement for a new service that is not currently available.

Four pharmacies said their premises have sufficient capacity to manage an increase in demand with the fifth saying it didn’t but could make adjustments to manage increased demand. One pharmacy said it has sufficient in its staffing levels to manage increased demand, with the other four saying they don’t but make adjustments to do so.

None of the pharmacies have plans to develop or expand their service provision.

One of the five dispensing practices responded to the dispensing doctor questionnaire and the following information is taken from those responses. They provide services from one premises.

- The dispensary opens 09.00-13.00 and 15.00-17.30 Monday to Friday.
- All types of appliances are dispensed.
- The practice does not provide a private delivery service.
- The practice has Welsh speakers in its staff. No other languages, other than English, are spoken.
- The practice doesn’t have sufficient capacity in its premises and staffing levels to make an increase in demand for the dispensing service and would have difficulty managing such an increase.

- The practice provides medication administration records to patients in care homes.

9.2.1 Clinical community pharmacy service

All the pharmacies had signed up to provide this service and in 2025/26 provided:

- 11,002 consultations for common ailments
- 830 consultations for contraception
- 2,219 emergency medicines supplies

9.2.2 Discharge medicines review

In 2025/26 all the pharmacies provided this service and completed 378 reviews.

9.2.3 Pharmacist independent prescribing service

Six pharmacies were commissioned to provide this service in 2025/26 and provided a total of 7,459 consultations over the year.

9.2.4 Seasonal influenza vaccination service

All the pharmacies were commissioned to provide this service in 2025/26 and provided a total of 1,509 vaccinations.

9.2.5 Stoma appliance customisation

None of the pharmacies provide this service despite dispensing prescriptions for appliances.

9.2.6 Appliance use reviews

None of the pharmacies provide this service despite dispensing prescriptions for appliances.

9.2.7 Lateral flow test supply service

All the pharmacies were commissioned to provide this service in 2025/26.

9.2.8 Blood borne virus testing service

No pharmacies were commissioned to provide this service in 2025/26.

9.2.9 Covid-19 vaccination service

No pharmacies were commissioned to provide this service in 2025/26.

9.2.10 Help me quit @ pharmacy

All the pharmacies were commissioned to provide this service in 2025/26.

9.2.11 Inhaler review service

Four pharmacies were commissioned to provide this service in 2025/26.

9.2.12 Naloxone supply service

No pharmacies were commissioned to provide this service in 2025/26.

9.2.13 National care home support service

Two pharmacies were commissioned to provide this service in 2025/26.

9.2.14 Return of patients sharps boxes

All the pharmacies were commissioned to provide this service in 2025/26.

9.2.15 Smoking cessation service level 2 service

All the pharmacies were commissioned to provide this service in 2025/26.

9.2.16 Supervised administration service

All the pharmacies were commissioned to provide this service in 2025/26.

9.2.17 Needle and syringe programmes

Four pharmacies were commissioned to provide this service in 2025/26.

8.2.18 Urgent medicines service

One pharmacy was commissioned to provide this service in 2025/26.

9.3 Current provision of pharmaceutical services outside the locality's area

Some residents choose to access contractors outside both the locality and the health board's area in order to access services:

- Offered by dispensing appliance contractors
- Which are located near to where they work, shop, or visit for leisure or other purposes.

Whilst the majority of prescriptions written by the GP practices in 2024/25 were dispensed by either the nine pharmacies in the locality or the five dispensing practices, 8.0%% were dispensed outside the locality:

- 6.7% by pharmacies in Anglesey,
- 0.7% by contractors in England,

- 0.4% by pharmacies in other health boards in Wales, and
- 0.1% by pharmacies in Conwy West.

In the first nine months of 2025/26,8.1% were dispensed outside the locality:

- 6.7% by pharmacies in Anglesey,
- 0.5% by contractors in England,
- 0.3% by pharmacies in Dwyfor and North Meirionnydd,
- 0.3% by pharmacies in other health boards in Wales, and
- 0.1% by pharmacies in Conwy West.

In addition, residents may have accessed one or more pharmaceutical services provided by another pharmacy outside of both the locality and the health board's area; however, it is not possible to quantify this activity from the recorded data.

9.4 Other NHS services

Details of the NHS services which affect the need for pharmaceutical services can be found in chapter six.

9.5 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 9.2 and 9.3, those living within the locality and registered with one of the GP practices generally choose to access one of the pharmacies in the locality in order to have their prescriptions dispensed or, if eligible, to be dispensed to by their practice. Those that look outside the locality usually do so either to access a neighbouring pharmacy or a dispensing appliance contractor outside of the health board's area.

In 2024/25, over 124 contractors dispensed items written by one of the GP practices in this locality, of which:

- Nine were located within the locality,
- 69 were located elsewhere within the health board's area,
- 42 were located elsewhere in Wales, and
- A number of prescriptions were dispensed in England.

In the first nine months of 2025/26, over 115 contractors dispensed items written by one of the GP practices in this locality, of which:

- Nine were located within the locality,
- 66 were located elsewhere within the health board's area,
- 40 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

9.6 Gaps in provision

When considering if there are any gaps in the provision of pharmaceutical services

the health board has noted that four pharmacies said their premises have sufficient capacity to manage an increase in demand with the fifth saying it didn't but could make adjustments to manage increased demand. One pharmacy said it has sufficient in its staffing levels to manage increased demand, with the other four saying they don't but make adjustments to do so.

9.6.1 Essential services

The health board has noted:

- The pharmacies are spread across the locality and are located in areas of greater population density and higher deprivation. The dispensing practices are generally located in areas of lower population density.
- Some parts of the locality are not within a 20-minute drive time of a pharmacy however there is no resident population in those areas.
- The expected number of new houses for the locality.
- The opening hours of the pharmacies.

The health board has not identified any current needs in relation to the provision of essential services in this locality.

The health board has identified that should there be a loss of essential services due to the withdrawal of a pharmacy from the pharmaceutical list there will be a future need for either:

- a new pharmacy in the same town/village providing essential services, the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services for 40 core opening hours per week, or
- the GP dispensing service if the town/village is in a controlled locality,

unless there is another pharmacy in that town/village and then this future need will not arise.

The health board has identified that should there be a loss of supplementary opening hours on Saturdays from 1 October 2026 which results in less than three hours of provision of pharmaceutical services within a town/village there will be a future need for three core opening hours on Saturdays in the town/village or towns/villages where the reduction in supplementary opening hours has occurred, between 09.00 and 17.00, unless there is another pharmacy in that town/village and then the future need will not arise.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and

- the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

9.6.2 Clinical community pharmacy service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/25. It has therefore not identified any current or future needs for this service within the locality.

9.6.3 Discharge medicines review

The health board has noted all the pharmacies provided this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

9.6.4 Pharmacist independent prescribing service

The health board has noted:

- six pharmacies were commissioned to provide this service in 2025/25,
- The aspiration set out in Pharmacy: Delivering a Healthier Wales is for each pharmacy to have an independent prescriber by 2030 and has set interim targets of 50% of pharmacies to be providing this service in each locality by April 2027 and 70% by April 2029.
- From 2026 it is anticipated that all newly qualified pharmacists will also qualify as independent prescribers on completion of their undergraduate programme.

Based on the above, the health board has not identified any current needs for this service within the locality.

Should the interim targets not be met there will be a future need for the provision of this service by sufficient pharmacies in the locality to meet the two targets.

9.6.5 Seasonal influenza vaccination service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

9.6.6 Stoma appliance customisation

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

It is therefore anticipated that these contractors will be customising stoma appliances as required before dispatching or delivering them to patients.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

9.6.7 Appliance use reviews

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

Individuals requiring the appliance use review service are likely to access this service from the contractor that dispenses their prescriptions for appliances or may access it from other healthcare providers such as stoma nurses.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

9.6.8 Lateral flow tests supply service

The health board has noted seven pharmacies were commissioned to provide this service in 2025/25. It has also noted that this service is only available to specified patient groups. As a result, the health board has not identified any current or future needs for this service within the locality.

9.6.9 Blood borne virus testing service

The health board has noted no pharmacies were commissioned to provide this service in 2025/25. However, there are other providers of the service, for example the health board's harm reduction team.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

9.6.10 Covid-19 vaccination service

The health board has noted no pharmacies were commissioned to provide this service in 2025/25. It has also noted that GP practices and the health board's vaccination team provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

9.6.11 Help me quit @ pharmacy

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

9.6.12 Inhaler review service

The health board has noted:

- Four pharmacies were commissioned to provide this service in 2025/25.
- GP practices also provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

9.6.13 Naloxone supply service

The health board has noted no pharmacies were commissioned to provide this service in 2025/25. There are, however, other providers of the service such as the health board's harm reduction team and the 'click and deliver' service provided by DAN24/7.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

9.6.14 National care home support service

The health board has noted:

- two pharmacies were commissioned to provide this service in 2025/25.
- The service is provided by pharmacies to the care homes that they provide services to, or where a care home has requested the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

9.6.15 Return of patients sharps boxes

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

9.6.16 Smoking cessation level 2

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

9.6.17 Supervised administration service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

9.6.18 Needle and syringe programme

The health board has noted:

- Four pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service, and a postal service is being established for those who are unable to use a pharmacy.
- If a pharmacy is asked to provide the service, they can approach the health board and asked to be commissioned to provide it.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

8.6.19 Urgent medicines service

The health board has noted one pharmacy was commissioned to provide this service in 2025/25. Due to the nature of the service, it is commissioned to ensure a good geographical spread of pharmacies providing it across the health board's geography.

The health board has therefore not identified any current or future needs for this service within the locality.

9.6.20 GP dispensing service

The health board has not identified any current needs in relation to this service.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and
    - the clinical community pharmacy service, patient sharps, smoking cessation level 2, and help me quit @ pharmacy services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

10 Dwyfor and North Meirionnydd locality

10.1 Key facts

- Gwynedd has a population of 120,813, which is the second highest population of the six unitary authorities in North Wales.
- The population density is 0.4 persons per hectare, compared to 1.1 for North Wales and 1.5 for Wales[144].
- 23.4% of the population of Gwynedd is aged 65 or over. This is higher than the Wales average of 21.7% but slightly lower than the health board's average of 24.0%.
- 15.2% of the locality's population is aged 0-15 years, lower than the average for Wales at 17.1% and lower than the health board's average of 16.7%.
- 22.2% of the locality's population are aged 66-84 years, higher than the average for Wales at 17.7%, and higher than the health board's average of 19.6%.
- 4.2% of the locality's population is aged 85+ years, higher than the health board's average of 3.1% and higher than the Wales average of 2.7%.
- The overall population of the health board is expected to increase by just over 50,000 residents (6.8%) between 2022 and 2047. At unitary authority level, the largest increases are expected in Gwynedd (10.8%) and Denbighshire (10.4%).
- Gwynedd has the highest percentage of adults who can speak Welsh at 64.0%. The average for the whole of Wales is 18.0%.
- Gwynedd has the highest proportion of one-person households across the health board (34.6%), although the figure is higher in the locality at 35.9%; 18.6% of one-person households in the locality are occupied by a single occupant aged 66 years and over.
- 17.7% of households have no car or van.
- None of the locality's population lives in the most deprived 20% of the Welsh Index of Multiple Deprivation[145].
- Life expectancy in Gwynedd is 79.2 for males and 83.1 for females[146].
- Healthy life expectancy in Gwynedd is 64.9 years for males and 65.0 years for females and the inequality gap for healthy life expectancy in Gwynedd is 3.0 years for males and 2.8 years for females.
- 31.2% of four and five year olds in Dwyfor and North Meirionnydd have overweight or obesity.
- Almost 37% of 11 to 16-year-olds report drinking alcohol in North Wales compared to 35.6% across Wales. The highest reported levels of alcohol drinking across the region are in Flintshire (39.3%) and Gwynedd (38.2%).
- Healthy lifestyles and behaviour data for adults in Gwynedd are shown below.

[144] North Wales Regional Partnership Board – Dwyfor and North Meirionnydd primary care cluster statistical profile 2025
[145] Public Health Wales - Primary care clusters dashboard
[146] InfoBaseCymru data for an intelligent Wales - Life expectancy in males and females (2020 to 2022)

Area	Physically active for at least 60 minutes per day	Eat at least one portion of fruit or vegetable daily	Smoke tobacco at least weekly	Tried e-cigarettes at least weekly	Reporting drinking alcohol
Gwynedd	18.3%	50.2%	3.4%	6.6%	38.2%
Betsi Cadwaladr University Health Board	18.3%	45.7%	3.3%	8.2%	36.8%
Wales	18.3%	46.5%	2.6%	6.9%	35.6%

- Numbers of patients with chronic conditions as reported on the Digital Health and Care Wales disease registers, April 2025, are shown below.

Disease register	Dwyfor and North Meirionnydd	Betsi Cadwaladr University Health Board	Wales
Asthma	7.6%	7.6%	7.1%
Atrial fibrillation	3.0%	2.8%	2.7%
Cancer	5.0%	4.3%	3.7%
Chronic obstructive pulmonary disease	2.8%	2.7%	2.3%
Diabetes	8.3%	8.3%	8.4%
Epilepsy	0.9%	0.9%	1.0%
Heart failure	1.3%	1.4%	1.4%
Hypertension	20.0%	17.9%	16.3%
Stroke transient ischaemic attack	2.4%	2.3%	2.2%
Secondary prevention of coronary heart disease	3.4%	3.6%	3.4%

- The locality has the highest rate of hypertension compared to the rest of North Wales.

The Anglesey and Gwynedd Joint Local Development Plan 2011 – 2026[147] identifies that 393 additional housing units will be built in Bangor. It is noted that the seventh annual monitoring report on the local development plan for the period 1 April 2024 to 31 March 2025 confirms the number of units completed in 2024/25 was 212 lower than the average annual requirement of 479 units. The report also confirmed that 2,687 units have been completed between 2011/12 and 2024/25, whilst the trajectory anticipated a figure of 3,487 units.

[147] Anglesey and Gwynedd Joint Local Development Plan 2011 – 2026

10.2 Current provision of pharmaceutical services within the locality's area

There are 13 pharmacies in the locality operated by four different contractors. Two the pharmacies are covered by the essential small pharmacy scheme. Of the six GP practices, two dispense from two premises. The level of dispensing is 57.4% of one practice's registered population and 66.2% of the other practice's registered population.

The map below shows the location of the pharmacies and dispensing practice premises. It should be noted that where premises are close to each other the symbols will overlap.

Map 10.1 – location of pharmacies and dispensing doctor premises



© OpenStreetMap © CARTO Dispensing doctor premises Pharmacy

In 2025/26, 82.8% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practices dispensed or personally administered 13.2% of the prescribed items. Whilst the data available doesn't show the percentage split between dispensed and personally administered items, based on the level of personal administration elsewhere in Wales it can be assumed that less than 2% of items were personally administered.

In the first nine months of 2025/26 84.0% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practices dispensed or personally administered 13.7% of the prescribed items.

The map in chapter 5 indicates that some parts of the locality that are not within a 20-minute drive of a pharmacy. The area in the south west of the locality contains scattered houses, farms, and caravan and camping sites along the coastline.

The area to the west of Blaenau Ffestiniog is in Eryri National Park and contains no resident population. The areas around Harlech are either nature reserves, moors, or mountainous areas with little or no resident population.

With regard to when the pharmacies are open:

- One open Monday to Thursday (Trawsfynydd)
- Two open Monday to Friday,
- Four open Monday to Friday, and part of Saturday, and
- Five open Monday to Saturday and
- One opens Monday to Friday, plus part of Sunday

With regard to the times at which these pharmacies are open between Monday and Friday:

- All the pharmacies open at 09.00,
- Closing times vary between 17.30 and 18.30.

Five pharmacies were commissioned to stay open for an extra 30 minutes on Mondays to Fridays (17.30 to 18.00) in 2025/26.

Ten pharmacies close for lunch at varying times between 12:30 and 14.00. The remaining pharmacies open all day.

On Saturday, the nine pharmacies open at 09.00. Of the five pharmacies that open all day, three close for lunch between 12:30 and 13.40. They close between 16.00 and 17.30. Eight pharmacies have core opening hours on Saturdays.

One pharmacy in Penrhyndeudraeth opens between 10:30 and 14:30 on a Sunday. These are core opening hours.

The health board asks the pharmacies whether they will be open on public and bank holidays and Easter Sunday. The responses are collated, and the health board establishes whether or not there are any geographic gaps in provision. Where a gap exists, a pharmacy is either commissioned or directed to open.

Seven pharmacies responded to the pharmacy contractor questionnaire and the following information is taken from those responses.

Six pharmacies are accessible by wheelchair, but all seven consultation areas are accessible by wheelchair. All nine consultation areas are:

- closed rooms,
- a designated area where the patient and pharmacist can sit down together and talk at normal volumes without being overheard, and
- clearly designated as an area for confidential consultations distinct from the general public areas of the pharmacy.

All seven pharmacies confirmed they have Welsh speakers. One pharmacy also reported that Urdu is spoken.

All seven pharmacies dispense prescriptions for all types of appliances.

All seven pharmacies collect prescriptions from GP practices. In relation to the delivery of dispensed items, six pharmacies offer a delivery service to specific patient groups (housebound patients, and elderly and vulnerable housebound patients) and one is considering introducing a change for its service.

Two pharmacies stated that there is a requirement for an existing additional clinical service that is not currently provided in the locality:

- travel health vaccinations on the NHS – trained staff are currently offering travel health services privately,
- ear microsuction.

One pharmacy was of the opinion that there is a requirement for a new additional service which is not currently available:

- mole checking, and
- cryotherapy.

All seven pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide. One has sufficient staffing capacity and six don't but could make adjustments to manage increased demand.

One pharmacy is looking to add an extension in the next 12 to 18 months, if it can apply for and receive a grant. This would allow a second consultation room to be added, increase the size of the dispensary and provide better staff facilities. Another is looking into providing more private services.

None of the dispensing practices responded to the dispensing doctor questionnaire.

10.2.1 Clinical community pharmacy service

All the pharmacies had signed up to provide this service and in 2025/26 provided:

- 10,092 consultations for common ailments
- 362 consultations for contraception
- 3,010 emergency medicines supplies

10.2.2 Discharge medicines review

In 2025/26 all the pharmacies provided this service and completed 534 reviews.

10.2.3 Pharmacist independent prescribing service

Seven pharmacies were commissioned to provide this service in 2025/26 and provided a total of 6,200 consultations over the year.

10.2.4 Seasonal influenza vaccination

All the pharmacies were commissioned to provide this service in 2025/26 and provided a total of 2,804 vaccinations.

10.2.5 Stoma appliance customisation

None of the pharmacies provide this service despite dispensing prescriptions for appliances.

10.2.6 Appliance use reviews

None of the pharmacies provide this service despite dispensing prescriptions for appliances.

10.2.7 Lateral flow test supply service

12 pharmacies were commissioned to provide this service in 2025/26.

10.2.8 Blood borne virus testing service

Two pharmacies were commissioned to provide this service in 2025/26.

10.2.9 Covid-19 vaccination service

Six pharmacies were commissioned to provide this service in 2025/26.

10.2.10 Help me quit @ pharmacy

All the pharmacies were commissioned to provide this service in 2025/26.

10.2.11 Inhaler review service

11 pharmacies were commissioned to provide this service in 2025/26.

10.2.12 Naloxone supply service

One pharmacy was commissioned to provide this service in 2025/26.

10.2.13 National care home support service

Five pharmacies were commissioned to provide this service in 2025/26.

10.2.14 Return of patients sharps boxes

All the pharmacies were commissioned to provide this service in 2025/26.

10.2.15 Smoking cessation service level 2

All the pharmacies were commissioned to provide this service in 2025/26.

10.2.16 Supervised administration service

All the pharmacies were commissioned to provide this service in 2025/26.

10.2.17 Needle and syringe programmes

Five pharmacies were commissioned to provide this service in 2025/26.

10.2.18 Urgent medicines service

One pharmacy was commissioned to provide this service in 2025/26.

10.3 Current provision of pharmaceutical services outside the locality's area

Some residents choose to access contractors outside both the locality and the health board's area in order to access services:

- Offered by dispensing appliance contractors
- Which are located near to where they work, shop, or visit for leisure or other purposes.

Whilst the majority of prescriptions written by the GP practices in 2025/26were dispensed by either the pharmacies in the locality or the dispensing practices, 2.8% were dispensed outside the locality:

- 2.2% by contractors in England,
- 0.4% elsewhere in Wales.
- 0.1% by pharmacies in Arfon, and
- 0.1% by pharmacies in South Meirionnydd.

In the first nine months of 2025/26, 1.9% of items were dispensed outside of the locality:

- 1.4% by contractors in England
- 0.4% elsewhere in Wales, and
- 0.1% by pharmacies in South Meirionnydd.

In addition, residents may have accessed one or more pharmaceutical services provided by another pharmacy outside of both the locality and the health board's area; however, it is not possible to quantify this activity from the recorded data.

10.4 Other NHS services

Details of the NHS services which affect the need for pharmaceutical services can be found in chapter six.

10.5 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 10.2 and 10.3, those living within the locality and registered with one of the GP practices generally choose to access one of the pharmacies in the locality in order to have their prescriptions dispensed or, if eligible, to be dispensed to by their practice. Those that look outside the locality usually do so either to access a neighbouring pharmacy or a dispensing appliance contractor outside of the health board's area.

In 2024/25 over 107 contractors dispensed items written by one of the GP practices in this locality, of which:

- 15 were located within the locality,
- 60 were located elsewhere within the health board's area,
- 32 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

In the first nine months of 2025/26, over 72 contractors dispensed items written by one of the GP practices in this locality, of which:

- 13 were located within the locality,
- 40 were located elsewhere within the health board's area,
- 19 were located elsewhere in Wales, and
- A number of prescriptions were dispensed in England.

10.6 Gaps in provision

When considering if there are any gaps in the provision of pharmaceutical services the health board has noted that seven pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide. One has sufficient staffing capacity and six don't but could make adjustments to manage increased demand.

10.6.1 Essential services

The health board has noted:

- The pharmacies are spread across the locality and are located in areas of greater population density. The dispensing practices are located in areas of lower deprivation.
- Some parts of the locality are not within a 20-minute drive time of a pharmacy however there is little or no resident population in those areas.
- The opening hours of the pharmacies.

The health board has not identified any current needs in relation to the provision of essential services in this locality.

The health board has identified that should there be a loss of supplementary opening hours on Saturdays from 1 October 2026 which results in less than three hours of provision of pharmaceutical services in a town/village there will be a future need for three core opening hours on Saturdays in the town/village or towns/villages where the reduction in supplementary opening hours has occurred, between 09.00 and 17.00, unless there is another pharmacy in that town/village and then the future need will not arise.

The health board has identified that should there be a loss of essential services due to the withdrawal of a pharmacy from the pharmaceutical list there will be a future need for either:

- a new pharmacy in the same town/village providing essential services, the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services, or
- the GP dispensing service if the town/village is in a controlled locality,

unless there is another pharmacy in that town/village and then this future need will not arise.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and
    - the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

10.6.2 Clinical community pharmacy service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/25. It has therefore not identified any current or future needs for this service within the locality.

10.6.3 Discharge medicines review

The health board has noted all the pharmacies provided this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

10.6.4 Pharmacist independent prescribing service

The health board has noted:

- seven pharmacies were commissioned to provide this service in 2025/25.
- The aspiration set out in Pharmacy: Delivering a Healthier Wales is for each pharmacy to have an independent prescriber by 2030 and has set interim targets of 50% of pharmacies to be providing this service in each locality by April 2027 and 70% by April 2029.
- From 2026 it is anticipated that all newly qualified pharmacists will also qualify as independent prescribers on completion of their undergraduate programme.

Based on the above, the health board has not identified any current needs for this service within the locality.

Should the interim targets not be met there will be a future need for the provision of this service by sufficient pharmacies in the locality to meet the two targets.

10.6.5 Seasonal influenza vaccination service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/25. It has therefore not identified any current or future needs for this service within the locality.

10.6.6 Stoma appliance customisation

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

It is therefore anticipated that these contractors will be customising stoma appliances as required before dispatching or delivering them to patients.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.7 Appliance use reviews

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

Individuals requiring the appliance use review service are likely to access this service from the contractor that dispenses their prescriptions for appliances or may access it from other healthcare providers such as stoma nurses.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.8 Lateral flow tests supply service

The health board has noted seven pharmacies were commissioned to provide this service in 2025/25. It has also noted that this service is only available to specified patient groups. As a result, the health board has not identified any current or future needs for this service within the locality.

10.6.9 Blood borne virus testing service

The health board has noted no pharmacies were commissioned to provide this service in 2025/25. However, there are other providers of the service, for example the health board's harm reduction team.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.10 Covid-19 vaccination service

The health board has noted no pharmacies were commissioned to provide this service in 2025/25. It has also noted that GP practices and the health board's vaccination team provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.11 Help me quit @ pharmacy

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

10.6.12 Inhaler review service

The health board has noted:

- four pharmacies were commissioned to provide this service in 2025/25.
- GP practices also provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.13 Naloxone supply service

The health board has noted no pharmacies were commissioned to provide this service in 2025/25. There are, however, other providers of the service such as the health board's harm reduction team and the 'click and deliver' service provided by DAN24/7.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.14 National care home support service

The health board has noted:

- two pharmacies were commissioned to provide this service in 2025/25.
- The service is provided by pharmacies to the care homes that they provide services to, or where a care home has requested the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.15 Return of patients sharps boxes

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

10.6.16 Smoking cessation level 2

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

10.6.17 Supervised administration service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

10.6.18 Needle and syringe programme

The health board has noted:

- Four pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service, and a postal service is being established for those who are unable to use a pharmacy.
- If a pharmacy is asked to provide the service, they can approach the health board and asked to be commissioned to provide it.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

10.6.19 Urgent medicines service

The health board has one pharmacy was commissioned to provide this service in 2025/25. Due to the nature of the service, it is commissioned to ensure a good geographical spread of pharmacies providing it across the health board’s geography.

The health board has therefore not identified any current or future needs for this service within the locality.

10.6.20 GP dispensing service

The health board has not identified any current needs in relation to this service.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and
    - the clinical community pharmacy service, patient sharps, smoking cessation level 2, and help me quit @ pharmacy services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

11 South Meirionnydd locality

11.1 Key facts

- Gwynedd has a population of 120,813, which is the second highest population of the six unitary authorities in North Wales.
- The population density is 0.2 persons per hectare, compared to 1.1 for North Wales and 1.5 for Wales[148].
- 23.4% of the population is aged 65 or over. This is higher than the Wales average of 21.7% but slightly lower than the health board's average of 24.0%.
- 13.7% of the population of the locality is aged 0-15 years, lower than the average for Wales of 17.1%, and lower than the health board's average of 16.7%.
- 24.5% of the population of the locality is aged 66-84 years, higher than the average for Wales of 17.7% and higher than the health board's average of 19.6%.
- 4.2% of the locality's population is aged 85+ years, higher than the health board's average of 3.1% and higher than the Wales average of 2.7%.
- The overall population of the health board is expected to increase by just over 50,000 residents (6.8%) between 2022 and 2047. At unitary authority level, the largest increases are expected in Gwynedd (10.8%) and Denbighshire (10.4%).
- Gwynedd has the highest percentage of adults who can speak Welsh at 64.0% This is compared to Flintshire at 12.4%. The average for the whole of Wales is 18.0%.
- Gwynedd has the highest proportion of one-person households across the health board (34.6%), and it is even higher in South Meirionnydd at 37.8%; 19.8% of one-person households in the locality are occupied by a single occupant aged 66 years and over.
- 17.7% of households have no car or van.
- None of the locality's population live in the most deprived 20% of the Welsh Index of Multiple deprivation[149].
- Life expectancy in Gwynedd is 79.2 for males and 83.1 for females[150].
- Healthy life expectancy in Gwynedd is 64.9 years for males and 65.0 years for females and the inequality gap for healthy life expectancy in Gwynedd is 3.0 years for males and 2.8 years for females.
- 26.8% of four and five year olds in South Meirionnydd have overweight or obesity.
- Almost 37% of 11 to 16-year-olds report drinking alcohol in North Wales compared to 35.6% across Wales. The highest reported levels of alcohol drinking across the region are in Flintshire (39.3%) and Gwynedd (38.2%)
- Healthy lifestyles and behaviour data for adults in Gwynedd are shown below.

[148] North Wales Regional Partnership Board – South Meirionnydd primary care cluster statistical profile 2025
[149] Public Health Wales - Primary care clusters dashboard
[150] InfoBaseCymru data for an intelligent Wales - Life expectancy in males and females (2020 to 2022)

Area	Physically active for at least 60 minutes per day	Eat at least one portion of fruit or vegetable daily	Smoke tobacco at least weekly	Tried e-cigarettes at least weekly	Reporting drinking alcohol
Gwynedd	18.3%	50.2%	3.4%	6.6%	38.2%
Betsi Cadwaladr University Health Board	18.3%	45.7%	3.3%	8.2%	36.8%
Wales	18.3%	46.5%	2.6%	6.9%	35.6%

- Numbers of patients with chronic conditions as reported on the Digital Health and Care Wales disease registers, April 2025, are shown below.

Disease register	South Meirionnydd	Betsi Cadwaladr University Health Board	Wales
Asthma	7.5%	7.6%	7.1%
Atrial fibrillation	3.8%	2.8%	2.7%
Cancer	5.7%	4.3%	3.7%
Chronic obstructive pulmonary disease	3.5%	2.7%	2.3%
Diabetes	9.5%	8.3%	8.4%
Epilepsy	0.9%	0.9%	1.0%
Heart failure	2.2%	1.4%	1.4%
Hypertension	19.6%	17.9%	16.3%
Stroke transient ischaemic attack	2.9%	2.3%	2.2%
Secondary prevention of coronary heart disease	4.4%	3.6%	3.4%

- South Meirionnydd has the second highest rate of hypertension compared to the rest of North Wales.

The Eryri Local Development Plan 2016-2031[151] sets a requirement for a total of 750 to 852 housing units, at an average of 50 to 55 per year. During the lifetime of this pharmaceutical needs assessment that equates to an approximate total of 250 to 275 units. Around a third of these are in the local/key service centres of Dolgellau and Bala, 10 to 14% in the service settlements of Harlech, Aberdyfi, Betws y Coed, Trawsfynydd and Llanberis (which is only partly within Eryri National Park), with no more than 47% in secondary settlements. However, the fifth annual monitoring report[152] covering 2023/24 confirms that the there is a shortfall of 41% for the cumulative required build rate from 2016/17 to 31 March 2024. The local development plan is therefore falling significantly short of what is intended.

[151] Eryri Local Development Plan 2016-2031
[152] Eyri National Park Authority, Eyri Local Development Plan Annual Monitoring Report 2023/24, October 2024

11.2 Current provision of pharmaceutical services within the locality's area

There are six pharmacies in the locality operated by three different contractors. One pharmacy is covered by the essential small pharmacy scheme. Of the four GP practices, one practice dispenses from one premises. The level of dispensing is 50.6% of the practice's registered population.

The map below shows the location of the pharmacies and dispensing practice premises. It should be noted that where premises are close to each other the symbols will overlap.

Map 11.1 – location of pharmacies and dispensing doctor premises



© OpenStreetMap © CARTO Dispensing doctor premises Pharmacy

In 2024/25, 83.9% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practices dispensed or personally administered 13.1% of the prescribed items. Whilst the data available doesn't show the percentage split between dispensed and personally administered items, based on the level of personal administration elsewhere in Wales it can be assumed that less than 2% of items were personally administered.

In the first nine months of 2025/26 85.8% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practices dispensed or personally administered 12.3% of the prescribed items.

The map in chapter 5 indicates that some areas are not within a 20-minute drive of a pharmacy. Further analysis reveals they generally have no resident population as they are within Eryri National Park and are mountains. There are, however, scattered houses and farms, and camping and caravan sites located near to the roads crossing the area.

With regard to when the pharmacies are open:

- Four open Monday to Friday, and part of Saturday, and
- Two open Monday to Sunday.

With regard to the times at which these pharmacies are open between Monday and Friday:

- One pharmacy opens at 08:30 and five open at 09:00,
- One pharmacy closes at 15.00 each weekday (other than on Tuesdays when it closes at 13.00), four close at 17:30 and one pharmacy closes at 18:00 (except on a Wednesday when they close at 17:00).

Five pharmacies close for lunch at varying times between 13.00 and 14.00. The remaining pharmacy does not close for lunch but is the pharmacy that closes at 15:00 (except on a Tuesday, when it closes at 13:00).

On Saturday, one pharmacy opens at 08.30 and the remainder open at 09.00. Two pharmacies that open all day close for lunch between 13.00 and 14:00. All the pharmacies have core opening hours on Saturdays.

No pharmacies are open on Sundays.

The health board asks the pharmacies whether they will be open on public and bank holidays and Easter Sunday. The responses are collated, and the health board establishes whether or not there are any geographic gaps in provision. Where a gap exists, a pharmacy is either commissioned or directed to open.

Five pharmacies responded to the pharmacy contractor questionnaire and the following information is taken from those responses.

All five pharmacies are accessible by wheelchair, and all have a consultation area that is accessible by wheelchair. Their consultation areas are:

- closed rooms,
- a designated area where the patient and pharmacist can sit down together and talk at normal volumes without being overheard, and
- clearly designated as an area for confidential consultations distinct from the general public areas of the pharmacy.

All five pharmacies confirmed they have Welsh speakers. Other languages spoken are South Korean and Romanian.

All five pharmacies dispense prescriptions for all types of appliances.

All five pharmacies collect prescriptions from GP practices. Four provide a delivery service, three restricting it to elderly and vulnerable housebound patients.

There were no suggestions for existing services that are not currently provided in the area and no pharmacies were of the opinion that there is a requirement for an existing additional clinical service to be provided in the area.

Five pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide. One also has sufficient staffing capacity, and four said they do not but could make adjustments to manage any increase in demand.

Two pharmacies have plans to develop or expand their service provision.

- One has a pharmacist who is currently training to be an independent prescriber.
- One plans to enlarge the consultation room.

No response was received to the dispensing doctor questionnaire.

11.2.1 Clinical community pharmacy service

In 2025/26 all the pharmacies have signed up to provide this service. provided:

- 3,637 consultations for common ailments
- 184 consultations for contraception
- 1,463 emergency medicines supplies

11.2.2 Discharge medicines review

All the pharmacies provided this service in 2025/26 and completed 97 reviews.

11.2.3 Pharmacist independent prescribing service

Two pharmacies were commissioned to provide this service in 2025/26 and provided a total of 589 consultations over the year.

11.2.4 Seasonal influenza vaccination service

All the pharmacies were commissioned to provide this service in 2025/26 and provided a total of 661 vaccinations.

11.2.5 Stoma appliance customisation

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

11.2.6 Appliance use reviews

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

11.2.7 Lateral flow test supply service

All the pharmacies were commissioned to provide this service in 2025/26.

11.2.8 Blood borne virus testing service

No pharmacies were commissioned to provide this service in 2025/26.

11.2.9 Covid-19 vaccination service

One pharmacy was commissioned to provide this service in 2025/26.

11.2.10 Help me quit @ pharmacy

Five pharmacies were commissioned to provide this service in 2025/26.

11.2.11 Inhaler review service

Five pharmacies were commissioned to provide this service in 2025/26.

11.2.12 Naloxone supply service

No pharmacies were commissioned to provide this service in 2025/26.

11.2.13 National care home support service

Three pharmacies were commissioned to provide this service in 2025/26.

11.2.14 Return of patients sharps boxes

All the pharmacies were commissioned to provide this service in 2025/26.

11.2.15 Smoking cessation service level 2

All the pharmacies were commissioned to provide this service in 2025/26.

11.2.16 Supervised administration service

All the pharmacies were commissioned to provide this service in 2025/26.

11.2.17 Needle and syringe programmes

Three pharmacies were commissioned to provide this service in 2025/26.

11.2.18 Urgent medicines service

Two pharmacies were commissioned to provide this service in 2025/26.

11.3 Current provision of pharmaceutical services outside the locality's area

Some residents choose to access contractors outside both the locality and the health board's area in order to access services:

- Offered by dispensing appliance contractors
- Which are located near to where they work, shop, or visit for leisure or other purposes.

Whilst the majority of prescriptions written by the GP practices in 2024/25 were dispensed by either the pharmacies in the locality or the dispensing practice, 1.7% were dispensed outside the locality:

- 0.8% by contractors in England
- 0.6% by pharmacies in Dwyfor and North Meirionnydd, and
- 0.2% by pharmacies in other health boards in Wales.

In the first nine months of 2025/26, 1.5% of items were dispensed outside of the locality:

- 0.7% by contractors in England
- 0.6% by pharmacies in Dwyfor and North Meirionnydd, and
- 0.2% by pharmacies in other health boards in Wales

In addition, residents may have accessed one or more pharmaceutical services provided by another pharmacy outside of both the locality and the health board's area; however, it is not possible to quantify this activity from the recorded data.

11.4 Other NHS services

Details of the NHS services which affect the need for pharmaceutical services can be found in chapter six.

11.5 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 11.2 and 11.3, those living within the locality and registered with one of the GP practices generally choose to access one of the pharmacies in the locality in order to have their prescriptions dispensed or, if eligible, to be dispensed to by their practice. Those that look outside the locality usually do so either to access a neighbouring pharmacy or a dispensing appliance contractor outside of the health board's area.

In 2024/25 over 82 contractors dispensed items written by one of the GP practices in this locality, of which:

- Six were located within the locality,
- 45 were located elsewhere within the health board's area,
- 31 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

In the first nine months of 2025/26, over 66 contractors dispensed items written by one of the GP practices in this locality, of which:

- Six were located within the locality,
- 35 were located elsewhere within the health board's area,
- 25 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

11.6 Gaps in provision

When considering if there are any gaps in the provision of pharmaceutical services the health board has noted that five pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide. One also has sufficient staffing capacity, and four said they do not but could make adjustments to manage any increase in demand.

11.6.1 Essential services

The health board has noted:

- The pharmacies and dispensing practices are spread across the locality and generally are located in areas of greater population density and higher deprivation.
- Some parts of the locality are not within a 20-minute drive time of a pharmacy. However, they are generally areas with no resident population as they are within Eryri National Park and are mountains. There are however scattered houses and farms, and camping and caravan sites located near to the roads crossing the area.
- The local development plan sets a requirement of 50 to 55 houses per year until 2031.
- The population of the locality increases during the holiday season due to an influx of visitors and tourists.
- No pharmacies are open on Sundays.

The health board has not identified any current needs in relation to the provision of essential services in this locality.

The health board has identified that should there be a loss of supplementary opening hours on Saturdays from 1 October 2026 which results in less than three hours of provision of pharmaceutical services within a town/village there will be a future need for the provision of essential services for three core opening hours on Saturdays in the town/village or towns/villages where the reduction in supplementary opening hours has occurred, between 09.00 and 17.00, unless there is another pharmacy in that town/village and then the future need will not arise.

The health board has identified that should there be a loss of essential services due to the withdrawal of a pharmacy from the pharmaceutical list in a town/village there will be a future need for either:

- a new pharmacy in the same town/village providing essential services the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services for 40 core opening hours per week, or
- the GP dispensing service if the town/village is in a controlled locality,

unless there is another pharmacy in that town/village and then this future need will not arise.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and
    - the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

11.6.2 Clinical community pharmacy service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

11.6.3 Discharge medicines review

The health board has noted all the pharmacies provided this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

11.6.4 Pharmacist independent prescribing service

The health board has noted:

- two pharmacies were commissioned to provide this service in 2025/26.
- A third pharmacy had a pharmacist in training in early 2026.
- The aspiration set out in Pharmacy: Delivering a Healthier Wales is for each pharmacy to have an independent prescriber by 2030 and has set interim targets of 50% of pharmacies to be providing this service in each locality by April 2027 and 70% by April 2029.
- From 2026 it is anticipated that all newly qualified pharmacists will also qualify as independent prescribers on completion of their undergraduate programme.

Based on the above, the health board has not identified any current needs for this service within the locality.

Should the interim targets not be met there will be a future need for the provision of this service by sufficient pharmacies in the locality to meet the two targets.

11.6.5 Seasonal influenza vaccination service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

11.6.6 Stoma appliance customisation

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

It is therefore anticipated that these contractors will be customising stoma appliances as required before dispatching or delivering them to patients.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

11.6.7 Appliance use reviews

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

Individuals requiring the appliance use review service are likely to access this service from the contractor that dispenses their prescriptions for appliances or may access it from other healthcare providers such as stoma nurses.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

11.6.8 Lateral flow tests supply service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has not identified any current or future needs for this service within the locality.

11.6.9 Blood borne virus testing service

The health board has noted three pharmacies were commissioned to provide this service in 2025/26. It has also noted that GP practices and the health board's vaccination team provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

11.6.10 Covid-19 vaccination service

The health board has noted one pharmacy was commissioned to provide this service in 2025/26. It has also noted that GP practices and the health board's vaccination team provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

11.6.11 Help me quit @ pharmacy

The health board has noted:

- Five pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service for example Help me quit for baby, Help me quit in hospital, and the general Help me quit service.
- Demand for the service is dictated by people wishing to stop smoking.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

11.6.12 Inhaler review service

The health board has noted:

- Five pharmacies were commissioned to provide this service in 2025/26.
- GP practices also provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

11.6.13 Naloxone supply service

The health board has noted no pharmacies were commissioned to provide this

service in 2025/26. There are, however, other providers of the service such as the health board's harm reduction team and the 'click and deliver' service provided by DAN24/7.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

11.6.14 National care home support service

The health board has noted:

- three pharmacies were commissioned to provide this service in 2025/26.
- The service is provided by pharmacies to the care homes that they provide services to, or where a care home has requested the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

11.6.15 Return of patients sharps boxes

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

11.6.16 Smoking cessation level 2

The health board has noted:

- All the pharmacies were commissioned to provide this service in 2025/26.
- Demand for the service is dictated by people wishing to stop smoking.

Based on the above, the health board has therefore not identified any current or future needs for this service within the locality.

11.6.17 Supervised administration service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

11.6.18 Needle and syringe programme

The health board has noted:

- Three pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service, and a postal service is being established for those who are unable to use a pharmacy.
- If a pharmacy is asked to provide the service, they can approach the health board and asked to be commissioned to provide it.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

11.6.19 Urgent medicines service

The health board has noted two pharmacies were commissioned to provide this service in 2025/26. Due to the nature of the service, it is commissioned to ensure a good geographical spread of pharmacies providing it across the health board's geography.

The health board has therefore not identified any current or future needs for this service within the locality.

11.6.20 GP dispensing service

The health board has not identified any current needs in relation to this service.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and
    - the clinical community pharmacy service, patient sharps, smoking cessation level 2, and help me quit @ pharmacy services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

12 Conwy West locality

12.1 Key facts[153]

- Conwy Unitary Authority has the third smallest population of the six unitary authorities at 114,891.
- The population density is 0.7 persons per hectare, compared to 1.1 for North Wales and 1.5 for Wales[154].
- It has the highest proportion of residents aged 65 years and over (28.3%) followed by the Isle of Anglesey (27.4%) which are above the Wales average (21.7%).
- The population of the health board aged 65 years and over is expected to increase by 2047. Residents aged 65 years and over are predicted to increase by almost 34%, with the largest percentage increased expected in Denbighshire (36%). The largest increases in terms of numbers of residents are expected in Conwy Unitary Authority and Flintshire.
- For residents aged 85 years and over, Conwy Unitary Authority has the highest proportion at 3.9% alongside the Isle of Anglesey (3.6%). Both are higher that the Wales average of 2.7%.
- 22.9% of the locality's population are aged 66-84 years, which is higher than the Wales average of 17.7% and higher than the health board's average of 19.6%.
- 15.1% of the locality's population are aged 0-15 years, which is lower than the Wales average of 17.1% and the health board's average of 16.7%.
- 3.9% of the locality's population is aged 85+ years, higher than the health board's average of 3.1% and higher than the Wales average of 2.7%.
- One-person households in the locality make-up 34.6% of total households. 18.2% of households are occupied by one person aged over 66. This is higher than the average for Wales (14.6%) and the health board's average of 15.8%.
- 18.5% of households have no car or van (third highest percentage across North Wales).
- 5.7% of the locality's population live in the most deprived 20% of the Welsh Index of Multiple deprivation[155].
- Life expectancy in Conwy is 78.5 for males and 82.6 for females[156].
- Healthy life expectancy in Conwy is 63.1 years for males and 63.3 years for females and the inequality gap for healthy life expectancy in Conwy is 7.5 years for males and 75.3 years for females.
- 29.4% of four and five year olds in Conwy West locality have overweight or obesity.
- In the 2021 Census, almost 21% of residents in the health board's area are reported to have a limiting long-term illness, which is similar to Wales (21.6%). Across the region, the highest proportions were reported in Conwy unitary authority at 22.6% and Denbighshire at 23.3%.

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[153] Public Health Profiles - North West Collaborative profiles 2025
[154] North Wales Regional Partnership Board – Conwy West primary care cluster statistical profile 2025
[155] Public Health Wales - Primary care clusters dashboard
[156] InfoBaseCymru data for an intelligent Wales - Life expectancy in males and females (2020 to 2022)

- Healthy lifestyles and behaviour data for adults in Conwy Unitary Authority are shown below.

Area	Physically active for at least 60 minutes per day	Eat at least one portion of fruit or vegetable daily	Smoke tobacco at least weekly	Tried e-cigarettes at least weekly	Reporting drinking alcohol
Conwy	20.2%	46.9%	2.9%	7.4%	36.2%
Betsi Cadwaladr University Health Board	18.3%	45.7%	3.3%	8.2%	36.8%
Wales	18.3%	46.5%	2.6%	6.9%	35.6%

- The Annual Population Survey in Wales records Welsh language ability and frequency. In 2025, almost 39% of residents in the health board reported being able to speak Welsh. In Conwy 40.4% of the population reported being able to speak Welsh.
- Numbers of patients with chronic conditions as reported on the Digital Health and Care Wales disease registers, April 2025, are shown below.

Disease register	Conwy West	Betsi Cadwaladr University Health Board	Wales
Asthma	7.2%	7.6%	7.1%
Atrial fibrillation	3.0%	2.8%	2.7%
Cancer	4.8%	4.3%	3.7%
Chronic obstructive pulmonary disease	2.6%	2.7%	2.3%
Diabetes	8.1%	8.3%	8.4%
Epilepsy	0.9%	0.9%	1.0%
Heart failure	1.5%	1.4%	1.4%
Hypertension	18.8%	17.9%	16.3%
Stroke transient ischaemic attack	2.6%	2.3%	2.2%
Secondary prevention of coronary heart disease	4.0%	3.6%	3.4%

The locality is covered by two local development plans.

The Conwy Local Development Plan[157] identifies the need for 4,300 homes between 2018 and 2033 at an annual rate of 290. Some of the identified developments fall within the lifetime of this pharmaceutical needs assessment:

- Llanfairfechan – 400 units between 2021 and 2029
- Llanrhos – 250 units between 2024 and 2031

[157] Conwy Local Development Plan

- Llanrwst – 200 units between 2021 and 2026.

The council carried out a full review of the local development plan and in April 2026 was at stage 6 “Deposit replacement local development plan” with stages 7 and 8 still to be completed.

The Eryri Local Development Plan 2016-2031[158] sets a requirement for a total of 750 to 852 housing units, at an average of 50 to 55 per year. During the lifetime of this pharmaceutical needs assessment that equates to an approximate total of 250 to 275 units. Around a third of these are in the local/key service centres of Dolgellau and Bala, 10 to 14% in the service settlements of Harlech, Aberdyfi, Betws y Coed, Trawsfynydd and Llanberis (which is only partly within Eryri National Park), with no more than 47% in secondary settlements. However, the fifth annual monitoring report[159] covering 2023/24 confirms that the there is a shortfall of 41% for the cumulative required build rate from 2016/17 to 31 March 2024. The local development plan is therefore falling significantly short of what is intended.

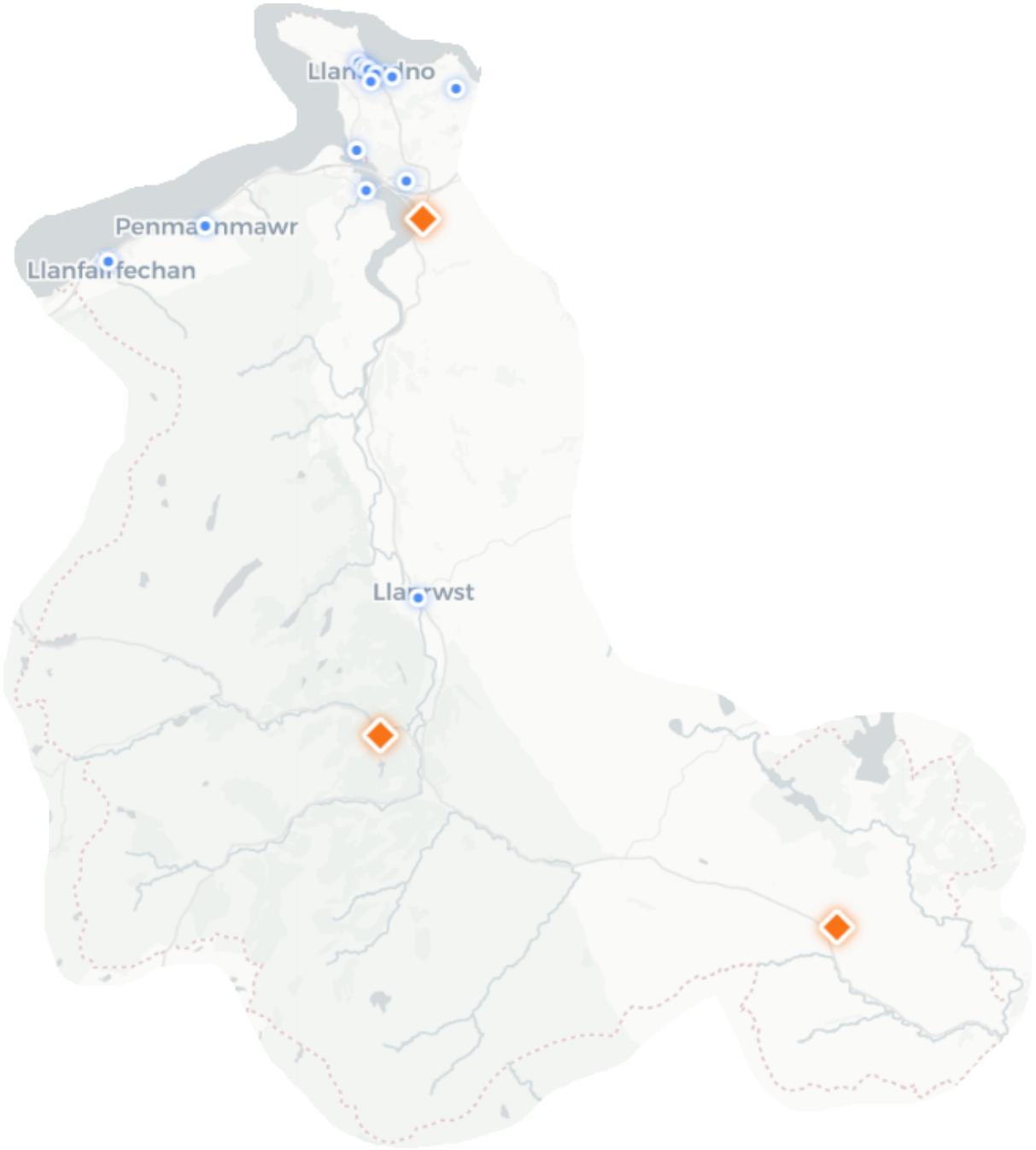
12.2 Current provision of pharmaceutical services within the locality’s area

There are 13 pharmacies in the locality operated by six different contractors. Of the 11 GP practices, three dispense from three premises. The level of dispensing ranges from 42.9% to 94.1% of the practices’ registered populations.

The map below shows the location of the pharmacies and dispensing practice premises. It should be noted that where premises are close to each other the symbols will overlap.

[158] Eyri National Park Authority, Eyri Local Development Plan 2016-2031
[159] Eyri National Park Authority, Eyri Local Development Plan Annual Monitoring Report 2023/24, October 2024

Map 12.1 – location of pharmacies and dispensing doctor premises



© OpenStreetMap © CARTO Dispensing doctor premises Pharmacy

In 2024/25, 86.8% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practices dispensed or personally administered 8.3% of the prescribed items. Whilst the data available doesn't show the percentage split between dispensed and personally administered items, based on the level of personal administration elsewhere in Wales it can be assumed that less than 2% of items were personally administered.

In the first nine months of 2025/26, 87.4% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practices dispensed or personally administered 8.6% of the prescribed items.

The map in chapter 5 indicates that some areas are not within a 20-minute drive of a pharmacy. The areas in the west of the locality are mountainous and Google maps reveals no resident population. The areas in the south are mountainous with a number of small villages with resident populations, for example Ysbyty Ifan.

With regard to when the pharmacies are open:

- Five open Monday to Friday, and part of Saturday,
- Five open Monday to Saturday, and
- Three open Monday to Sunday, all of which are in Llandudno.

With regard to the times at which these pharmacies are open between Monday and Friday:

- One opens at 08.30, one opens at 08.45 and the remainder open at 09.00,
- Closing times vary between 17.30 and 18.30 with one pharmacy in Llandudno Park open until 19:00 and another in Llandudno open until 20:00.

One pharmacy in Penmaenmawr is commissioned to open between for an additional 30 minutes (17.30 and 18.30) on weekdays.

Nine pharmacies close for lunch at varying times between 13.00 and 15.00. The remaining pharmacies open all day.

On Saturday, one pharmacy opens between 13:00 and 16:00. The remaining pharmacies open at 09:00 Of the eight pharmacies that open all day, six close for lunch between 13.00 and 15.00. They close between 16.00 and 20.00. 11 pharmacies have core opening hours on Saturdays.

The three pharmacies that open on Sunday between them cover the hours 10.00 to 17.00. Only one pharmacy has core opening hours on Sundays.

The health board asks the pharmacies whether they will be open on public and bank holidays and Easter Sunday. The responses are collated, and the health board establishes whether or not there are any geographic gaps in provision. Where a gap exists, a pharmacy is either commissioned or directed to open.

Five pharmacies responded to the pharmacy contractor questionnaire and the following information is taken from those responses.

Four pharmacies are accessible by wheelchair, but all five have a consultation area that is accessible by wheelchair. Four consultation areas are:

- closed rooms,

- a designated area where the patient and pharmacist can sit down together and talk at normal volumes without being overheard, and
- clearly designated as an area for confidential consultations distinct from the general public areas of the pharmacy.

The fifth consultation area does not allow the patient and pharmacist to talk at normal volumes without being overheard.

Four pharmacies confirmed that they have Welsh speakers. Other than English, no other languages were reported as spoken by staff.

Four pharmacies dispense prescriptions for all types of appliances, and one dispenses dressings only.

Four pharmacies collect prescriptions from GP practices. In relation to the delivery of dispensed items:

- one does not provide a delivery service,
- two provide a delivery service that is not restricted to any particular patient group, and
- two provide a delivery service to the elderly and vulnerable housebound patients.

None of the pharmacies were of the opinion that there is a requirement for a new additional clinical service which is not currently available.

There were no suggestions for a new service that is not currently available in the area.

Three pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide, one said it doesn't but could make adjustments, and one said it doesn't and would have difficulty in managing an increase in demand. Two pharmacies confirmed that they have sufficient capacity within their staffing levels to manage an increase in demand, and three confirmed they don't but could make adjustments to manage an increase.

One pharmacy plans to expand its independent prescribing service.

One of the dispensing practices responded to the dispensing doctor questionnaire:

- the dispensary opens 08.00 to 18.00
- all types of appliances are dispensed
- it has Welsh speakers in its staff
- the practice doesn't have sufficient premises and capacity at present but could make adjustments to manage an increase in demand
- in addition to the dispensing service the practice disposes of patient sharps and provides medication administration review charts for care homes.

12.2.1 Clinical community pharmacy service

All the pharmacies had signed up to provide this service and in 2025/26 they provided:

- 6,166 consultations for common ailments
- 626 consultations for contraception
- 2,825 emergency medicines supplies

12.2.2 Discharge medicines review

In 2025/26, all the pharmacies provided this service and 580 completed reviews.

12.2.3 Pharmacist independent prescribing service

Five pharmacies were commissioned to provide this service in 2025/26 and provided a total of 1,629 consultations over the year.

12.2.4 Seasonal influenza vaccination

All the pharmacies were commissioned to provide this service in 2025/26 and provided a total of 1,847 vaccinations.

12.2.5 Stoma appliance customisation

None of the pharmacies provide this service despite dispensing prescriptions for appliances.

12.2.6 Appliance use reviews

None of the pharmacies provide this service despite dispensing prescriptions for appliances.

12.2.7 Lateral flow test supply service

12 pharmacies were commissioned to provide this service in 2025/26.

12.2.8 Blood borne virus testing service

No pharmacies were commissioned to provide this service in 2025/26.

12.2.9 Covid-19 vaccination service

No pharmacies were commissioned to provide this service in 2025/26.

12.2.10 Help me quit @ pharmacy

11 pharmacies were commissioned to provide this service in 2025/26.

12.2.11 Inhaler review service

Eight pharmacies were commissioned to provide this service in 2025/26.

12.2.12 Naloxone supply service

No pharmacies were commissioned to provide this service in 2025/26.

12.2.13 National care home support service

Three pharmacies were commissioned to provide this service in 2025/26.

12.2.14 Return of patients sharps boxes

All the pharmacies were commissioned to provide this service in 2025/26.

12.2.15 Smoking cessation service level 2

All the pharmacies were commissioned to provide this in 2025/26.

12.2.16 Supervised administration service

11 pharmacies were commissioned to provide this service in 2025/26.

12.2.17 Needle and syringe programmes

Three pharmacies were commissioned to provide this service in 2025/26.

12.2.18 Urgent medicines service

No pharmacies were commissioned to provide this service in 2025/26.

12.3 Current provision of pharmaceutical services outside the locality's area

Some residents choose to access contractors outside both the locality and the health board's area in order to access services:

- Offered by dispensing appliance contractors
- Which are located near to where they work, shop, or visit for leisure or other purposes.

Whilst the majority of prescriptions written by the GP practices in 2024/25 were dispensed by either the pharmacies in the locality or the dispensing practices, 3.4% were dispensed outside the locality:

- 1.9% by pharmacies in Conwy East,
- 0.7% by contractors in England,
- 0.4% by pharmacies in other health boards in Wales,
- 0.2% by pharmacies in Central and South Denbighshire, and

- 0.1% in North Denbighshire.

In the first nine months of 2025/26 3.4% was also dispensed outside of the locality:

- 2.0% by pharmacies in Conwy East,
- 0.6% by contractors in England,
- 0.3% by pharmacies in other health boards in Wales,
- 0.2% by pharmacies in Central and South Denbighshire, and
- 0.1% in North Denbighshire.

In addition, residents may have accessed one or more pharmaceutical services provided by another pharmacy outside of both the locality and the health board's area; however, it is not possible to quantify this activity from the recorded data.

12.4 Other NHS services

Details of the NHS services which affect the need for pharmaceutical services can be found in chapter six.

12.5 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 12.2 and 12.3, those living within the locality and registered with one of the GP practices generally choose to access one of the pharmacies in the locality in order to have their prescriptions dispensed or, if eligible, to be dispensed to by their practice. Those that look outside the locality usually do so either to access a neighbouring pharmacy or a dispensing appliance contractor outside of the health board's area.

In 2024/25, over 144 contractors dispensed items written by one of the GP practices in this locality, of which:

- 13 were located within the locality,
- 100 were located elsewhere within the health board's area,
- 31 were located elsewhere in Wales, and
- A number of prescriptions were dispensed in England.

In the first nine months of 2025/26, over 125 contractors dispensed items written by one of the GP practices in this locality, of which:

- 13 were located within the locality,
- 88 were located elsewhere within the health board's area,
- 24 were located elsewhere in Wales, and
- A number of prescriptions were dispensed in England.

12.6 Gaps in provision

When considering if there are any gaps in the provision of pharmaceutical services the health board has noted that three pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the

services they provide, one said it doesn't but could make adjustments, and one said it doesn't and would have difficulty in managing an increase in demand. Two pharmacies confirmed that they have sufficient capacity within their staffing levels to manage an increase in demand, and three confirmed they don't but could make adjustments to manage an increase.

12.6.1 Essential services

The health board has noted:

- The pharmacies are spread across the locality and are located in areas of greater population density and higher deprivation. The dispensing practices are generally located in areas of lower deprivation.
- Some parts of the locality are not within a 20-minute drive time of a pharmacy. Whilst some areas are mountainous and have no resident population, in the southern part of the locality there are a number of small villages with resident populations, for example Ysbyty Ifan (according to Wikipedia, the second smallest population of any Welsh community, the smallest being Ganllwyd in Gwynedd).
- There are three known housing developments due within the lifetime of this document which will deliver up to 850 new houses by 2033.
- The resident population of the locality is increased by the number of tourists and visitors that visit the area all year round, particularly in the middle of the locality.
- The opening hours of the pharmacies.

Based on the above, the health board has identified that there is a current need for a pharmacy in Betws-y-Coed which, as a minimum, has core opening hours of:

- 09.00 to 17.00 Monday to Friday, and
- Six hours on Saturdays.

There is a current need for this pharmacy to provide the following services from the point it is included in the pharmaceutical list:

- All essential services,
- clinical community pharmacy service,
- return of patient sharps,
- smoking cessation level 2, and
- help me quit @ pharmacy service.

The health board has identified that should there be a loss of essential services due to the withdrawal of a pharmacy from the pharmaceutical list there will be a future need for either:

- a new pharmacy in the same town/village providing essential services, the clinical community pharmacy service, return of patient sharps boxes,

supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services for 40 core opening hours per week, or
- the GP dispensing service if the town/village is in a controlled locality,

unless there is another pharmacy in that town/village and then this future need will not arise.

The health board has identified that should there be any loss of supplementary opening hours on Saturdays from 1 October 2026 which results in less than three hours of provision of pharmaceutical services within a town/village there will be a future need for the provision of essential services for three core opening hours on Saturdays in the town/village or towns/villages where the reduction in supplementary opening hours has occurred, between 09.00 and 17.00, unless there is another pharmacy in that town/village and then the future need will not arise.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and
    - the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

12.6.2 Clinical community pharmacy service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

12.6.3 Discharge medicines review

The health board has noted all the pharmacies provided this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

12.6.4 Pharmacist independent prescribing service

The health board has noted:

- five pharmacies were commissioned to provide this service in 2025/26.
- The aspiration set out in Pharmacy: Delivering a Healthier Wales is for each pharmacy to have an independent prescriber by 2030 and has set interim

targets of 50% of pharmacies to be providing this service in each locality by April 2027 and 70% by April 2029.
- From 2026 it is anticipated that all newly qualified pharmacists will also qualify as independent prescribers on completion of their undergraduate programme.

Based on the above, the health board has not identified any current needs for this service within the locality.

Should the interim targets not be met there will be a future need for the provision of this service by sufficient pharmacies in the locality to meet the two targets.

12.6.5 Seasonal influenza vaccination

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

12.6.6 Stoma appliance customisation

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

It is therefore anticipated that these contractors will be customising stoma appliances as required before dispatching or delivering them to patients.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

12.6.7 Appliance use reviews

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

Individuals requiring the appliance use review service are likely to access this service from the contractor that dispenses their prescriptions for appliances or may access it from other healthcare providers such as stoma nurses.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

12.6.8 Lateral flow tests supply service

The health board has noted 12 pharmacies were commissioned to provide this service in 2025/26. It has also noted that this service is only available to specified patient groups. As a result, the health board has not identified any current or future needs for this service within the locality.

12.6.9 Blood borne virus testing service

The health board has noted no pharmacies were commissioned to provide this service in 2025/26. However, there are other providers of the service, for example the health board's harm reduction team.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

12.6.10 Covid-19 vaccination service

The health board has no pharmacies were commissioned to provide this service in 2025/26. It has also noted that GP practices and the health board's vaccination team provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

12.6.11 Help me quit @ pharmacy

The health board has noted:

- 11 pharmacies were commissioned to provide this service in 2025/26.
- Demand for the service is dictated by people wishing to stop smoking.

It has therefore not identified any current or future needs for this service within the locality.

12.6.12 Inhaler review service

The health board has noted:

- eight pharmacies were commissioned to provide this service in 2025/26.
- GP practices also provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

12.6.13 Naloxone supply service

The health board has noted no pharmacies were commissioned to provide this service in 2025/26. There are, however, other providers of the service such as the health board's harm reduction team and the 'click and deliver' service provided by DAN24/7.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

12.6.14 National care home support service

The health board has noted:

- three pharmacies were commissioned to provide this service in 2025/26.
- The service is provided by pharmacies to the care homes that they provide services to, or where a care home has requested the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

12.6.15 Return of patients sharps boxes

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

12.6.16 Smoking cessation level 2

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26.

Based on the above, the health board has therefore not identified any current or future needs for this service within the locality.

12.6.17 Supervised administration service

The health board has noted 11 pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

12.6.18 Needle and syringe programmes

The health board has noted:

- Three pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service, and a postal service is being established for those who are unable to use a pharmacy.
- If a pharmacy is asked to provide the service, they can approach the health board and asked to be commissioned to provide it.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

12.6.19 Urgent medicines service

The health board has noted that no pharmacies were commissioned to provide this service in 2025/26. Due to the nature of the service, it is commissioned to ensure a good geographical spread of pharmacies providing it across the health board’s geography.

The health board has therefore not identified any current or future needs for this service within the locality.

12.6.20 GP dispensing service

The health board has not identified any current needs in relation to this service.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and
    - the clinical community pharmacy service, return of patient sharps, smoking cessation level 2, and help me quit @ pharmacy services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

13 Conwy East locality

13.1 Key facts[160]

- Conwy Unitary Authority has the third smallest population of the six unitary authorities at 114,891.
- However, the population density is 3.7 persons per hectare, compared to 1.1 for North Wales and 1.5 for Wales[161].
- It has the highest proportion of residents aged 65 years and over (28.3%) followed by the Isle of Anglesey (27.4%), above the Wales average (21.7%).
- The population of the health board aged 65 years and over is expected to increase by 2047. Residents aged 65 years and over are predicted to increase by almost 34%, with the largest percentage increased expected in Denbighshire (36%). The largest increases in terms of numbers of residents are expected in Conwy and Flintshire.
- For residents aged 85 years and over, Conwy has the highest proportion at 3.9% alongside the Isle of Anglesey (3.6%). Both are higher that the Wales average of 2.7%.
- 22.9% of the locality's population is aged 66-84 years, higher than the Wales average of 17.7%, and higher than the health board's average of 19.6%.
- 3.9% are aged 85+ years, higher than the health board's average of 3.1% and the Wales average of 2.7%.
- 13% of the locality's population are aged 16-29 years, lower than the average for Wales (16.7%) and lower than the health board's average of 14.7%.
- 18.5% of households in Conwy Unitary Authority have no car or van (third highest percentage across North Wales)
- 21.3% of the locality's population live in the most deprived 20% of the Welsh Index of Multiple deprivation.[162] This is the second highest across the clusters in North Wales.
- Life expectancy in Conwy Unitary Authority is 78.5 for males and 82.6 for females[163]
- Healthy life expectancy in Conwy Unitary Authority is 63.1 years for males and 63.3 years for females and the inequality gap for healthy life expectancy in Conwy Unitary Authority is 7.5 years for males and 75.3 years for females.
- In the 2021 Census, almost 21% of residents in the health board's area are reported to have a limiting long-term illness, which is similar to Wales (21.6%). Across the region, the highest proportions were reported in Conwy Unitary Authority at 22.6% and Denbighshire at 23.3%.
- 29% of four and five year olds in Conwy East locality have overweight or obesity.
- Healthy lifestyles and behaviour data for adults in Conwy Unitary Authority show:

[160] Public Health Profiles - North West Collaborative profiles 2025
[161] North Wales Regional Partnership Board – Conwy East primary care cluster statistical profile 2025
[162] Public Health Wales - Primary care clusters dashboard
[163] InfoBaseCymru data for an intelligent Wales - Life expectancy in males and females (2020 to 2022)

Area	Physically active for at least 60 minutes per day	Eat at least one portion of fruit or vegetable daily	Smoke tobacco at least weekly	Tried e-cigarettes at least weekly	Reporting drinking alcohol
Conwy Unitary Authority	20.2%	46.9%	2.9%	7.4%	36.2%
Betsi Cadwaladr University Health Board	18.3%	45.7%	3.3%	8.2%	36.8%
Wales	18.3%	46.5%	2.6%	6.9%	35.6%

- The Annual Population Survey in Wales records Welsh language ability and frequency. In 2025, almost 39% of residents in the health board's area reported being able to speak Welsh. In Conwy Unitary Authority 40.4% of the population reported being able to speak Welsh.
- Numbers of patients with chronic conditions as reported on the Digital Health and Care Wales disease registers, April 2025, are shown below.

Disease register	Conwy East	Betsi Cadwaladr University Health Board	Wales
Asthma	8.3%	7.6%	7.1%
Atrial fibrillation	3.2%	2.8%	2.7%
Cancer	4.8%	4.3%	3.7%
Chronic obstructive pulmonary disease	2.8%	2.7%	2.3%
Diabetes	9.6%	8.3%	8.4%
Epilepsy	1.0%	0.9%	1.0%
Heart failure	1.6%	1.4%	1.4%
Hypertension	18.9%	17.9%	16.3%
Stroke transient ischaemic attack	2.6%	2.3%	2.2%
Secondary prevention of coronary heart disease	4.6%	3.6%	3.4%

The Conwy Local Development Plan[164] identifies the need for 4,300 homes between 2018 and 2033 at an annual rate of 290. One of the identified developments falls within the lifetime of this pharmaceutical needs assessment:

- Old Colwyn – 450 units between 2024 and 2033

The council carried out a full review of the local development plan and in April 2026 was at stage 6 "Deposit replacement local development plan" with stages 7 and 8 still to be completed.

[164] Conwy Local Development Plan

13.2 Current provision of pharmaceutical services within the locality's area

There are ten pharmacies in the locality operated by seven different contractors. Of the four GP practices, one dispenses to 11.7% of its registered population from one premises.

The map below shows the location of the pharmacies and dispensing practice premises. It should be noted that where premises are close to each other the symbols will overlap.

Map 13.1 – location of pharmacies and dispensing doctor premises



© OpenStreetMap © CARTO Dispensing doctor premises Pharmacy

In 2024/25, 88.0% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practice dispensed or personally administered 4.1% of the prescribed items. Whilst the data available doesn't show the percentage split between dispensed and personally administered items, based on the level of personal administration elsewhere in Wales it can be assumed that less than 2% of items were personally administered.

In the first nine months of 2025/26 88.8% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practice dispensed or personally administered 4.0% of the prescribed items.

The map in chapter 5 indicates one area in the south of the locality that is not within a 20-minute drive of a pharmacy. Google maps reveals it is part of Denbigh Moors with only a few scattered houses/farms.

With regard to when the pharmacies are open:

- two open Monday to Friday,
- five open Monday to Friday, and part of Saturday,
- two open Monday to Saturday, and
- one opens Monday to Sunday in Colwyn Bay.

With regard to the times at which these pharmacies are open between Monday and Friday:

- Three open at 08.30 and the remainder open at 09.00,
- Closing times vary between 17.30 and 18.30 with one pharmacy in Colwyn Bay open until 19.00.

Seven pharmacies close for lunch at varying times between 12.30 and 14.00. The remaining pharmacies open all day.

On Saturday, all the pharmacies open at 09.00. Of the three pharmacies that open all day, one closes for lunch between 13.00 and 13.20. They close between 17.00 and 18.00. Six pharmacies have core opening hours on Saturday.

The pharmacy that opens on Sunday does so between 10.00 and 16.00. These are supplementary opening hours.

The health board asks the pharmacies whether they will be open on public and bank holidays and Easter Sunday. The responses are collated, and the health board establishes whether or not there are any geographic gaps in provision. Where a gap exists, a pharmacy is either commissioned or directed to open.

Seven pharmacies responded to the pharmacy contractor questionnaire and the following information is taken from those responses.

All seven pharmacies are accessible by wheelchair and five have a consultation area that is accessible by wheelchair. One has a consultation room that doesn’t have wheelchair access, and one pharmacy can remove a chair to make the consultation room wheelchair accessible. Six consultation areas are:

- closed rooms,
- a designated area where the patient and pharmacist can sit down together and talk at normal volumes without being overheard, and

- clearly designated as an area for confidential consultations distinct from the general public areas of the pharmacy.

The seventh does not allow the patient and pharmacist to sit down together and talk at normal volumes without being overheard. This is the pharmacy that would need to remove a chair to ensure wheelchair access.

Four pharmacies confirmed they have Welsh speakers, and four pharmacies confirmed that languages other than English are spoken by staff.

- Polish and Urdu
- Polish
- Arabic
- Urdu.

All six pharmacies dispense prescriptions for all types of appliances.

All six pharmacies collect prescriptions from GP practices. In relation to the delivery of dispensed items:

- five provide a free of charge delivery service on request, free of charge, and one also provides the service for a fee,
- one pharmacy provides a delivery service for a fee, and
- one said it restricts the service to elderly and vulnerable housebound patients.

One pharmacy suggested there is a requirement for a new service that is not currently provided in the area – monitored dosage system packs.

One pharmacy was of the opinion that there is a requirement for new additional clinical services which are not currently available – period delay service and travel vaccinations.

All eight pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide. Four said they have sufficient staffing capacity, two said they do not but could make adjustments, and one did not confirm its position.

Two pharmacies have plans to develop or expand their premises or service provision:

- one intends to introduce prescribing services as it now has a prescribing pharmacist, and to expand its free delivery service.
- One has a pharmacist who is in the process of developing their scope of practice.

Neither pharmacy was commissioned to provide the pharmacist independent prescribing service in 2025/26.

There were no responses to the dispensing doctor questionnaire.

13.2.1 Clinical community pharmacy service

All the pharmacies had signed up to provide this service and in 2025/26 provided:

- 7,087 consultations for common ailments
- 426 consultations for contraception
- 1,950 emergency medicines supplies

13.2.2 Discharge medicines review

In 2025/26 all the pharmacies provided this service and completed 370 reviews.

13.2.3 Pharmacist independent prescribing service

Three pharmacies were commissioned to provide this service in 2025/26 and provided a total of 2,090 consultations over the year.

13.2.4 Seasonal influenza vaccination service

All the pharmacies were commissioned to provide this service in 2025/26 and provided a total of 2,718 vaccinations.

13.2.5 Stoma appliance customisation

None of the pharmacies provide this service despite dispensing prescriptions for appliances.

13.2.6 Appliance use reviews

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

13.2.7 Lateral flow test supply service

All the pharmacies were commissioned to provide this service in 2025/26.

13.2.8 Blood borne virus testing service

No pharmacies were commissioned to provide this service in 2025/26.

13.2.9 Covid-19 vaccination service

No pharmacies were commissioned to provide this service in 2025/26.

13.2.10 Help me quit @ pharmacy

Eight pharmacies were commissioned to provide this service in 2025/26.

13.2.11 Inhaler review service

Seven pharmacies were commissioned to provide this service in 2025/26.

13.2.12 Naloxone supply service

No pharmacies were commissioned to provide this service in 2025/26.

13.2.13 National care home support service

One pharmacy was commissioned to provide this service in 2025/.

13.2.14 Return of patients sharps boxes

All the pharmacies were commissioned to provide this service in 2025/26.

13.2.15 Smoking cessation service level 2 service

All the pharmacies were commissioned to provide this service in 2025/26.

13.2.16 Supervised administration service

Nine pharmacies were commissioned to provide this service in 2025/26.

13.2.17 Needle and syringe programmes

Four pharmacies were commissioned to provide this service in 2025/26.

13.2.18 Urgent medicine service

One pharmacy was commissioned to provide this service in 2025/26.

13.3 Current provision of pharmaceutical services outside the locality's area

Some residents choose to access contractors outside both the locality and the health board's area in order to access services:

- Offered by dispensing appliance contractors
- Which are located near to where they work, shop, or visit for leisure or other purposes.

Whilst the majority of prescriptions written by the GP practices in 2024/25 were dispensed by either the pharmacies in the locality or the dispensing practice, 7.2% were dispensed outside the locality:

- 4.2% by pharmacies in Conwy West,

- 2.0% by pharmacies in North Denbighshire,
- 0.7% by contractors in England, and
- 0.3% in Cardiff and Vale University Health Board's area.

In addition, residents may have accessed one or more pharmaceutical services provided by another pharmacy outside of both the locality and the health board's area; however, it is not possible to quantify this activity from the recorded data.

13.4 Other NHS services

Details of the NHS services which affect the need for pharmaceutical services can be found in chapter six.

13.5 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 13.2 and 13.3, those living within the locality and registered with one of the GP practices generally choose to access one of the pharmacies in the locality in order to have their prescriptions dispensed or, if eligible, to be dispensed to by their practice. Those that look outside the locality usually do so either to access a neighbouring pharmacy or a dispensing appliance contractor outside of the health board's area.

In 2024/25 over 98 contractors dispensed items written by one of the GP practices in this locality, of which:

- ten were located within the locality,
- 66 were located elsewhere within the health board's area,
- 22 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

In 2025/26 over 130 contractors dispensed items:

- ten were located within the locality,
- 62 were located elsewhere within the health board's area,
- 58 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

13.6 Gaps in provision

When considering if there are any gaps in the provision of pharmaceutical services the health board has noted that eight pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide. Four said they have sufficient staffing capacity, two said they do not but could make adjustments, and one did not confirm its position.

13.6.1 Essential services

The health board has noted:

- The pharmacies are spread along the coastline, in areas of greater population density and generally higher deprivation.
- An area in the south western corner of the locality is not within a 20-minute drive time of a pharmacy however it is part of Denbigh Moors with only a few scattered houses/farms.
- There is one known housing development due within the lifetime of this document which will deliver up to 450 new houses by 2033.
- The population of the locality increases during the holiday season due to an influx of visitors and tourists.
- The opening hours of the pharmacies.

The health board has identified that should there be a loss of essential services due to the withdrawal of a pharmacy from the pharmaceutical list there will be a future need for either:

- a new pharmacy in the same town/village providing essential services, the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services for 40 core opening hours per week, or
- the GP dispensing service if the town/village is in a controlled locality,

unless there is another pharmacy in that town/village and then this future need will not arise.

The health board has identified that should there be a loss of supplementary opening hours on Saturdays from 1 October 2026 which results in less than three hours of provision of pharmaceutical services within a town/village there will be a future need for the provision of essential services for three core opening hours on Saturdays in the town/village or towns/villages where the reduction in supplementary opening hours has occurred, between 09.00 and 17.00, unless there is another pharmacy in that town/village and then the future need will not arise.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and
    - the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

13.6.2 Clinical community pharmacy service

The health board has noted all the pharmacies were commissioned to provide this

service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

13.6.3 Discharge medicines review

The health board has noted all the pharmacies provided this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

13.6.4 Pharmacist independent prescribing service

The health board has noted:

- three pharmacies were commissioned to provide this service in 2025/26.
- Two pharmacies have plans to introduce this service.
- The aspiration set out in Pharmacy: Delivering a Healthier Wales is for each pharmacy to have an independent prescriber by 2030 and has set interim targets of 50% of pharmacies to be providing this service in each locality by April 2027 and 70% by April 2029.
- From 2026 it is anticipated that all newly qualified pharmacists will also qualify as independent prescribers on completion of their undergraduate programme.

Based on the above, the health board has not identified any current needs for this service within the locality.

Should the interim targets not be met there will be a future need for the provision of this service by sufficient pharmacies in the locality to meet the two targets.

13.6.5 Seasonal influenza vaccination service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

13.6.6 Stoma appliance customisation

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

It is therefore anticipated that these contractors will be customising stoma appliances as required before dispatching or delivering them to patients.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

13.6.7 Appliance use reviews

Although no pharmacies provide this service the health board has noted that

prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

Individuals requiring the appliance use review service are likely to access this service from the contractor that dispenses their prescriptions for appliances or may access it from other healthcare providers such as stoma nurses.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

13.6.8 Lateral flow tests supply service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. As a result, the health board has not identified any current or future needs for this service within the locality.

13.6.9 Blood borne virus testing service

The health board has noted no pharmacies were commissioned to provide this service in 2025/26. However, there are other providers of the service, for example the health board's harm reduction team.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

13.6.10 Covid-19 vaccination service

The health board has noted no pharmacies were commissioned to provide this service in 2025/26. It has also noted that GP practices and the health board's vaccination team provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

13.6.11 Help me quit @ pharmacy

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

13.6.12 Inhaler review service

The health board has noted:

- seven pharmacies were commissioned to provide this service in 2025/26.
- GP practices also provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

13.6.13 Naloxone supply service

The health board has noted no pharmacies were commissioned to provide this service in 2025/25. There are, however, other providers of the service such as the health board's harm reduction team and the 'click and deliver' service provided by DAN24/7.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

13.6.14 National care home support service

The health board has noted:

- one pharmacy was commissioned to provide this service in 2025/26.
- The service is provided by pharmacies to the care homes that they provide services to, or where a care home has requested the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

13.6.15 Return of patients sharps boxes

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

13.6.16 Smoking cessation level 2

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

13.6.17 Supervised administration service

The health board has noted nine pharmacies were commissioned to provide this service in 2025/16. It has therefore not identified any current or future needs for this service within the locality.

13.6.18 Needle and syringe programmes

The health board has noted:

- Four pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service, and a postal service is being established for those who are unable to use a pharmacy.
- If a pharmacy is asked to provide the service, they can approach the health board and asked to be commissioned to provide it.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

13.6.19 Urgent medicine service

The health board has noted one pharmacy was commissioned to provide this service in 2025/26. Due to the nature of the service, it is commissioned to ensure a good geographical spread of pharmacies providing it across the health board's geography.

The health board has therefore not identified any current or future needs for this service within the locality.

13.6.20 GP dispensing service

The health board has not identified any current needs in relation to this service.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and
    - the clinical community pharmacy service, patient sharps, smoking cessation level 2, and help me quit @ pharmacy services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

14 North Denbighshire locality

14.1 Key facts[165]

- Denbighshire Unitary Authority has the second smallest population of the six unitary authorities at 98,202.
- The population density is 7.97 persons per hectare, compared to 1.1 for North Wales and 1.5 for Wales[166].
- The overall population of the health board is expected to increase by just over 50,000 residents (6.8%) between 2022 and 2047. At a local authority level, the largest increases are expected in Gwynedd (10.8%) and Denbighshire (10.4%). The smallest increase is predicted to be in Wrexham (2.4%).
- The population of the health board aged 65 years and over is also expected to increase by 2047. Residents aged 65 years and over are predicted to increase by almost 34%, with the largest percentage increased expected in Denbighshire (36%).
- For residents aged 85 years and over, Denbighshire Unitary Authority has the third highest proportion at 3.2%. This is higher than the Wales average of 2.7%.
- Most unitary authority areas across the health board's area have a lower percentage of residents from ethnic minority backgrounds compared to the average for Wales (5.2%), except for Denbighshire which is also 5.2%.
- 20.2% of the locality's population is aged 66-84 years, higher than the Wales average of 17.7%, and higher than the health board's average of 19.6%.
- 3.1% of the locality's population is aged 85+ years, the same as the health board's average of 3.1% and higher than the Wales average of 2.7%.
- 18% of the locality's population is aged 0-15 years, higher than the average for Wales (17.1%) and of the health board's average of 16.7%.
- One-person households in North Denbighshire make-up 34.1% of total households; 16.9% of households in North Denbighshire are occupied by one person aged over 66. This is higher than the average for Wales (14.6%) and the health board's average of 15.8%.
- At locality level, North Denbighshire has the highest proportion of unpaid carers (11.4%) and the highest numbers, at just over 6,500.
- 22.1% of households in the locality have no car or van (second highest percentage across North Wales)
- 27.8% of the locality's population live in the most deprived 20% of the Welsh Index of Multiple deprivation.[167] This is the highest proportion of population across the localities.
- Life expectancy in Denbighshire is 77.5 for males and 81.0 for females[168].
- Healthy life expectancy in Denbighshire is 60.5 years for males and 59.6 years for females and the inequality gap for healthy life expectancy in Denbighshire is 9.2 years for males and 8.9 years for females.

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[165] Public Health Profiles - North West Collaborative profiles 2025
[166] North Wales Regional Partnership Board – North Denbighshire primary care cluster statistical profile 2025
[167] Public Health Wales - Primary care clusters dashboard
[168] InfoBaseCymru data for an intelligent Wales - Life expectancy in males and females (2020 to 2022)

- 29.7% of four and five year olds in North Denbighshire locality have overweight or obesity.
- In the 2021 Census, almost 21% of residents in the health board's area are reported to have a limiting long-term illness, which is similar to Wales (21.6%). Across the region, the highest proportions were reported in Conwy at 22.6% and Denbighshire at 23.3%.
- Healthy lifestyles and behaviour data for adults in Denbighshire Unitary Authority show:

Area	Physically active for at least 60 minutes per day	Eat at least one portion of fruit or vegetable daily	Smoke tobacco at least weekly	Tried e-cigarettes at least weekly	Reporting drinking alcohol
Denbighshire	19.7%	47.9%	2.5%	7.4%	33.7%
Betsi Cadwaladr University Health Board	18.3%	45.7%	3.3%	8.2%	36.8%
Wales	18.3%	46.5%	2.6%	6.9%	35.6%

- Less than 40% of working age adults across the health as a whole report to be of healthy weight. Denbighshire has the highest proportion at unitary authority level at 47.6%.
- The Annual Population Survey in Wales records Welsh language ability and frequency. In 2025, almost 39% of residents in the health board's area reported being able to speak Welsh. In Denbighshire 32.3% of the population reported being able to speak Welsh.
- Numbers of patients with chronic conditions as reported on the Digital Health and Care Wales disease registers, April 2025, are shown below.

Disease register	North Denbighshire	Betsi Cadwaladr University Health Board	Wales
Asthma	8.0%	7.6%	7.1%
Atrial fibrillation	2.9%	2.8%	2.7%
Cancer	4.2%	4.3%	3.7%
Chronic obstructive pulmonary disease	3.2%	2.7%	2.3%
Diabetes	9.4%	8.3%	8.4%
Epilepsy	1.1%	0.9%	1.0%
Heart failure	1.4%	1.4%	1.4%
Hypertension	17.7%	17.9%	16.3%
Stroke transient ischaemic attack	2.2%	2.3%	2.2%
Secondary prevention of coronary heart disease	4.1%	3.6%	3.4%

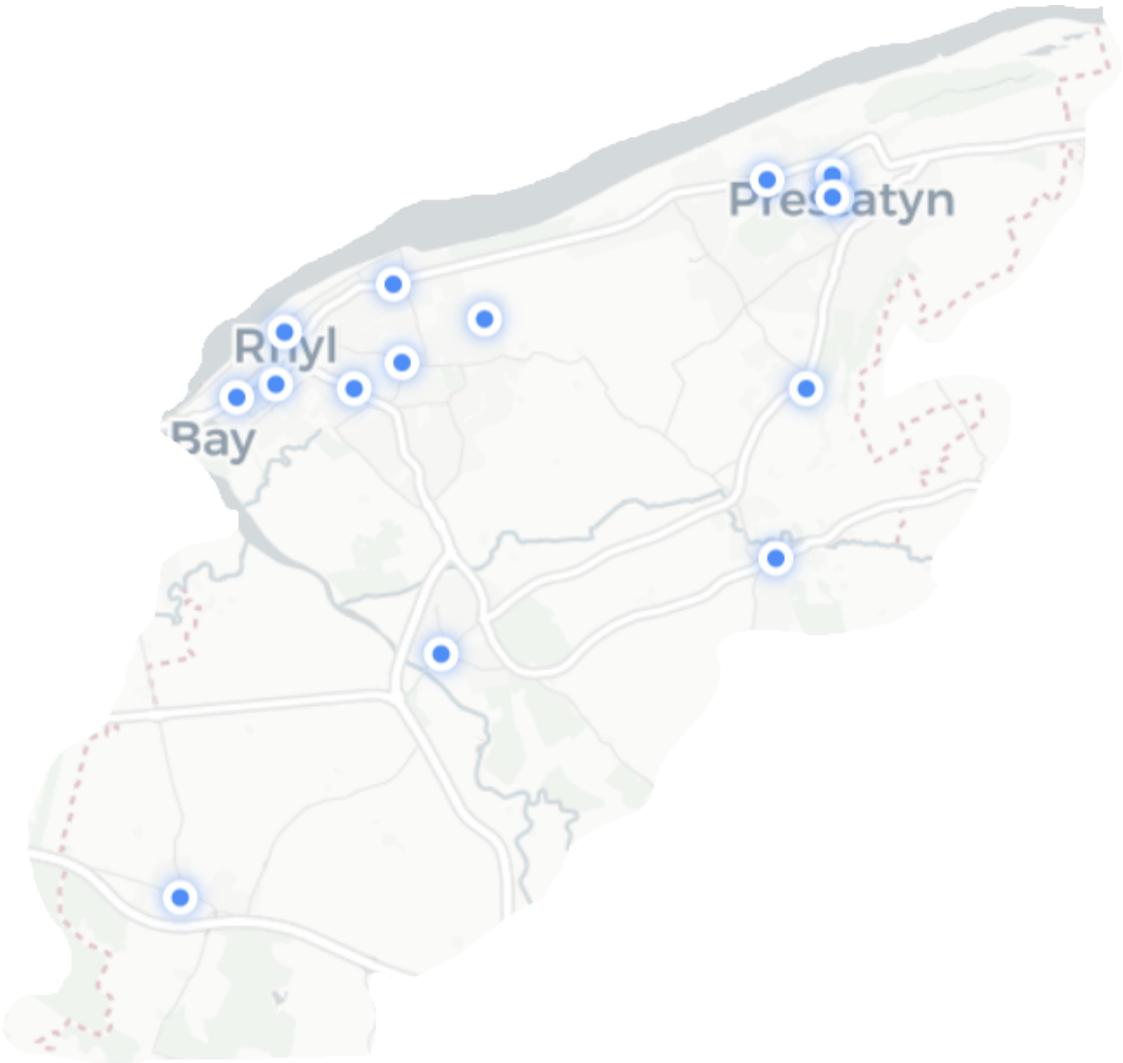
- The Denbighshire Local Development Plan[169] identifies the need for 3,775 housing units between 2018 and 2033. According to the Annual Monitoring Report 2025, although the annual build rate for the council is 500 units per year, 351 were completed in 2024/25 and 85 and 93 were predicted to be completed in 2025/26 and 2026/27 respectively. Whilst 1,715 units were expected to be built in Bodelwyddan, the report confirms that outline planning permission has expired.

14.2 Current provision of pharmaceutical services within the locality

There are 15 pharmacies in the locality operated by ten different contractors. None of the six practices dispense.

The map below shows the location of the pharmacies. It should be noted that where premises are close to each other the symbols will overlap.

Map 14.1 – location of pharmacies



© OpenStreetMap © CARTO

[169] Denbighshire Local Development Plan and Annual Monitoring Reports

In 2025/26, 93.3% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality.

In the first nine months of 2025/26 93.6% of prescriptions written by the GP practices in the locality.

The map in chapter 5 shows that all of the locality is within a 20-minute drive of a pharmacy, with most residents within a ten-minute drive.
With regard to when the pharmacies are open:

- five open Monday to Friday,
- six open Monday to Friday, and part of Saturday,
- two open Monday to Saturday, and
- two open Monday to Sunday, one in Bodelwyddan and one in Prestatyn.

With regard to the times at which these pharmacies are open between Monday and Friday:

- one opens at 08.45 and the remainder open at 09.00,
- Closing times vary between 17.30 and 18.00 with one pharmacy in Prestatyn open until 20.00 and one in Bodelwyddan until 22.00. One pharmacy closes at 13.00 on Wednesdays.

11 pharmacies close for lunch at varying times between 12.45 and 14.15. The remaining pharmacies open all day.

On Saturday, one pharmacy opens at 08.45m the others at 09.00. Of the four pharmacies that open all day, one closes for lunch between 12.45 and 13.30, and another from 13.00 to 16.30. Two pharmacies close at 17.30, one at 19.00 and one at 22.00. Ten pharmacies have core opening hours on Saturday.

The two pharmacies that open on Sunday between them cover the hours 08.45 to 22.00. These are all supplementary opening hours.

The health board asks the pharmacies whether they will be open on public and bank holidays and Easter Sunday. The responses are collated, and the health board establishes whether or not there are any geographic gaps in provision. Where a gap exists, a pharmacy is either commissioned or directed to open.

Two pharmacies responded to the pharmacy contractor questionnaire and the following information is taken from those responses.

Both pharmacies are accessible by wheelchair and have a consultation area that is accessible by wheelchair. Both consultation areas are:

- closed rooms,
- a designated area where the patient and pharmacist can sit down together and talk at normal volumes without being overheard, and

- clearly designated as an area for confidential consultations distinct from the general public areas of the pharmacy.

Neither pharmacy has Welsh speakers. No languages other than English are spoken.

Both pharmacies dispense prescriptions for all types of appliances.

Both pharmacies collect prescriptions from GP practices. They offer a delivery service to elderly and vulnerable housebound patients.

Neither pharmacy was of the opinion that there is a requirement for an existing additional clinical service which is not currently provided in the area, nor that there is a requirement for a new service.

Both pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide. Whilst they don't have sufficient staffing and premises capacity, they could make adjustments to manage an increase in demand.

Neither pharmacy has plans to develop or expand their service provision.

14.2.1 Clinical community pharmacy service

14 of the pharmacies had signed up to provide this service and in 2025/26 provided:

- 7,461 consultations for common ailments
- 510 consultations for contraception
- 3,310 emergency medicines supplies

14.2.2 Discharge medicines review

In 2025/26, all the pharmacies provided this service and completed 558 reviews.

14.2.3 Pharmacist independent prescribing service

Seven pharmacies were commissioned to provide this service in 2025/26 and provided a total of 4,534 consultations over the year.

14.2.4 Seasonal influenza vaccination service

14 pharmacies were commissioned to provide this service in 2025/26 and provided a total of 1,677 vaccinations.

14.2.5 Stoma appliance customisation

None of the pharmacies provide this service despite dispensing prescriptions for appliances.

14.2.6 Appliance use reviews

None of the pharmacies provide this service despite dispensing prescriptions for appliances.

14.2.7 Lateral flow test supply service

Ten pharmacies were commissioned to provide this service in 2025/26.

14.2.8 Blood borne virus testing service

One pharmacy was commissioned to provide this service in 2025/26.

14.2.9 Covid-19 vaccination service

Four pharmacies were commissioned to provide this service in 2025/26.

14.2.10 Help me quit @ pharmacy

12 pharmacies were commissioned to provide this service in 2025/26.

14.2.11 Inhaler review service

Five pharmacies were commissioned to provide this service in 2025/26.

14.2.12 Naloxone supply service

One pharmacy was commissioned to provide this service in 2025/.

14.2.13 National care home support service

Seven pharmacies were commissioned to provide this service in 2025/26.

14.2.14 Return of patients sharps boxes

All the pharmacies were commissioned to provide this service in 2025/26.

14.2.15 Smoking cessation service level 2 service

All the pharmacies were commissioned to provide this service in 2025/26.

14.2.16 Supervised administration service

12 pharmacies were commissioned to provide this service in 2025/26.

14.2.17 Needle and syringe programmes

Four pharmacies were commissioned to provide this service in 2025/26.

14.2.18 Urgent medicines service

One pharmacy was commissioned to provide this service in 2025/26.

14.3 Current provision of pharmaceutical services outside the locality's area

Some residents choose to access contractors outside both the locality and the health board's area in order to access services:

- Offered by dispensing appliance contractors
- Which are located near to where they work, shop, or visit for leisure or other purposes.

Whilst the majority of prescriptions written by the GP practices in 2024/25 were dispensed by the pharmacies in the locality, 5.7% were dispensed outside the locality:

- 2.8% by pharmacies in Conwy East,
- 1.0% by pharmacies in Conwy West,
- 0.9% by contractors in England,
- 0.3% by pharmacies in each of North East Flintshire and North West Flintshire,
- 0.3% in Cardiff and Vale University Health Board's area, and
- 0.1% in Central and South Denbighshire.

In the first nine months of 2025/26, 6.0% of items were dispensed outside the locality:

- 3.3% by pharmacies in Conwy East,
- 1.0% by pharmacies in Conwy West,
- 1.0% by contractors in England,
- 0.2% by pharmacies in North West Flintshire,
- 0.1% by pharmacies in North East Flintshire,
- 0.2% in Cardiff and Vale University Health Board's area, and
- 0.1% in Central and South Denbighshire.

In addition, residents may have accessed one or more pharmaceutical services provided by another pharmacy outside of both the locality and the health board's area; however, it is not possible to quantify this activity from the recorded data.

14.4 Other NHS services

Details of the NHS services which affect the need for pharmaceutical services can be found in chapter six.

14.5 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 14.2 and 14.3, those living within the locality and registered with one of the GP practices generally choose to access one of the pharmacies in the locality in order to have their prescriptions dispensed or, if eligible, to be dispensed to by their practice. Those that look outside the locality usually do so either to access a neighbouring pharmacy or a dispensing appliance contractor outside of the health board's area.

In 2024/25 over 124 contractors dispensed items written by one of the GP practices in this locality, of which:

- 15 were located within the locality,
- 85 were located elsewhere within the health board's area,
- 24 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

In the first nine months of 2025/26 over 127 contractors dispensed items:

- 15 were located within the locality,
- 97 were located elsewhere within the health board's area,
- 24 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

14.6 Gaps in provision

When considering if there are any gaps in the provision of pharmaceutical services the health board has noted that two pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide. Whilst they don't have sufficient staffing and premises capacity, they could make adjustments to manage an increase in demand.

14.6.1 Essential services

The health board has noted:

- The pharmacies are spread across the locality and are located in areas of greater population density and higher deprivation.
- All of the locality is within a 20-minute drive time of a pharmacy, with most residents within a ten-minute drive.
- The level of housing for Denbighshire as a whole and the lack of any significant proposed development of 500 or more dwellings.
- The opening hours of the pharmacies.

The health board has not identified any current needs for these services within the locality.

The health board has identified that should there be a loss of essential services due to the withdrawal of a pharmacy from the pharmaceutical list there will be a future need for either:

- a new pharmacy in the same town/village providing essential services the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services for 40 core opening hours per week, or
- the GP dispensing service if the town/village is in a controlled locality,

unless there is another pharmacy in that town/village and then this future need will not arise.

The health board has identified that should the pharmacy in Bodelwyddan withdraw from the pharmaceutical list there will be a future need for a new pharmacy in the town providing essential services during the following core opening hours:

- At least ten core opening hours per day Monday to Friday,
- Six core opening hours on Saturdays, and
- Six core opening hours on Sundays.

The health board has identified that should there be any loss of supplementary opening hours on Saturdays from 1 October 2026 which results in less than three hours of provision of pharmaceutical services within a town/village there will be a future need for the provision of essential services for three core opening hours on Saturdays in the town/village or towns/villages where the reduction in supplementary opening hours has occurred, between 09.00 and 17.00, unless there is another pharmacy in that town/village and then the future need will not arise.

14.6.2 Clinical community pharmacy service

The health board has noted 14 pharmacies were commissioned to provide this service in 2025/26.

Based on the above, the health board has not identified any current needs for this service within the locality.

However, the pharmacy that does not provide the service has extended opening hours and the population would benefit from the provision of this service. The health board has identified that there is a gap in the provision of this service in Bodelwyddan. The health board will work with the existing pharmacy in connection with the lack of provision of this service. However, should this gap not be closed, then from 1 April 2027 there will be a future need for this service to be provided in Bodelwyddan, seven days a week for:

- eight hours a day Monday to Friday,
- six hours on Saturdays to include 13.00 to 15.00, and
- three hours on Sundays after 12 noon.

14.6.3 Discharge medicines review

The health board has noted all the pharmacies provided this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

14.6.4 Pharmacist independent prescribing service

The health board has noted:

- 7 pharmacies were commissioned to provide this service in 2025/26.
- The aspiration set out in Pharmacy: Delivering a Healthier Wales is for each pharmacy to have an independent prescriber by 2030 and has set interim targets of 50% of pharmacies to be providing this service in each locality by April 2027 and 70% by April 2029.
- From 2026 it is anticipated that all newly qualified pharmacists will also qualify as independent prescribers on completion of their undergraduate programme.

Based on the above, the health board has not identified any current needs for this service within the locality.

Should the interim targets not be met there will be a future need for the provision of this service by sufficient pharmacies in the locality to meet the two targets.

14.6.5 Seasonal influenza vaccination

The health board has noted the following points:

- 14 pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service, for example the GP practices.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

14.6.6 Stoma appliance customisation

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

It is therefore anticipated that these contractors will be customising stoma appliances as required before dispatching or delivering them to patients.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

14.6.7 Appliance use reviews

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

Individuals requiring the appliance use review service are likely to access this service from the contractor that dispenses their prescriptions for appliances or may access it from other healthcare providers such as stoma nurses.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

14.6.8 Lateral flow tests supply service

The health board has noted ten pharmacies were commissioned to provide this service in 2025/26. It has also noted that this service is only available to specified patient groups. As a result, the health board has not identified any current or future needs for this service within the locality.

14.6.9 Blood borne virus testing service

The health board has noted one pharmacy was commissioned to provide this service in 2025/26. However, there are other providers of the service, for example the health board's harm reduction team.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

14.6.10 Covid-19 vaccination service

The health board has noted four pharmacies were commissioned to provide this service in 2025/26. It has also noted that GP practices and the health board's vaccination team provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

14.6.11 Help me quit @ pharmacy

The health board has noted:

- 12 pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service for example Help me quit for baby, Help me quit in hospital, and the general Help me quit service.
- Demand for the service is dictated by people wishing to stop smoking.

It has therefore not identified any current or future needs for this service within the locality.

14.6.12 Inhaler review service

The health board has noted:

- five pharmacies were commissioned to provide this service in 2025/26.
- GP practices also provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

14.6.13 Naloxone supply service

The health board has noted one pharmacy was commissioned to provide this service in 2025/26. There are, however, other providers of the service such as the health board's harm reduction team and the 'click and deliver' service provided by DAN24/7.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

14.6.14 National care home support service

The health board has noted:

- seven pharmacies were commissioned to provide this service in 2025/26.
- The service is provided by pharmacies to the care homes that they provide services to, or where a care home has requested the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

14.6.15 Return of patients sharps boxes

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

14.6.16 Smoking cessation level 2

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

14.6.17 Supervised administration service

The health board has noted 12 pharmacies were commissioned to provide this service in 2025/26. It has not identified any current or future needs for this service within the locality.

14.6.18 Needle and syringe programmes

The health board has noted the following points:

- Four pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service, and a postal service is being established for those who are unable to use a pharmacy.
- If a pharmacy is asked to provide the service, they can approach the health board and asked to be commissioned to provide it.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

14.6.19 Urgent medicines service

The health board has noted one pharmacy was commissioned to provide this service in 2025/26. Due to the nature of the service, it is commissioned to ensure a good geographical spread of pharmacies providing it across the health board's geography.

The health board has therefore not identified any current or future needs for this service within the locality.

15 Central and South Denbighshire locality

15.1 Key facts[170]

- Denbighshire Unitary Authority has the second smallest population of the six unitary authorities at 98,202.
- The population density is 0.5 persons per hectare, compared to 1.1 for North Wales and 1.5 for Wales[171].
- The overall population of the health board is expected to increase by just over 50,000 residents (6.8%) between 2022 and 2047. At a local authority level, the largest increases are expected in Gwynedd (10.8%) and Denbighshire (10.4%). The smallest increase is predicted to be in Wrexham (2.4%).
- The population of the health board aged 65 years and over is also expected to increase by 2047. Residents aged 65 years and over are predicted to increase by almost 34%, with the largest percentage increased expected in Denbighshire (36%).
- For residents aged 85 years and over, Denbighshire Unitary Authority has the third highest proportion at 3.2% This is higher than the Wales average of 2.7%.
- Most unitary authority areas across North Wales have a lower percentage of residents from ethnic minority backgrounds compared to the average for Wales (5.2%), except for Denbighshire which is also 5.2%.
- 21.2% of the locality's population is aged 66-84 years, higher than the Wales average of 17.7%, and higher than the health board's average of 19.6%.
- 3.2% of the locality's population is aged 85+ years, similar to health board's average of 3.1% and higher than the Wales average of 2.7%.
- 16.3% of the locality's population is aged 0-15 years, lower than the average for Wales (17.1%) and lower than the health board's average of 16.7%.
- One-person households in the locality make up 31.3% of total households; 15.8% of households are occupied by one person aged over 66. This is higher than the average for Wales (14.6%) and the same as the health board's average of 15.8%.
- In Central and South Denbighshire, 12.4% of households have no car or van (second lowest percentage across North Wales)
- 3.5% of the cluster population live in the most deprived 20% of the Welsh Index of Multiple deprivation.[172]
- Life expectancy in Denbighshire is 77.5 for males and 81.0 for females[173].
- Healthy life expectancy in Denbighshire is 60.5 years for males and 59.6 years for females and the inequality gap for healthy life expectancy in Denbighshire is 9.2 years for males and 8.9 years for females.
- 30.8% of four and five year olds in Central and South Denbighshire have overweight or obesity.

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[170] Public Health Profiles - North West Collaborative profiles 2025
[171] North Wales Regional Partnership Board - Central and South Denbighshire primary care cluster statistical profile 2025
[172] Public Health Wales - Primary care clusters dashboard
[173] InfoBaseCymru data for an intelligent Wales - Life expectancy in males and females (2020 to 2022)

- In the 2021 Census, almost 21% of residents in the health board's area are reported to have a limiting long-term illness, which is similar to Wales (21.6%). Across the region, the highest proportions were reported in Conwy local authority at 22.6% and Denbighshire at 23.3%.
- Healthy lifestyles and behaviour data for adults in Denbighshire Unitary Authority show:

Area	Physically active for at least 60 minutes per day	Eat at least one portion of fruit or vegetable daily	Smoke tobacco at least weekly	Tried e-cigarettes at least weekly	Reporting drinking alcohol
Denbighshire	19.7%	47.9%	2.5%	7.4%	33.7%
Betsi Cadwaladr University Health Board	18.3%	45.7%	3.3%	8.2%	36.8%
Wales	18.3%	46.5%	2.6%	6.9%	35.6%

- Less than 40% of working age adults across the health board as a whole report to be of healthy weight. Denbighshire has the highest proportion at unitary authority level at 47.6%.
- The Annual Population Survey in Wales records Welsh language ability and frequency. In 2025, almost 39% of residents in the health board reported being able to speak Welsh. In Denbighshire 32.3% of the population reported being able to speak Welsh.
- Numbers of patients with chronic conditions as reported on the Digital Health and Care Wales disease registers, April 2025, are shown below.

Disease register	Central and South Denbighshire	Betsi Cadwaladr University Health Board	Wales
Asthma	7.8%	7.6%	7.1%
Atrial fibrillation	3.1%	2.8%	2.7%
Cancer	4.6%	4.3%	3.7%
Chronic obstructive pulmonary disease	2.7%	2.7%	2.3%
Diabetes	7.9%	8.3%	8.4%
Epilepsy	0.9%	0.9%	1.0%
Heart failure	1.4%	1.4%	1.4%
Hypertension	18.4%	17.9%	16.3%
Stroke transient ischaemic attack	2.3%	2.3%	2.2%
Secondary prevention of coronary heart disease	3.6%	3.6%	3.4%

- The Denbighshire Local Development Plan[174] identifies the need for 3,775 housing units between 2018 and 2033. According to the Annual Monitoring Report 2025, although the annual build rate for the council is 500 units per year, 351 were completed in 2024/25 and 85 and 93 were predicted to be completed in 2025/26 and 2026/27 respectively.

15.2 Current provision of pharmaceutical services within the locality's area

There are eight pharmacies in the locality operated by five different contractors. One pharmacy is covered by the essential small pharmacy scheme. Of the eight GP practices, six dispense from a total of six premises. The level of dispensing ranges from 36.7% to 53.4% of the practices' registered populations.

The map below shows the location of the pharmacies and dispensing practice premises. It should be noted that where premises are close to each other the symbols will overlap.

Map 15.1 – location of pharmacies and dispensing doctor premises



[174] Denbighshire Local Development Plan and Annual Monitoring Reports



In 2024/25, 55.3% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practices dispensed or personally administered 39.2% of the prescribed items. Whilst the data available doesn't show the percentage split between dispensed and personally administered items, based on the level of personal administration elsewhere in Wales it can be assumed that less than 2% of items were personally administered.

In the first nine months of 2025/26 58.0% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practices dispensed or personally administered 36.7% of the prescribed items. Less than 2% of items were personally administered.

The map in chapter 5 indicates that there are areas that are not within a 20-minute drive of a pharmacy. The area to the south-west of Ruthin is rural in nature, with a few scattered houses/farms and campsites. The area to the south of Corwen is Y Berwyn National Nature Reserve.
With regard to when the pharmacies are open:

- two open Monday to Friday,
- Four open Monday to Friday, and part of Saturday, and
- Two open Monday to Saturday.

With regard to the times at which these pharmacies are open between Monday and Friday:

- all open at 09.00,
- closing times are either 17.30 or 18.00.

Each of the two pharmacies in Ruthin were commissioned to stay open for an extra 30 minutes (17.30 to 18.00) on Mondays, Tuesdays, Wednesdays and Fridays on alternate weeks in 2025/26.

All the pharmacies close for lunch at varying times between 12.30 and 14.00.

On Saturday, the six pharmacies open at 09.00. Both of the pharmacies that open all day close for lunch, with one closing at 17.00 and the other at 17.30. The six pharmacies all have core opening hours on Saturday.

No pharmacies open on Sundays.

The health board asks the pharmacies whether they will be open on public and bank holidays and Easter Sunday. The responses are collated, and the health board establishes whether or not there are any geographic gaps in provision. Where a gap exists, a pharmacy is either commissioned or directed to open.

Six pharmacies responded to the pharmacy contractor questionnaire and the following information is taken from those responses.

All six pharmacies are accessible by wheelchair, and of these five have a consultation area that is accessible by wheelchair. Five consultation areas are:

- closed rooms,
- a designated area where the patient and pharmacist can sit down together and talk at normal volumes without being overheard, and
- clearly designated as an area for confidential consultations distinct from the general public areas of the pharmacy.

The sixth is not a closed room and does not allow the patient and pharmacist to sit down together and talk at normal volumes without being overheard. There are, however, alternative arrangements for confidential discussions.

Five pharmacies confirmed they have Welsh speakers. Two pharmacies confirmed staff can speak Polish.

Five pharmacies dispense prescriptions for all types of appliances. The sixth doesn't dispense any appliances.

All the pharmacies collect prescriptions from GP practices. In relation to the delivery of dispensed items:

- two provide a free of charge delivery service on request, and one provides a service for a fee, and
- three said they restrict the service to specific patient groups (elderly and vulnerable housebound patients).

One pharmacy was of the opinion that there is a requirement for an existing additional clinical service to be provided, namely blood pressure checks.

Five pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide, and one said it didn't but could make adjustments to manage any increase in demand. Three pharmacies confirmed they have sufficient staffing capacity, and three said they could make adjustments to manage any increase in demand.

With regard to plans to develop or expand premises or service provision:

- one pharmacy stated it had recently expanded to two consultation rooms to meet demand and has the capacity to grow,
- another is awaiting a refit/extension of the pharmacy and consultation room, and
- another pharmacy has a pharmacist who is undertaking training to become an independent prescriber.

Four of the six dispensing practices responded to the dispensing doctor questionnaire and the following information is taken from those responses. They provide services over four premises.

The four dispensaries are open all day, Monday to Friday with three opening at 08.30 and one at 09.00. They all close at 18.00.

With regard to the dispensing of prescriptions for appliances all dispense prescriptions for all types of appliances.

Three provide a delivery service, one to selected areas, one to five village shops, and one to housebound patients only.

Three practices have Welsh speakers.

Three practices have sufficient capacity in their premises and staffing levels to manage the increase in demand in their area. One doesn't but would be able to adjust staffing levels.

With regard to other activities provided that are related to the dispensing service:

- one practice provides medication administration record charts to care homes,
- one provides medication administration record charts and blister packs following a needs assessment,
- one disposes of patients' sharps and provides blister packs, and
- one provides medication administration record charts, disposes of patients' sharps, has a Medpoint prescription collection point allowing 24/7 collection of dispensed medicines, and provides blister packs.

15.2.1 Clinical community pharmacy service

All the pharmacies had signed up to provide this service and in 2025/26 provided:

- 5,407 consultations for common ailments
- 222 consultations for contraception
- 1,578 emergency medicines supplies

15.2.2 Discharge medicines review

In 2025/26, five pharmacies provided this service and completed 179 reviews.

15.2.3 Pharmacist independent prescribing service

Two pharmacies were commissioned to provide this service in 2025/26 and provided a total of 2,533 consultations over the year.

15.2.4 Seasonal influenza vaccination service

All the pharmacies were commissioned to provide this service in 2025/26 and provided a total of 767 vaccinations.

15.2.5 Stoma appliance customisation

None of the pharmacies provide this service despite dispensing prescriptions for appliances.

15.2.6 Appliance use reviews

None of the pharmacies provide this service despite dispensing prescriptions for appliances.

15.2.7 Lateral flow test supply service

All the pharmacies were commissioned to provide this service in 2025/26.

15.2.8 Blood borne virus testing service

No pharmacies were commissioned to provide this service in 2025/26.

15.2.9 Covid-19 vaccination service

No pharmacies were commissioned to provide this service in 2025/26.

15.2.10 Help me quit @ pharmacy

Seven pharmacies were commissioned to provide this service in 2025/26.

15.2.11 Inhaler review service

Six pharmacies were commissioned to provide this service in 2025/26.

15.2.12 Naloxone supply service

No pharmacies were commissioned to provide this service in 2025/26.

15.2.13 National care home support service

Three pharmacies were commissioned to provide this service in 2025/26.

15.2.14 Return of patients sharps boxes

All the pharmacies were commissioned to provide this service 2025/26.

15.2.15 Smoking cessation service level 2 service

All the pharmacies were commissioned to provide this service in 2025/26.

15.2.16 Supervised administration service

Seven pharmacies were commissioned to provide this service in 2025/26.

15.2.17 Needle and syringe programmes

Two pharmacies were commissioned to provide this service in 2025/26.

15.2.18 Urgent medicines service

No pharmacies were commissioned to provide this service in 2025/26.

15.3 Current provision of pharmaceutical services outside the locality's area

Some residents choose to access contractors outside both the locality and the health board's area in order to access services:

- Offered by dispensing appliance contractors
- Which are located near to where they work, shop, or visit for leisure or other purposes.

Whilst the majority of prescriptions written by the GP practices in 2024/25 were dispensed by either the pharmacies in the locality or the dispensing practices, 5.2% were dispensed outside the locality:

- 3.8% by pharmacies in North Denbighshire,
- 0.7% by contractors in England,
- 0.2% by pharmacies in Conwy West,
- 0.1% by pharmacies in Conwy East,
- 0.2% by pharmacies in South Flintshire, and
- 0.2% in Cardiff and Vale University Health Board's area.

In the first nine months of 2025/26 5.2% were dispensed outside the locality:

- 3.8% by pharmacies in North Denbighshire,
- 0.7% by contractors in England,
- 0.2% by pharmacies in South Flintshire,
- 0.2% in Cardiff and Vale University Health Board's area,
- 0.1% by pharmacies in each of Conwy East and Conwy West, and
- 0.1% by pharmacies in Powys Teaching Health Board.

In addition, residents may have accessed one or more pharmaceutical services provided by another pharmacy outside of both the locality and the health board's area; however, it is not possible to quantify this activity from the recorded data.

15.4 Other NHS services

Details of the NHS services which affect the need for pharmaceutical services can be found in chapter six.

15.5 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 15.2 and 15.3, those living within the locality and registered with one of the GP practices generally choose to access one of the pharmacies in the locality in order to have their prescriptions dispensed or, if eligible, to be dispensed to by their practice. Those that look outside the locality usually do so either to access a neighbouring pharmacy or a dispensing appliance contractor outside of the health board's area.

In 2024/25 over 128 contractors dispensed items written by one of the GP practices in this locality, of which:

- eight were located within the locality,
- 98 were located elsewhere within the health board's area,
- 22 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

In the first nine months of 2025/26 over 113 contractors dispensed items, of which:

- eight were located within the locality,
- 88 were located elsewhere within the health board's area,
- 16 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

15.6 Gaps in provision

When considering if there are any gaps in the provision of pharmaceutical services the health board has noted that five pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide, and one said it didn't but could make adjustments to manage any increase in demand. Three pharmacies confirmed they have sufficient staffing capacity, and three said they could make adjustments to manage any increase in demand.

15.6.1 Essential services

The health board has noted:

- The pharmacies are spread across the locality and are located in areas of greater population density and higher deprivation.
- Some parts of the locality are not within a 20-minute drive time of a pharmacy however there is either no resident population or only a few scattered properties in those areas.
- The level of housing for Denbighshire as a whole and the lack of any significant proposed development of 500 or more dwellings.
- There are no pharmacies open on Sundays.

The health board has not identified any current needs in relation to the provision of essential services in the locality.

The health board has identified that should there be a loss of essential services due to the withdrawal of a pharmacy from the pharmaceutical list there will be a future need for either:

- a new pharmacy in the same town/village providing essential, the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services for 40 core opening hours per week, or
- the GP dispensing service if the town/village is in a controlled locality,

unless there is another pharmacy in that town/village and then this future need will not arise.

The health board has identified that should there be a loss of supplementary opening hours on Saturdays from 1 October 2026 which results in less than three hours of provision of pharmaceutical services within a town/village there will be a future need for the provision of essential services for three core opening hours on Saturdays in the town/village or towns/villages where the reduction in supplementary opening hours has occurred, between 09.00 and 17.00, unless there is another pharmacy in that town/village and then the future need will not arise.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and
    - the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

15.6.2 Clinical community pharmacy service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

15.6.3 Discharge medicines review

The health board has noted five of the pharmacies provided this service in 2025/26

It has not identified any current or future needs for this service within the locality.

15.6.4 Pharmacist independent prescribing service

The health board has noted:

- two pharmacies were commissioned to provide this service in 2025/26.
- One pharmacy has a pharmacist who is undertaking their independent prescriber training.
- The aspiration set out in Pharmacy: Delivering a Healthier Wales is for each pharmacy to have an independent prescriber by 2030 and has set interim targets of 50% of pharmacies to be providing this service in each locality by April 2027 and 70% by April 2029.
- From 2026 it is anticipated that all newly qualified pharmacists will also qualify as independent prescribers on completion of their undergraduate

Based on the above, the health board has not identified any current or future needs for this service within the locality.

Should the interim targets not be met there will be a future need for the provision of this service by sufficient pharmacies in the locality to meet the two targets.

15.6.5 Seasonal influenza vaccination service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

15.6.6 Stoma appliance customisation

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

It is therefore anticipated that these contractors will be customising stoma appliances as required before dispatching or delivering them to patients.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

15.6.7 Appliance use reviews

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

Individuals requiring the appliance use review service are likely to access this service from the contractor that dispenses their prescriptions for appliances or may access it from other healthcare providers such as stoma nurses.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

15.6.8 Lateral flow tests supply service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

15.6.9 Blood borne virus testing service

The health board has noted no pharmacies were commissioned to provide this service in 2025/26. However, there are other providers of the service, for example the health board's harm reduction team.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

15.6.10 Covid-19 vaccination service

The health board has noted no pharmacies were commissioned to provide this service in 2025/26. It has also noted that GP practices and the health board's vaccination team provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

15.6.11 Help me quit @ pharmacy

The health board has noted:

- Seven pharmacies were commissioned to provide this service in 2025/26.
- Demand for the service is dictated by people wishing to stop smoking.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

15.6.12 Inhaler review service

The health board has noted:

- six pharmacies were commissioned to provide this service in 2025/26.
- GP practices also provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

15.6.13 Naloxone supply service

The health board has noted:

- no pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service such as the health board's harm reduction team and the 'click and deliver' service provided by DAN24/7.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

15.6.14 National care home support service

The health board has noted:

- three pharmacies were commissioned to provide this service in 2025/26.
- The service is provided by pharmacies to the care homes that they provide services to, or where a care home has requested the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

15.6.15 Return of patients sharps boxes

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

15.6.16 Smoking cessation level 2

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26.

It has therefore not identified any current or future needs for this service within the locality.

15.6.17 Supervised administration service

The health board has noted seven pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

15.6.18 Needle and syringe programmes

The health board has noted:

- two pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service, and a postal service is being established for those who are unable to use a pharmacy.

- If a pharmacy is asked to provide the service, they can approach the health board and asked to be commissioned to provide it.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

15.6.19 Urgent medicines service

The health board has noted no pharmacies were commissioned to provide this service in 2025/26. Due to the nature of the service, it is commissioned to ensure a good geographical spread of pharmacies providing it across the health board's geography.

The health board has therefore not identified any current or future needs for this service within the locality.

15.6.20 GP dispensing service

The health board has not identified any current needs in relation to this service.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and
    - the clinical community pharmacy service, patient sharps, smoking cessation level 2, and help me quit @ pharmacy services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

16 North West Flintshire locality

16.1 Key facts[175]

- Flintshire Unitary Authority has the largest population of the six local authorities at 155,867.
- There has been a general increase in population density across North Wales between 2020 and 2023. The eastern area of the health board remains the most densely populated, with more persons per square kilometre compared to the Wales average (152.6). Flintshire is the most densely populated unitary authority area at 354.3 persons per square kilometre.
- The population of the health board aged 65 years and over is expected to increase by 2047. Residents aged 65 years and over are predicted to increase by almost 34%, with the largest percentage increased expected in Denbighshire (36%). The largest increases in terms of numbers of residents are expected in Conwy and Flintshire.
- 14.6% of households in the locality have no car or van (lowest percentage across North Wales).
- 17.6% of the locality's population is aged 66-84 years, similar to the Wales average of 17.7%, and lower than the health board's average of 19.6%.
- 2.3% of the locality's population is aged 85+ years, lower than the health board's average of 3.1% and lower than the Wales average of 2.7%.
- 17.7% of the locality's population is aged 0-15 years, higher than the average for Wales (17.1%) and higher than the health board's average of 16.7%.
- One-person households in the locality make up 29.9% of total households. 14.3% of households in the locality are occupied by one person aged over 66. This is lower than the average for Wales (14.6%) and lower than the health board's average of 15.8%.
- 18.9% of the locality's population live in the most deprived 20% of the Welsh Index of Multiple deprivation.[176]
- Life expectancy in Flintshire is 78.6 for males and 82.1 for females[177].
- Healthy life expectancy in Flintshire is 61.3 years for males and 62.0 years for females and the inequality gap for healthy life expectancy in Flintshire is 8.0 years for males and 5.5 years for females.
- 32.4% of four and five year olds in North West Flintshire have overweight or obesity.
- Healthy lifestyles and behaviour data for adults in Flintshire Unitary Authority show:

[175] Public Health Profiles - North West Collaborative profiles 2025
[176] Public Health Wales - Primary care clusters dashboard
[177] InfoBaseCymru data for an intelligent Wales - Life expectancy in males and females (2020 to 2022)

Area	Physically active for at least 60 minutes per day	Eat at least one portion of fruit or vegetable daily	Smoke tobacco at least weekly	Tried e-cigarettes at least weekly	Reporting drinking alcohol
Flintshire	17.6%	44.2%	3.6%	9.6%	39.3%
Betsi Cadwaladr University Health Board	18.3%	45.7%	3.3%	8.2%	36.8%
Wales	18.3%	46.5%	2.6%	6.9%	35.6%

- Across the health board area, the percentage of adults reporting to drink above the recommended guidelines ranges from 9.9% in Denbighshire to 20.4% in Flintshire.
- Almost 37% of 11 to 16-year-olds report drinking alcohol in North Wales compared to 35.6% across Wales. The highest reported levels of alcohol drinking across the region are in Flintshire (39.3%) and Gwynedd (38.2%).
- The Annual Population Survey in Wales records Welsh language ability and frequency. In 2025, almost 39% of residents in the health board reported being able to speak Welsh. In Flintshire, 15.5% of the population reported being able to speak Welsh. This is the lowest percentage across North Wales.
- Numbers of patients with chronic conditions as reported on the Digital Health and Care Wales disease registers, April 2025, are shown below.

Disease register	North West Flintshire	Betsi Cadwaladr University Health Board	Wales
Asthma	7.4%	7.6%	7.1%
Atrial fibrillation	2.5%	2.8%	2.7%
Cancer	3.7%	4.3%	3.7%
Chronic obstructive pulmonary disease	2.8%	2.7%	2.3%
Diabetes	8.5%	8.3%	8.4%
Epilepsy	0.9%	0.9%	1.0%
Heart failure	1.4%	1.4%	1.4%
Hypertension	18.9%	17.9%	16.3%
Stroke transient ischaemic attack	2.0%	2.3%	2.2%
Secondary prevention of coronary heart disease	3.6%	3.6%	3.4%

- In the health board just over half of 50 to 64 year olds with a clinical risk received their influenza vaccination; this is above the average for Wales. Across the region, uptake ranged from 46.5% in Denbighshire to 53.1% in Flintshire.

- Estimates of the number of people with dementia in North Wales show an increase of 14.1% between 2013 and 2023. The highest increase has been in Flintshire at 24.5%.

The Flintshire Local Development Plan[178] identifies two key strategic sites which will deliver 1,625 housing units, 23% of the plan's total. Both are within North East Flintshire.

There are 11 non-strategic employment sites within the local development plan which across Flintshire are expected to deliver:

- 2026/27 – 465
- 2027/28 – 404
- 2028/29 – 205
- 2029/2030 – 173
- 2030 and beyond – 20

This equates to 3,168 people in total across the sites.

16.2 Current provision of pharmaceutical services within the locality's area

There are seven pharmacies in the locality operated by five different contractors. Of the seven GP practices, three dispense from a total of three premises. The level of dispensing ranges from 27.3% to 44.3% of the practices' registered populations.

The map below shows the location of the pharmacies and dispensing practice premises. It should be noted that where premises are close to each other the symbols will overlap.

[178] Flintshire County Council, Flintshire Local Development Plan 2015 to 2030

Map 16.1 – location of pharmacies and dispensing doctor premises



© OpenStreetMap © CARTO Dispensing doctor premises Pharmacy

In 2024/25, 74.9% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practices dispensed or personally administered 20.6% of the prescribed items. Whilst the data available doesn't show the percentage split between dispensed and personally administered items, based on the level of personal administration elsewhere in Wales it can be assumed that less than 2% of items were personally administered.

In the first nine months of 2025/26 75.8% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practices dispensed or personally administered 20.2% of the prescribed items.

The map in chapter 5 indicates that all the locality is within a 20-minute drive of a pharmacy, with most residents within ten minutes of a pharmacy. With regard to when the pharmacies are open:

- One opens Monday to Friday,
- four open Monday to Friday, and part of Saturday, and
- two open Monday to Saturday.

With regard to the times at which these pharmacies are open between Monday and Friday:

- All open at 09.00,
- Three close at 17.30 and the remainder at 18.00.

Four pharmacies close for lunch at varying times between 13.00 and 14.00. The remaining pharmacies open all day.

On Saturday, five pharmacies open at 09.00, and one opens at 09.30. Of the two pharmacies that open all day, one closes for lunch. They close between 16.30 and 17.30. All six pharmacies have core opening hours on Saturday.

None of the pharmacies open on Sundays.

The health board asks the pharmacies whether they will be open on public and bank holidays and Easter Sunday. The responses are collated, and the health board establishes whether or not there are any geographic gaps in provision. Where a gap exists, a pharmacy is either commissioned or directed to open.

Four pharmacies responded to the pharmacy contractor questionnaire and the following information is taken from those responses.

All the pharmacies are accessible by wheelchair, and also have a consultation area that is accessible by wheelchair. All four consultation areas are:

- closed rooms,
- a designated area where the patient and pharmacist can sit down together and talk at normal volumes without being overheard, and
- clearly designated as an area for confidential consultations distinct from the general public areas of the pharmacy.

One pharmacy confirmed that it has Welsh speakers. Another pharmacy confirmed that staff speak Polish.

All four pharmacies dispense prescriptions for all types of appliances.

All four pharmacies collect prescriptions from GP practices. In relation to the delivery of dispensed items:

- one provides a free of charge delivery service on, and
- three restrict the service to specific patient groups (elderly and vulnerable housebound patients).

No pharmacies were of the opinion that there is a requirement for either an existing additional clinical service or new service that is not currently provided or available.

Three pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments to manage any increase in demand. Three pharmacies didn't have sufficient staffing capacity but could make adjustments.

One pharmacy plans to increase the number of independent prescriber consultations undertaken, and another plans to start to start to provide the pharmacist independent prescriber service in 2026.

There were no responses to the dispensing doctor questionnaire.

16.2.1 Clinical community pharmacy service

All the pharmacies had signed up to provide this service and in 2025/26 they provided:

- 3,436 consultations for common ailments
- 190 consultations for contraception
- 470 emergency medicines supplies

16.2.2 Discharge medicines review

In 2025/26 five pharmacies provided this service and completed 50 reviews.

16.2.3 Pharmacist independent prescribing service

Two pharmacies were commissioned to provide this service in 2025/26 and provided a total of 1,024 consultations over the year.

16.2.4 Seasonal influenza vaccination service

All the pharmacies were commissioned to provide this service in 2025/26 and provided a total of 1,056 vaccinations.

16.2.5 Stoma appliance customisation

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

16.2.6 Appliance use reviews

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

16.2.7 Lateral flow test supply service

Six pharmacies were commissioned to provide this service in 2025/26.

16.2.8 Blood borne virus testing service

No pharmacies were commissioned to provide this service in 2025/26.

16.2.9 Covid-19 vaccination service

No pharmacies were commissioned to provide this service in 2025/26.

16.2.10 Help me quit @ pharmacy

Three of the pharmacies were commissioned to provide this service in 2025/26.

16.2.11 Inhaler review service

Four pharmacies were commissioned to provide this service in 2025/26.

16.2.12 Naloxone supply service

No pharmacies were commissioned to provide this service in 2025/26.

16.2.13 National care home support service

Two pharmacies were commissioned to provide this service in 2025/26.

16.2.14 Return of patients sharps boxes

All the pharmacies were commissioned to provide this service in 2025/26.

16.2.15 Smoking cessation service level 2 service

All the pharmacies were commissioned to provide this service in 2025/26.

16.2.16 Supervised administration service

Six pharmacies were commissioned to provide this service in 2025/26.

16.2.17 Needle and syringe programmes

Four pharmacies were commissioned to provide this service in 2025/26

16.2.18 Urgent medicines service

No pharmacies were commissioned to provide this service in 2025/26.

16.3 Current provision of pharmaceutical services outside the locality's area

Some residents choose to access contractors outside both the locality and the health board's area in order to access services:

- Offered by dispensing appliance contractors
- Which are located near to where they work, shop, or visit for leisure or other purposes.

Whilst the majority of prescriptions written by the GP practices in 2024/25 were dispensed by either the pharmacies in the locality or the dispensing practices, 4.2% were dispensed outside the locality:

- 1.5% by contractors in England,
- 0.8% by pharmacies in North East Flintshire,
- 0.6% by pharmacies in Central and South Denbighshire,
- 0.4% by pharmacies in North Denbighshire,
- 0.4% by pharmacies in South Flintshire, and
- 0.2% in Cardiff and Vale University Health Board's area.

In the first nine months of 2025/26, the majority of prescriptions were dispensed by either the pharmacies in the locality or the dispensing practices. 4.0% were dispensed outside the locality:

- 1.5% by contractors in England,
- 0.6% in Central and South Denbighshire,
- 0.6% in North East Flintshire,
- 0.4% in North Denbighshire,
- 0.3% in South Flintshire,
- 0.2% in Cardiff and Vale University Health Board's area.

In addition, residents may have accessed one or more pharmaceutical services provided by another pharmacy outside of both the locality and the health board's area; however, it is not possible to quantify this activity from the recorded data.

16.4 Other NHS services

Details of the NHS services which affect the need for pharmaceutical services can be found in chapter six.

16.5 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 16.2 and 16.3, those living within the locality and registered with one of the GP practices generally choose to access one of the pharmacies in the locality in order to have their prescriptions dispensed or, if eligible, to be dispensed to by their practice. Those that look outside the locality usually do so either to access a neighbouring pharmacy or a dispensing appliance contractor outside of the health board's area.

In 2024/25 over 152 contractors dispensed items written by one of the GP practices in this locality, of which:

- seven were located within the locality,
- 126 were located elsewhere within the health board's area,
- 19 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

In the first nine months of 2025/26, over 140 dispensed items written by one of the GP practices.

- Seven were located within the locality,
- 122 were located elsewhere within the health board's area,
- 11 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

16.6 Gaps in provision

When considering if there are any gaps in the provision of pharmaceutical services the health board has noted that three pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide, and one said it doesn't but could make adjustments to manage any increase in demand. Three pharmacies didn't have sufficient staffing capacity but could make adjustments.

16.6.1 Essential services

The health board has noted:

- The pharmacies are spread are generally located in areas of greater population density and higher deprivation.
- The entire locality is within a 20-minute drive time of a pharmacy, with many residents within a ten-minute drive of a pharmacy.
- The known housing developments.
- No pharmacies open on Sundays.

The health board has not identified any current needs for these services within the locality.

The health board has identified that should there be a loss of essential services due to the withdrawal of a pharmacy from the pharmaceutical list there will be a future need for either:

- a new pharmacy in the same town/village providing essential services, the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services for 40 core opening hours per week, or
- the GP dispensing service if the town/village is in a controlled locality,

unless there is another pharmacy in that town/village and then this future need will not arise.

The health board has identified that should there be a loss of supplementary opening hours on Saturdays from 1 October 2026 which results in less than three hours of provision of pharmaceutical services within a town/village there will be a future need for the provision of essential services for three core opening hours on Saturdays in the town/village or towns/villages where the reduction in supplementary opening hours has occurred, between 09.00 and 17.00, unless there is another pharmacy in that town/village and then the future need will not arise.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and
    - the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

16.6.2 Clinical community pharmacy service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

16.6.3 Discharge medicines review

The health board has noted five of the pharmacies provided this service in 2025/26. It has not identified any current or future needs for this service within the locality.

16.6.4 Pharmacist independent prescribing service

The health board has noted:

- two pharmacies were commissioned to provide this service in 2025/26.
- One pharmacy intends to start providing the service in 2026.
- The aspiration set out in Pharmacy: Delivering a Healthier Wales is for each pharmacy to have an independent prescriber by 2030 and has set interim targets of 50% of pharmacies to be providing this service in each locality by April 2027 and 70% by April 2029.
- From 2026 it is anticipated that all newly qualified pharmacists will also qualify as independent prescribers on completion of their undergraduate

Based on the above, the health board has not identified any current needs for this service within the locality.

Should the interim targets not be met there will be a future need for the provision of this service by sufficient pharmacies in the locality to meet the two targets.

16.6.5 Seasonal influenza vaccination

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

16.6.6 Stoma appliance customisation

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

It is therefore anticipated that these contractors will be customising stoma appliances as required before dispatching or delivering them to patients.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

16.6.7 Appliance use reviews

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

Individuals requiring the appliance use review service are likely to access this service from the contractor that dispenses their prescriptions for appliances or may access it from other healthcare providers such as stoma nurses.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

16.6.8 Lateral flow tests supply service

The health board has noted six pharmacies were commissioned to provide this service in 2025/26. It has also noted that this service is only available to specified patient groups. If one of the pharmacies that doesn't provide the service identified a need for it, the health board would commission the service from that pharmacy. As a result, the health board has not identified any current or future needs for this service within the locality.

16.6.9 Blood borne virus testing service

The health board has noted no pharmacies were commissioned to provide this service in 2025/26. However, there are other providers of the service, for example the health board's harm reduction team.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

16.6.10 Covid-19 vaccination service

The health board has noted no pharmacies were commissioned to provide this service in 2025/26. It has also noted that GP practices and the health board's vaccination team provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

16.6.11 Help me quit @ pharmacy

The health board has noted:

- Three pharmacies were commissioned to provide this service in 2025/26.
- Demand for the service is dictated by people wishing to stop smoking.
- There are other providers of the service for example Help me quit for baby, Help me quit in hospital, and the general Help me quit service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

16.6.12 Inhaler review service

The health board has noted:

- three pharmacies were commissioned to provide this service in 2025/26.
- GP practices also provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

16.6.13 Naloxone supply service

The health board has noted:

- no pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service such as the health board's harm reduction team and the 'click and deliver' service provided by DAN24/7.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

16.6.14 National care home support service

The health board has noted:

- two pharmacies were commissioned to provide this service in 2025/26.

- The service is provided by pharmacies to the care homes that they provide services to, or where a care home has requested the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

16.6.15 Return of patients sharps boxes

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

16.6.16 Smoking cessation level 2

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

16.6.17 Supervised administration service

The health board has noted six pharmacies were commissioned to provide this service in 2025/26. It has not identified any current or future needs for this service within the locality.

16.6.18 Needle and syringe programmes

The health board has noted:

- four pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service, and a postal service is being established for those who are unable to use a pharmacy.
- If a pharmacy is asked to provide the service, they can approach the health board and asked to be commissioned to provide it.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

16.6.19 Urgent medicines service

The health board has noted no pharmacies were commissioned to provide this service in 2025/26. Due to the nature of the service, it is commissioned to ensure a good geographical spread of pharmacies providing it across the health board's geography.

The health board has therefore not identified any current or future needs for this service within the locality.

16.6.20 GP dispensing service

The health board has not identified any current needs in relation to this service.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and
    - the clinical community pharmacy service, patient sharps, smoking cessation level 2, and help me quit @ pharmacy services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

17 North East Flintshire locality

17.1 Key facts[179]

- Flintshire Unitary Authority has the largest population of the six unitary authorities at 155,867.
- There has been a general increase in population density across North Wales between 2020 and 2023. The eastern area of the health board remains the most densely populated, with more persons per square kilometre compared to the Wales average (152.6). Flintshire is the most densely populated unitary authority area at 354.3 persons per square kilometre.
- The population of the health board aged 65 years and over is expected to increase by 2047. Residents aged 65 years and over are predicted to increase by almost 34%, with the largest percentage increased expected in Denbighshire (36%). The largest increases in terms of numbers of residents are expected in Conwy and Flintshire.
- 15.9% of households in the locality have no car or van.
- 16.1% of the locality's population is aged 66-84 years, lower than the Wales average of 17.7%, and lower than the health board's average of 19.6%.
- 2.4% of the locality's population is aged 85+ years, lower than the health board's average of 3.1% and lower than the Wales average of 2.7%.
- 17.9% of the locality's population is aged 0-15 years, higher than the average for Wales (17.1%) and higher than the health board's average of 16.7%.
- One-person households in the locality make up 28.4% of total households; 13.4% of households are occupied by one person aged over 66. This is lower than the average for Wales (14.6%) and lower than the health board's average of 15.8%.
- 13.5% of the locality's population live in the most deprived 20% of the Welsh Index of Multiple deprivation.[180]
- Life expectancy in Flintshire is 78.6 for males and 82.1 for females[181].
- Healthy life expectancy in Flintshire is 61.3 years for males and 62.0 years for females and the inequality gap for healthy life expectancy in Flintshire is 8.0 years for males and 5.5 years for females.
- 30.3% of four and five year olds in North East Flintshire locality have overweight or obesity.
- Healthy lifestyles and behaviour data for adults in Flintshire Unitary Authority show:

[179] Public Health Profiles - North West Collaborative profiles 2025
[180] Public Health Wales - Primary care clusters dashboard
[181] InfoBaseCymru data for an intelligent Wales - Life expectancy in males and females (2020 to 2022)

Area	Physically active for at least 60 minutes per day	Eat at least one portion of fruit or vegetable daily	Smoke tobacco at least weekly	Tried e-cigarettes at least weekly	Reporting drinking alcohol
Flintshire	17.6%	44.2%	3.6%	9.6%	39.3%
Betsi Cadwaladr University Health Board	18.3%	45.7%	3.3%	8.2%	36.8%
Wales	18.3%	46.5%	2.6%	6.9%	35.6%

- Across the health board's area, the percentage of adults reporting to drink above the recommended guidelines ranges from 9.9% in Denbighshire to 20.4% in Flintshire.
- Almost 37% of 11 to 16-year-olds report drinking alcohol in North Wales compared to 35.6% across Wales. The highest reported levels of alcohol drinking across the region are in Flintshire (39.3%) and Gwynedd (38.2%).
- The Annual Population Survey in Wales records Welsh language ability and frequency. In 2025, almost 39% of residents in the health board reported being able to speak Welsh. In Flintshire, 15.5% of the population reported being able to speak Welsh. This is the lowest percentage across North Wales.
- Numbers of patients with chronic conditions as reported on the Digital Health and Care Wales disease registers, April 2025, are shown below.

Disease register	North East Flintshire	Betsi Cadwaladr University Health Board	Wales
Asthma	7.3%	7.6%	7.1%
Atrial fibrillation	2.5%	2.8%	2.7%
Cancer	3.7%	4.3%	3.7%
Chronic obstructive pulmonary disease	2.2%	2.7%	2.3%
Diabetes	7.9%	8.3%	8.4%
Epilepsy	0.9%	0.9%	1.0%
Heart failure	1.3%	1.4%	1.4%
Hypertension	17.0%	17.9%	16.3%
Stroke transient ischaemic attack	1.9%	2.3%	2.2%
Secondary prevention of coronary heart disease	3.5%	3.6%	3.4%

- In the health board, just over half of 50 to 64 year olds with a clinical risk received their influenza vaccination; this is above the average for Wales. Across the region, uptake ranged from 46.5% in Denbighshire to 53.1% in Flintshire.

- Estimates of the number of people with dementia in North Wales show an increase of 14.1% between 2013 and 2023. The highest increase has been in Flintshire at 24.5%.

The Flintshire Local Development Plan[182] identifies two key strategic sites which will deliver 1,625 housing units, 23% of the plan's total. Both are within North East Flintshire – the Northern Gateway mixed use development site (1,325 units) and the Warren Hall mixed use development site (300 units).

Five developers are on site at the Northern Gateway. Completions are behind the plan's trajectory but are projected to remain over the next three years due to the significant activity currently taking place across the site. Completion projections are as follows.

- 2026/27 – 240
- 2027/28 – 186
- 2028/29 – 102
- 2029/2030 – 71
- 2030 and beyond – 60[183].

Based on 2.4 people per dwelling, this equates to a total of 1,584.

Welsh Government will be undertaking an initial phase of feasibility, surveys and design work relating to land at Warren Hall - studies which are required to support any future planning applications (January 2026).

There are 11 non-strategic employment sites within the local development plan which across Flintshire are expected to deliver:

- 2026/27 – 465
- 2027/28 – 404
- 2028/29 – 205
- 2029/2030 – 173
- 2030 and beyond – 20

This equates to 3,168 people in total across the sites.

17.2 Current provision of pharmaceutical services within the locality's area

There are 12 pharmacies in the locality operated by eight different contractors. None of the seven practices provide a dispensing service.

The map below shows the location of the pharmacies. It should be noted that where premises are close to each other the symbols will overlap.

[182] Flintshire County Council, Flintshire Local Development Plan 2015 to 2030
[183] Flintshire County Council – Annual monitoring report (AMR) 2 01/04/2024 – 31/03/25

Map 17.1 – location of pharmacies



© OpenStreetMap © CARTO

In 2024/25, 80.5% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality.

In the first nine months of 2025/26 81.7% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality.

The map in chapter 5 indicates that all the locality is within a 20-minute drive of a pharmacy, with most residents able to access a pharmacy within ten minutes.
With regard to when the pharmacies are open:

- Four open Monday to Friday,
- Five open Monday to Friday, and part of Saturday, and
- Three open Monday to Sunday in Bretton, Connah's Quay and Saltney.

With regard to the times at which these pharmacies are open between Monday and Friday:

- Four open at 08.30 and the remainder open at 09.00,
- Closing times vary between 17.30 and 18.30 with one closing at 19.00, another at 20.00 and a third at 21.00.

Eight pharmacies close for lunch at varying times between 12.00 and 14.00. The remaining pharmacies open all day.

On Saturday, all the pharmacies open at 09.00. Of the three pharmacies that open all day, one closes for lunch between 13.00 and 14.00. They close between 17.00 and 19.00. Eight pharmacies have core opening hours on Saturday.

The three pharmacies that open on Sunday cover the hours 10.00 to 17.00. One has core opening hours between 10.00 and 16.00.

The health board asks the pharmacies whether they will be open on public and bank holidays and Easter Sunday. The responses are collated, and the health board establishes whether or not there are any geographic gaps in provision. Where a gap exists, a pharmacy is either commissioned or directed to open.

Six pharmacies responded to the pharmacy contractor questionnaire and the following information is taken from those responses.

All six pharmacies are accessible by wheelchair and five have a consultation area that is accessible by wheelchair. The sixth pharmacy has a consultation area that is not wheelchair accessible but is installing a second one that will be. All six consultation areas are:

- closed rooms,
- a designated area where the patient and pharmacist can sit down together and talk at normal volumes without being overheard, and
- clearly designated as an area for confidential consultations distinct from the general public areas of the pharmacy.

Three pharmacies confirmed they have Welsh speakers. With regard to other languages that are spoken by staff:

- one pharmacy has staff that speak Hundi and Punjabi,
- another has staff that speak French and Italian, and
- a third has staff that speak Portuguese.

All six pharmacies dispense prescriptions for all types of appliances.

Four pharmacies collect prescriptions from GP practices. In relation to the delivery of dispensed items:

- four provide a free of charge delivery service on request,
- one pharmacy restricts the service to specific areas, and
- three said they restrict the service to specific patient groups (housebound patients with additional needs, housebound patients or those who are temporarily unable to travel to the pharmacy, and two deliver to elderly and vulnerable housebound patients).

There was one suggestion for a new service that is not currently provided in the area, namely the inclusion of more appropriately remunerated prescribing services.

No pharmacies were of the opinion that there is a requirement for a new additional clinical service which is not currently available.

Five pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide, and one said it didn't but could make adjustments. Three pharmacies said they had sufficient staffing levels, and two said they could make adjustments. One pharmacy did not respond to this question.

No pharmacies have plans to develop or expand their service provision.

17.2.1 Clinical community pharmacy service

All the pharmacies had signed up to provide this service and in 2025/26 provided:

- 7,955 consultations for common ailments
- 811 consultations for contraception
- 2,233 emergency medicines supplies

17.2.2 Discharge medicines review

In 2025/26, seven pharmacies provided this service and completed 138 reviews.

17.2.3 Pharmacist independent prescribing service

Six pharmacies were commissioned to provide this service in 2025/26 and provided a total of 4,624 consultations over the year.

17.2.4 Seasonal influenza vaccination service

Ten pharmacies were commissioned to provide this service in 2025/26 and provided a total of 1,880 vaccinations.

17.2.5 Stoma appliance customisation

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

17.2.6 Appliance use reviews

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

17.2.7 Lateral flow test supply service

11 pharmacies were commissioned to provide this service in 2025/26.

17.2.8 Blood borne virus testing service

No pharmacies were commissioned to provide this service in 2025/26.

17.2.9 Covid-19 vaccination service

No pharmacies were commissioned to provide this service in 2025/26.

17.2.10 Help me quit @ pharmacy

Nine pharmacies were commissioned to provide this service in 2025/26.

17.2.11 Inhaler review service

Seven pharmacies were commissioned to provide this service in 2025/26.

17.2.12 Naloxone supply service

One pharmacy was commissioned to provide this service in 2025/26.

17.2.13 National care home support service

Three pharmacies were commissioned to provide this service in 2025/26.

17.2.14 Return of patients sharps boxes

11 pharmacies were commissioned to provide this service in 2025/26.

17.2.15 Smoking cessation service level 2 service

Ten pharmacies were commissioned to provide this service in 2025/26.

17.2.16 Supervised administration service

11 pharmacies were commissioned to provide this service in 2025/26.

17.2.17 Needle and syringe programmes

Three pharmacies were commissioned to provide this service in 2025/26.

17.2.18 Urgent medicines service

No pharmacies were commissioned to provide this service in 2025/26.

17.3 Current provision of pharmaceutical services outside the locality's area

Some residents choose to access contractors outside both the locality and the health board's area in order to access services:

- Offered by dispensing appliance contractors
- Which are located near to where they work, shop, or visit for leisure or other purposes.

Whilst the majority of prescriptions written by the GP practices in 2024/25 were dispensed by the pharmacies in the locality, 17.9% were dispensed outside the locality:

- 16.1% by pharmacies in South Flintshire,
- 1.1% by contractors in England
- 0.4% in North West Wrexham,
- 0.1% in North West Flintshire, and
- 0.1% in Cardiff and Vale University Health Board's area.

In the first nine months of 2025/26, the majority of prescriptions were dispensed by the pharmacies in the locality. 17.7% were dispensed outside the locality:

- 16.5% in South Flintshire,
- 1.0% by contractors in England, and
- 0.1% in Cardiff and Vale University Health Board's area.

In addition, residents may have accessed one or more pharmaceutical services provided by another pharmacy outside of both the locality and the health board's area; however, it is not possible to quantify this activity from the recorded data.

17.4 Other NHS services

Details of the NHS services which affect the need for pharmaceutical services can be found in chapter six.

17.5 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 17.2 and 17.3, those living within the locality and registered with one of the GP practices generally choose to access one of the pharmacies in the locality in order to have their prescriptions dispensed or, if eligible, to be dispensed to by their practice. Those that look outside the locality usually do so either to access a neighbouring pharmacy or a dispensing appliance contractor outside of the health board's area.

In 2024/25 over 113 contractors dispensed items written by one of the GP practices in this locality, of which:

- 12 were located within the locality,
- 85 were located elsewhere within the health board's area,
- 16 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

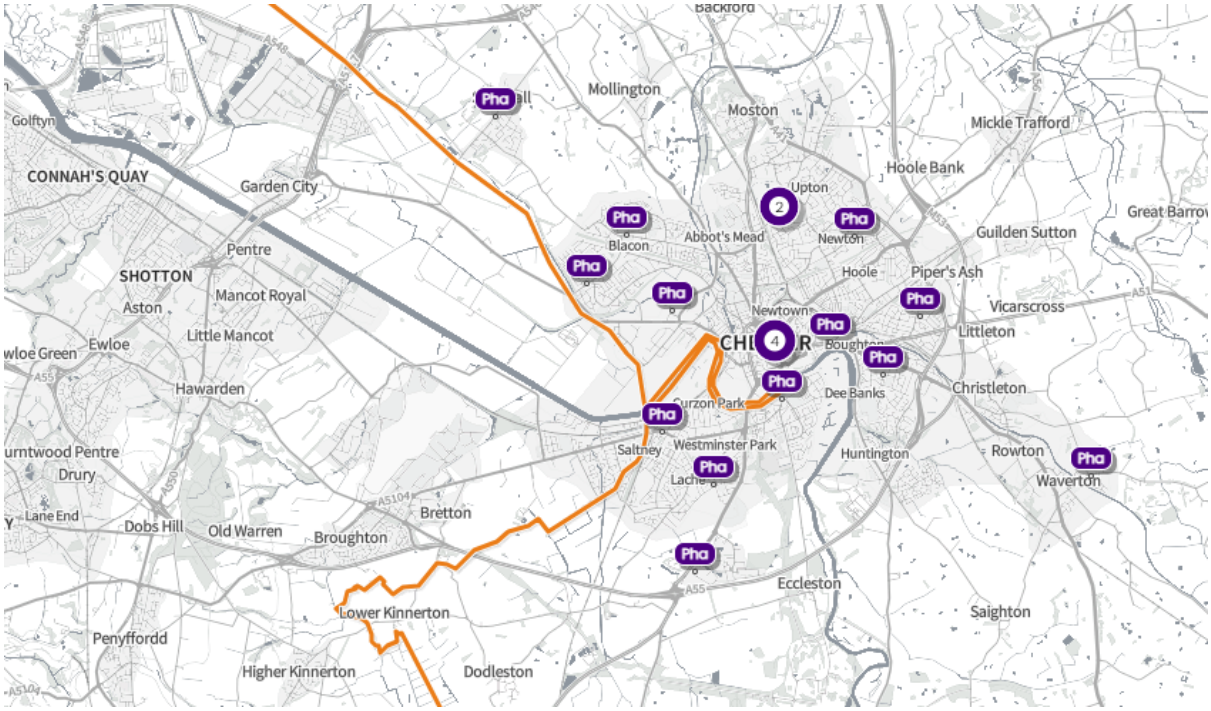
In the first nine months of 2025/26 over 105 contractors dispensed items written by one of the GP practices, of which:

- 12 were located within the locality,
- 73 were located elsewhere within the health board's area,
- 20 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

17.6 Gaps in provision

Whilst not providers of either pharmaceutical services or other NHS services as defined in the regulations, the health board has taken account of the pharmacies over the border within England. The map below shows the locations of pharmacies just over the border.

Map 17.2 – locations of pharmacies in England



© Copyright Parallel 2026 | Ordnance Survey | Mapbox | OpenStreetMap contributor

When considering if there are any gaps in the provision of pharmaceutical services the health board has noted that five pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide, and one said it didn't but could make adjustments. Three pharmacies said they had sufficient staffing levels, and two said they could make adjustments. One pharmacy did not respond to this question

17.6.1 Essential services

The health board has noted:

- The pharmacies are spread across the locality and are generally located in areas of greater population density and higher deprivation.
- All of the locality is within a 20-minute drive time of a pharmacy in either Wales or England, with many residents within ten minutes of a pharmacy.
- There are two known housing developments due within the lifetime of this document which will deliver up to 1,625 new houses – the Northern Gateway mixed use development site (1,325 units) and the Warren Hall mixed use development site (300 units).
- The opening hours of the pharmacies.

The health board has not identified any current needs for these services within the locality.

The health board has identified that should there be a loss of essential services due to the withdrawal of a pharmacy from the pharmaceutical list there will be a future need for either:

- a new pharmacy in the same town/village providing essential services the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services for 40 core opening hours per week, or
- the GP dispensing service if the town/village is in a controlled locality,

unless there is another pharmacy in that town/village and then this future need will not arise.

The health board has identified that should there be a loss of supplementary opening hours on Saturdays from 1 October 2026 which results in less than three hours of provision of pharmaceutical services within a town/village there will be a future need for the provision of essential services for three core opening hours on Saturdays in the town/village or towns/villages where the reduction in supplementary opening hours has occurred, between 09.00 and 17.00, unless there is another pharmacy in that town/village and then the future need will not arise.

17.6.2 Clinical community pharmacy service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

17.6.3 Discharge medicines review

The health board has noted seven pharmacies provided this service in 2025/26. It has not identified any current or future needs for this service within the locality.

17.6.4 Pharmacist independent prescribing service

The health board has noted:

- six pharmacies were commissioned to provide this service in 2025/26.
- The aspiration set out in Pharmacy: Delivering a Healthier Wales is for each pharmacy to have an independent prescriber by 2030 and has set interim targets of 50% of pharmacies to be providing this service in each locality by April 2027 and 70% by April 2029.
- From 2026 it is anticipated that all newly qualified pharmacists will also qualify as independent prescribers on completion of their undergraduate

Based on the above, the health board has not identified any current needs for this service within the locality.

Should the interim targets not be met there will be a future need for the provision of this service by sufficient pharmacies in the locality to meet the two targets.

17.6.5 Seasonal influenza vaccination

The health board has noted:

- 11 pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service, for example the GP practices.

It has therefore not identified any current or future needs for this service within the locality.

17.6.6 Stoma appliance customisation

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

It is therefore anticipated that these contractors will be customising stoma appliances as required before dispatching or delivering them to patients.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

17.6.7 Appliance use reviews

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

Individuals requiring the appliance use review service are likely to access this service from the contractor that dispenses their prescriptions for appliances or may access it from other healthcare providers such as stoma nurses.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

17.6.8 Lateral flow tests supply service

The health board has noted 11 pharmacies were commissioned to provide this service in 2025/26. It has also noted that this service is only available to specified patient groups. If one of the pharmacies that doesn't provide the service identified a need for it, the health board would commission the service from that pharmacy. As a result, the health board has not identified any current or future needs for this service within the locality.

17.6.9 Blood borne virus testing service

The health board has noted no pharmacies were commissioned to provide this service in 2025/26. However, there are other providers of the service, for example the health board's harm reduction team.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

17.6.10 Covid-19 vaccination service

The health board has noted no pharmacies were commissioned to provide this service in 2025/26. It has also noted that GP practices and the health board's vaccination team provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

17.6.11 Help me quit @ pharmacy

The health board has noted:

- Nine pharmacies were commissioned to provide this service in 2025/26.
- Demand for the service is dictated by people wishing to stop smoking.
- There are other providers of the service for example Help me quit for baby, Help me quit in hospital, and the general Help me quit service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

17.6.12 Inhaler review service

The health board has noted:

- seven pharmacies were commissioned to provide this service in 2025/26.
- GP practices also provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

17.6.13 Naloxone supply service

The health board has noted:

- one pharmacy was commissioned to provide this service in 2025/26.
- There are other providers of the service such as the health board's harm reduction team and the 'click and deliver' service provided by DAN24/7.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

17.6.14 National care home support service

The health board has noted:

- three pharmacies were commissioned to provide this service in 2025/26.
- The service is provided by pharmacies to the care homes that they provide services to, or where a care home has requested the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

17.6.15 Return of patients sharps boxes

The health board has noted 11 pharmacies were commissioned to provide this service in 2025/26. It has not identified any current or future needs for this service within the locality.

17.6.16 Smoking cessation level 2

The health board has noted:

- ten pharmacies were commissioned to provide this service in 2025/26.
- Demand for the service is dictated by people wishing to stop smoking.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

17.6.17 Supervised administration service

The health board has noted 11 pharmacies were commissioned to provide this service in 2025/26. It has not identified any current or future needs for this service within the locality.

17.6.18 Needle and syringe programmes

The health board has noted:

- Three pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service, and a postal service is being established for those who are unable to use a pharmacy.

- If a pharmacy is asked to provide the service, they can approach the health board and asked to be commissioned to provide it.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

17.6.19 Urgent medicines service

The health board has noted none of the pharmacies were commissioned to provide this service in 2025/26. Due to the nature of the service, it is commissioned to ensure a good geographical spread of pharmacies providing it across the health board's geography.

The health board has therefore not identified any current or future needs for this service within the locality.

18 South Flintshire locality

18.1 Key facts[184]

- Flintshire Unitary Authority has the largest population of the six unitary authorities at 155,867.
- There has been a general increase in population density across North Wales between 2020 and 2023. The eastern area of the health board remains the most densely populated, with more persons per square kilometre compared to the Wales average (152.6). Flintshire is the most densely populated unitary authority area at 354.3 persons per square kilometre.
- The population of the health board aged 65 years and over is expected to increase by 2047. Residents aged 65 years and over are predicted to increase by almost 34%, with the largest percentage increased expected in Denbighshire (36%). The largest increases in terms of numbers of residents are expected in Conwy and Flintshire.
- 14.6% of households in the locality have no car or van (lowest percentage across North Wales).
- 19.9% of the locality's population is aged 66-84 years, higher than the Wales average of 17.7%, and similar to the health board's average of 19.6%.
- 3.1% of the locality's population is aged 85+ years, the same as the health board's average of 3.1% and higher than the Wales average of 2.7%.
- 16.6% of the locality's population is aged 0-15 years, higher than the average for Wales (17.1%) and higher than the health board's average of 16.7%.
- One-person households in the locality make up 28.9% of total households; 15% of households are occupied by one person aged over 66. This is higher than the average for Wales (14.6%) but lower than the health board's average of 15.8%.
- 2.8% of the locality's population live in the most deprived 20% of the Welsh Index of Multiple deprivation.[185] This is the lowest in the three clusters in Flintshire, and the third lowest across the clusters in North Wales.
- Life expectancy in Flintshire Unitary Authority is 78.6 for males and 82.1 for females[186].
- Healthy life expectancy in Flintshire Unitary Authority is 61.3 years for males and 62.0 years for females and the inequality gap for healthy life expectancy in Flintshire is 8.0 years for males and 5.5 years for females.
- 23.1% of four and five year olds in the South Flintshire locality have overweight or obesity.
- Healthy lifestyles and behaviour data for adults in Flintshire Unitary Authority show:

[184] Public Health Profiles - North West Collaborative profiles 2025
[185] Public Health Wales - Primary care clusters dashboard
[186] InfoBaseCymru data for an intelligent Wales - Life expectancy in males and females (2020 to 2022)

Area	Physically active for at least 60 minutes per day	Eat at least one portion of fruit or vegetable daily	Smoke tobacco at least weekly	Tried e-cigarettes at least weekly	Reporting drinking alcohol
Flintshire	17.6%	44.2%	3.6%	9.6%	39.3%
Betsi Cadwaladr University Health Board	18.3%	45.7%	3.3%	8.2%	36.8%
Wales	18.3%	46.5%	2.6%	6.9%	35.6%

- Across the health board area, the percentage of adults reporting to drink above the recommended guidelines ranges from 9.9% in Denbighshire to 20.4% in Flintshire.
- Almost 37% of 11 to 16-year-olds report drinking alcohol in North Wales compared to 35.6% across Wales. The highest reported levels of alcohol drinking across the region are in Flintshire (39.3%) and Gwynedd (38.2%).
- The Annual Population Survey in Wales records Welsh language ability and frequency. In 2025, almost 39% of residents in the health board reported being able to speak Welsh. In Flintshire, 15.5% of the population reported being able to speak Welsh. This is the lowest percentage across North Wales.
- Numbers of patients with chronic conditions as reported on the Digital Health and Care Wales disease registers, April 2025, are shown below.

Disease register	South Flintshire	Betsi Cadwaladr University Health Board	Wales
Asthma	7.4%	7.6%	7.1%
Atrial fibrillation	2.8%	2.8%	2.7%
Cancer	4.5%	4.3%	3.7%
Chronic obstructive pulmonary disease	2.1%	2.7%	2.3%
Diabetes	7.5%	8.3%	8.4%
Epilepsy	0.9%	0.9%	1.0%
Heart failure	1.3%	1.4%	1.4%
Hypertension	17.1%	17.9%	16.3%
Stroke transient ischaemic attack	2.4%	2.3%	2.2%
Secondary prevention of coronary heart disease	3.5%	3.6%	3.4%

- In the health board just over half of 50 to 64 year olds with a clinical risk received their influenza vaccination; this is above the average for Wales. Across the region, uptake ranged from 46.5% in Denbighshire to 53.1% in Flintshire.

- Estimates of the number of people with dementia in North Wales show an increase of 14.1% between 2013 and 2023. The highest increase has been in Flintshire at 24.5%.

The Flintshire Local Development Plan identifies two key strategic sites which will deliver 1,625 housing units, 23% of the plan's total. Both are within North East Flintshire.

There are 11 non-strategic employment sites within the local development plan which across Flintshire are expected to deliver:

- 2026/27 – 465
- 2027/28 – 404
- 2028/29 – 205
- 2029/2030 – 173
- 2030 and beyond – 20

This equates to 3,168 people in total across the sites.

18.2 Current provision of pharmaceutical services within the locality's area

There are eight pharmacies in the locality operated by eight different contractors. Of the six GP practices, four dispense from a total of four premises. The level of dispensing ranges from 7.0% to 96.0% of the practices' registered populations.

The map below shows the location of the pharmacies and dispensing practice premises. It should be noted that where premises are close to each other the symbols will overlap.

Map 18.1 – location of pharmacies and dispensing doctor premises



© OpenStreetMap © CARTO Dispensing doctor premises Pharmacy

In 2024/25, 74.4% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practices dispensed or personally administered 16.4% of the prescribed items. Whilst the data available doesn't show the percentage split between dispensed and personally administered items, based on the level of personal administration elsewhere in Wales it can be assumed that less than 2% of items were personally administered.

In the first nine months of 2025/26 74.6% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practices dispensed or personally administered 16.6% of the prescribed items.

The map in chapter 5 indicates that all the locality is within a 20-minute drive of a pharmacy, with many residents within ten minutes of a pharmacy. With regard to when the pharmacies are open:

- One opens Monday to Friday,
- Five open Monday to Friday, and part of Saturday,
- One opens Monday to Saturday, and
- One opens Monday to Sunday in Mold.

With regard to the times at which these pharmacies are open between Monday and Friday:

- all the pharmacies open at 09.00,
- Closing times vary between 17.30 and 18.00.

Three pharmacies close for lunch at varying times between 13.00 and 13.30. The remaining pharmacies open all day.

On Saturday, the seven pharmacies that open do so at 09.00. Of the two pharmacies that open all day, neither closes for lunch. They close at 17.30. Five pharmacies have core opening hours on Saturday.

The pharmacy that opens on Sunday does so between 10.00 and 16.00. These are supplementary opening hours.

The health board asks the pharmacies whether they will be open on public and bank holidays and Easter Sunday. The responses are collated, and the health board establishes whether or not there are any geographic gaps in provision. Where a gap exists, a pharmacy is either commissioned or directed to open.

Four pharmacies responded to the pharmacy contractor questionnaire and the following information is taken from those responses.

All the pharmacies are accessible by wheelchair and have a consultation area that is accessible by wheelchair. All the consultation areas are:

- closed rooms,
- a designated area where the patient and pharmacist can sit down together and talk at normal volumes without being overheard, and
- clearly designated as an area for confidential consultations distinct from the general public areas of the pharmacy.

Two pharmacies confirmed they have Welsh speakers. Other than English, no other languages are spoken.

All four pharmacies dispense prescriptions for all types of appliances.

All four pharmacies collect prescriptions from GP practices. In relation to the delivery of dispensed items:

- one provides a free of charge delivery service on request,
- one provides a free delivery service to housebound patients within a three-mile radius,
- one provides a delivery service for a fee, to specific areas, and
- one provides a delivery service to elderly and vulnerable housebound patients.

One pharmacy has an automated collection point allowing people to collect their dispensed medicines at a time that is convenient for them.

There were no suggestions for an existing additional clinical service that is not currently provided in the area.

With regard to the requirement for a new service that is not currently available, two pharmacies stated a blood pressure would be useful, and one also said that patients ask for a wider range of vaccinations than are currently available eg shingles.
All four pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide. Two said they also have sufficient staffing capacity, and one said they don't have sufficient staffing capacity but could make adjustments. The fourth didn't respond to this point.

Two pharmacies have plans to develop or expand their premises or service provision.

- One is moving to new premises in August 2026. The new premises will have eight consultation rooms and will increase the delivery of services.
- One is looking to increase the range of private services offered eg travel vaccinations and weight loss, should there not be an increase in the range of NHS services commissioned.

One dispensing practice responded to the dispensing doctor questionnaire and the following information is taken from that response. It provides services from one premises.

- The dispensary is open from 08.00 to 18.00 Monday to Friday.
- Just dressings are dispensed.
- Dispensed items are delivered to housebound dispensing patients.
- The practice has no Welsh speakers.
- Other than English, no other languages are spoken by staff.
- The practice has capacity within its premises and staff to manage an increase in demand.

18.2.1 Clinical community pharmacy service

All the pharmacies had signed up to provide this service and in 2025/26 provided:

- 8,507 consultations for common ailments400 consultations for contraception
- 5,174 emergency medicines supplies

18.2.2 Discharge medicines review

In 2026/26, six pharmacies provided this service and completed 466 reviews.

18.2.3 Pharmacist independent prescribing service

Five pharmacies were commissioned to provide this service in 2025/26 and provided a total of 3,636 consultations over the year.

18.2.4 Seasonal influenza vaccination service

All the pharmacies were commissioned to provide this service in 2025/26 and provided a total of 1,625 vaccinations.

18.2.5 Stoma appliance customisation

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

18.2.6 Appliance use reviews

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

18.2.7 Lateral flow test supply service

Six pharmacies were commissioned to provide this service in 2025/26.

18.2.8 Blood borne virus testing service

No pharmacies were commissioned to provide this service in 2025/26.

18.2.9 Covid-19 vaccination service

No pharmacies were commissioned to provide this service in 2025/26.

18.2.10 Help me quit @ pharmacy

Six pharmacies were commissioned to provide this service in 2025/26.

18.2.11 Inhaler review service

Seven pharmacies were commissioned to provide this service in 2025/26.

18.2.12 Naloxone supply service

One pharmacy was commissioned to provide this service in 2025/26.

18.2.13 National care home support service

One pharmacy was commissioned to provide this service in 2025/26.

18.2.14 Return of patients sharps boxes

Seven pharmacies were commissioned to provide this service in 2025/26.

18.2.15 Smoking cessation service level 2

All the pharmacies were commissioned to provide this service in 2025/26.

18.2.16 Supervised administration service

Six pharmacies were commissioned to provide this service in 2025/26.

18.2.17 Needle and syringe programmes

Three pharmacies were commissioned to provide this service in 2025/26.

18.2.18 Urgent medicines service

One pharmacy was commissioned to provide this service in 2025/26.

18.3 Current provision of pharmaceutical services outside the locality's area

Some residents choose to access contractors outside both the locality and the health board's area in order to access services:

- Offered by dispensing appliance contractors
- Which are located near to where they work, shop, or visit for leisure or other purposes.

Whilst the majority of prescriptions written by the GP practices in 2024/25 were dispensed by either the eight pharmacies in the locality or the four dispensing practices, 8.5% were dispensed outside the locality:

- 2.6% by pharmacies in North East Flintshire,
- 2.6% by pharmacies in Central and South Denbighshire,
- 2.0% by pharmacies in North and West Wrexham,
- 0.9% by contractors in England,
- 0.2% in Cardiff and Vale University Health Board's area, and
- 0.2% by pharmacies in Central Wrexham.

In the first nine months of 2025/26, the majority of prescriptions were dispensed by either the pharmacies or the dispensing practices in the locality. 8.6% were dispensed outside the locality:

- 2.8% by pharmacies in Central and South Denbighshire,
- 2.5% by pharmacies in North East Flintshire,
- 2.0% by pharmacies in North and West Wrexham,
- 0.8% by contractors in England,
- 0.2% in Cardiff and Vale University Health Board's area, and
- 0.2% by pharmacies in Central Wrexham.

In addition, residents may have accessed one or more pharmaceutical services provided by another pharmacy outside of both the locality and the health board's area; however, it is not possible to quantify this activity from the recorded data.

18.4 Other NHS services

Details of the NHS services which affect the need for pharmaceutical services can be found in chapter six.

18.5 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 18.2 and 18.3, those living within the locality and registered with one of the GP practices generally choose to access one of the pharmacies in the locality in order to have their prescriptions dispensed or, if eligible, to be dispensed to by their practice. Those that look outside the locality usually do so either to access a neighbouring pharmacy or a dispensing appliance contractor outside of the health board's area.

In 2024/25 over 135 contractors dispensed items written by one of the GP practices in this locality, of which:

- eight were located within the locality,
- 102 were located elsewhere within the health board's area,
- 24 were located elsewhere in Wales, and
- A number of prescriptions were dispensed in England.

In the first nine months of 2025/26 over 113 contractors dispensed items written by one of the GP practices, of which:

- eight were located within the locality,
- 84 were located elsewhere within the health board's area,
- 108were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

18.6 Gaps in provision

When considering if there are any gaps in the provision of pharmaceutical services the health board has noted that four pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide. Two said they also have sufficient staffing capacity, and one said they don't have sufficient staffing capacity but could make adjustments. The fourth didn't respond to this point.

18.6.1 Essential services

The health board has noted:

- The pharmacies are located in areas of greater population density and generally higher deprivation.
- All the locality is within a 20-minute drive of a pharmacy, with many residents within ten minutes of a pharmacy.
- The known housing developments.

- The opening hours of the pharmacies.

The health board has not identified any current needs for these services within the locality.

The health board has identified that should there be a loss of essential services due to the withdrawal of a pharmacy from the pharmaceutical list there will be a future need for either:

- a new pharmacy in the same town/village providing essential services, the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services for 40 core opening hours per week, or
- the GP dispensing service if the town/village is in a controlled locality,

unless there is another pharmacy in that town/village and then this future need will not arise.

The health board has identified that should there be a loss of supplementary opening hours on Saturdays from 1 October 2026 which results in less than three hours of provision of pharmaceutical services within a town/village there will be a future need for the provision of essential services for three core opening hours on Saturdays in the town/village or towns/village where the reduction in supplementary opening hours has occurred, between 09.00 and 17.00, unless there is another pharmacy in that town/village and then the future need will not arise.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and
    - the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

18.6.2 Clinical community pharmacy service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

18.6.3 Discharge medicines review

The health board has noted six pharmacies provided this service in 2025/26. It has

not identified any current or future needs for this service within the locality.

18.6.4 Pharmacist independent prescribing service

The health board has noted:

- five pharmacies were commissioned to provide this service in 2025/26.
- The aspiration set out in Pharmacy: Delivering a Healthier Wales is for each pharmacy to have an independent prescriber by 2030 and has set interim targets of 50% of pharmacies to be providing this service in each locality by April 2027 and 70% by April 2029.
- From 2026 it is anticipated that all newly qualified pharmacists will also qualify as independent prescribers on completion of their undergraduate

Based on the above, the health board has not identified any current needs for this service within the locality.

Should the interim targets not be met there will be a future need for the provision of this service by sufficient pharmacies in the locality to meet the two targets.

18.6.5 Seasonal influenza vaccination service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

18.6.6 Stoma appliance customisation

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England. It has also noted that these contractors provide this service.

It is therefore anticipated that these contractors will be customising stoma appliances as required before dispatching or delivering them to patients.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

18.6.7 Appliance use reviews

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England. It has also noted that these contractors provide this service.

Individuals requiring the appliance use review service are likely to access this service from the contractor that dispenses their prescriptions for appliances or may access it from other healthcare providers such as stoma nurses.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

18.6.8 Lateral flow tests supply service

The health board has noted six pharmacies were commissioned to provide this service in 2025/26. It has also noted that this service is only available to specified patient groups. If one of the pharmacies that doesn't provide the service identified a need for it, the health board would commission the service from that pharmacy. As a result, the health board has not identified any current or future needs for this service within the locality.

18.6.9 Blood borne virus testing service

The health board has noted none of the pharmacies were commissioned to provide this service in 2025/26. However, there are other providers of the service, for example the health board's harm reduction team.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

18.6.10 Covid-19 vaccination service

The health board has noted none of the pharmacies were commissioned to provide this service in 2025/26. It has also noted that GP practices and the health board's vaccination team provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

18.6.11 Help me quit @ pharmacy

The health board has noted:

- Six pharmacies were commissioned to provide this service in 2025/26.
- Demand for the service is dictated by people wishing to stop smoking.
- There are other providers of the service for example Help me quit for baby, Help me quit in hospital, and the general Help me quit service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

18.6.12 Inhaler review service

The health board has noted:

- seven pharmacies were commissioned to provide this service in 2025/26.
- GP practices also provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

18.6.13 Naloxone supply service

The health board has noted:

- one pharmacy was commissioned to provide this service in 2025/26.

18.6.14 National care home support service

The health board has noted:

- one pharmacy was commissioned to provide this service in 2025/26.
- There are other providers of the service such as the health board's harm reduction team and the 'click and deliver' service provided by DAN24/7.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

18.6.15 Return of patients sharps boxes

The health board has noted seven pharmacies were commissioned to provide this service 2025/26. It has not identified any current or future needs for this service within the locality.

18.6.16 Smoking cessation level 2

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

18.6.17 Supervised administration service

The health board has noted six pharmacies were commissioned to provide this service in 2025/26. It has not identified any current or future needs for this service within the locality.

18.6.18 Needle and syringe programmes

The health board has noted:

- Three pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service, and a postal service is being established for those who are unable to use a pharmacy.
- If a pharmacy is asked to provide the service, they can approach the health board and asked to be commissioned to provide it.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

18.6.19 Urgent medicines service

The health board has noted one pharmacy was commissioned to provide this service in 2025/26. Due to the nature of the service, it is commissioned to ensure a good geographical spread of pharmacies providing it across the health board's geography.

The health board has therefore not identified any current or future needs for this service within the locality.

18.6.20 GP dispensing service

The health board has not identified any current needs in relation to this service.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and
    - the clinical community pharmacy service, patient sharps, smoking cessation level 2, and help me quit @ pharmacy services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

19 North and West Wrexham locality

19.1 Key facts[187]

- Wrexham Unitary Authority has the second largest population of the six unitary authorities at 138,245.
- The numbers of children and young people (aged 0 to 17 years) in the health board have declined by around 6,200 between 2013 and 2023. The largest decline has been in Wrexham Unitary Authority, with a decline of 1,350.
- Wrexham Unitary Authority has the lowest proportion of residents aged 65 years and over at 20.8%, which is lower than the Wales average (21.7%). The picture is similar for residents aged 85 years and over, with Wrexham having 2.6% which is the lowest across the six local authority areas and below the average for Wales (2.7%).
- The overall population of the health board is expected to increase by just over 50,000 residents (6.8%) between 2022 and 2047. At unitary authority level the smallest increase is predicted to be in Wrexham at 2.4% compared to the largest increases in Gwynedd (10.8%) and Denbighshire (10.4%).
- The number of children and young people aged 0 to 15 years in the health board area is expected to decline by 13.5% by 2047. At unitary authority level the largest decline is expected in Wrexham at 20.8% compared to the smallest decline predicted to be in Gwynedd (4.8%).
- The resident population aged 85 years in the health board area is expected to increase by almost 98%. Across the region, the largest percentage increases are expected in Wrexham (114.6%) and on the Isle of Anglesey (109.4%).
- 19.2% of the locality's population is aged 66-84 years, higher than the Wales average of 17.7%, but lower than the health board's average of 19.6%.
- 2.6% of the locality's population is aged 85+ years, lower than the health board's average of 3.1% and lower than the Wales average of 2.7%.
- 17.7% of the locality's population is aged 0-15 years, higher than both the average for Wales (17.1%) and the health board (16.7%).
- One-person households in the locality make up 28.2% of total households; 13.9% of households in are occupied by one person aged over 66. This is lower than the average for Wales (14.6%) and lower than the health board's average of 15.8%.
- There has been a general increase in population density across North Wales between 2020 and 2023. The eastern area of the health board remains the most densely populated, with more persons per square kilometre compared to the Wales average (152.6). Wrexham is the second most densely populated local authority area at 270.3 persons per square kilometre.
- 13.7% of households in the locality have no car or.
- 8.4% of the locality's population live in the most deprived 20% of the Welsh Index of Multiple deprivation.[188]
- Life expectancy in Wrexham is 77.2 for males and 81.2 for females[189].

[187] Public Health Profiles - North West Collaborative profiles 2025
[188] Public Health Wales - Primary care clusters dashboard
[189] InfoBaseCymru data for an intelligent Wales - Life expectancy in males and females (2020 to 2022)

- Healthy life expectancy in Wrexham is 61.8 years for males and 61.5 years for females and the inequality gap for healthy life expectancy in Wrexham is 7.3 years for males and 7.5 years for females.
- 32.4% of four and five year olds in North and West Wrexham locality have overweight or obesity.
- Healthy lifestyles and behaviour data for adults in Wrexham Unitary Authority show:

Area	Physically active for at least 60 minutes per day	Eat at least one portion of fruit or vegetable daily	Smoke tobacco at least weekly	Tried e-cigarettes at least weekly	Reporting drinking alcohol
Wrexham	16.1%	40.9%	3.2%	8.7%	34.7%
Betsi Cadwaladr University Health Board	18.3%	45.7%	3.3%	8.2%	36.8%
Wales	18.3%	46.5%	2.6%	6.9%	35.6%

- Over 89,600 the health board patients are registered by their GP as having obesity; this is almost 15% of the population. At locality level the highest proportions are in North and West Wrexham (17.4%) and South Wrexham (16.8%).
- The Annual Population Survey in Wales records Welsh language ability and frequency. In 2025, almost 39% of residents in the health board reported being able to speak Welsh. In Wrexham, 26.1% of the population reported being able to speak Welsh. This is the second lowest percentage across North Wales.
- Numbers of patients with chronic conditions as reported on the Digital Health and Care Wales disease registers, April 2025, are shown below.

Disease register	North and West Wrexham	Betsi Cadwaladr University Health Board	Wales
Asthma	8.0%	7.6%	7.1%
Atrial fibrillation	2.7%	2.8%	2.7%
Cancer	4.5%	4.3%	3.7%
Chronic obstructive pulmonary disease	2.5%	2.7%	2.3%
Diabetes	8.0%	8.3%	8.4%
Epilepsy	0.8%	0.9%	1.0%
Heart failure	1.3%	1.4%	1.4%
Hypertension	18.0%	17.9%	16.3%
Stroke transient ischaemic attack	2.2%	2.3%	2.2%

Secondary prevention of coronary heart disease	3.5%	3.6%	3.4%

The Wrexham Local Development Plan 2013 to 2028 identified the need for 8,525 housing units, equating to 568 houses per annum or 2,840 within the lifetime of this pharmaceutical needs assessment. However, it was withdrawn on 18 March 2026 by Welsh Ministers[190]. The development plan for Wrexham now comprises Future Wales: the national plan 2024 and the Wrexham Unitary Development Plan 1996-2011 in order of legal hierarchy.

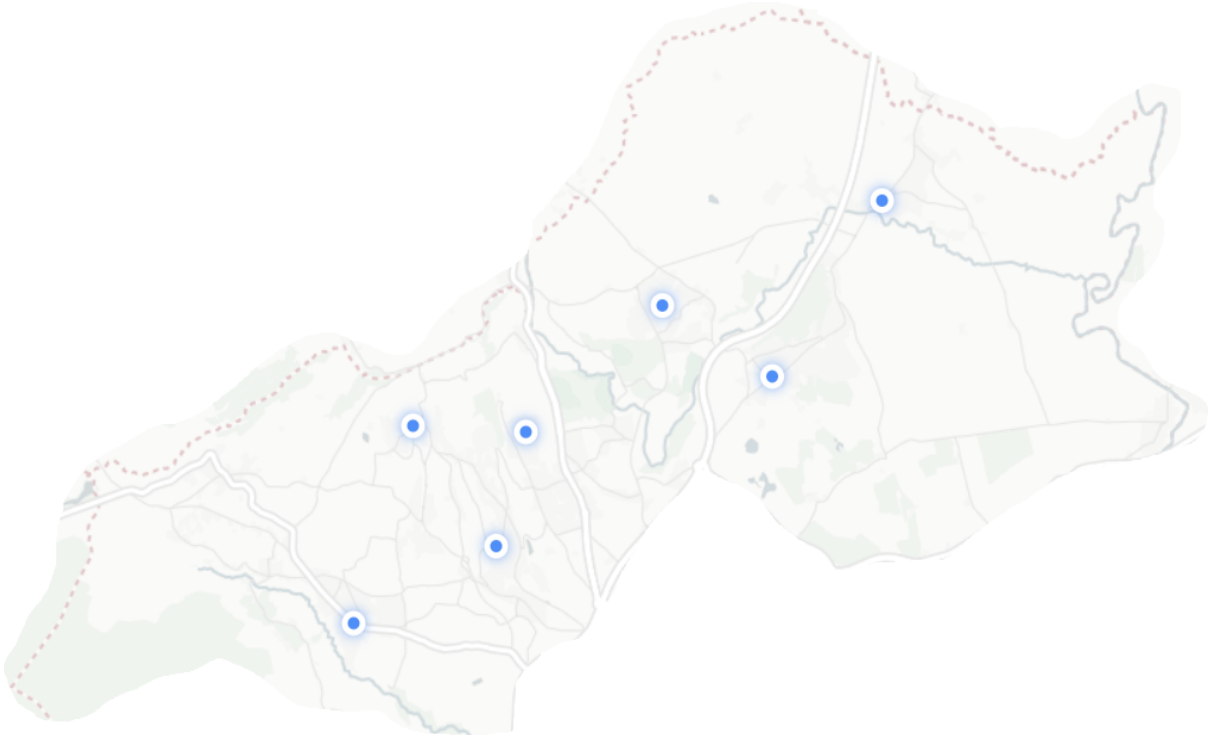
Based on the development trajectory in the council's Annual Monitoring Report for 2023/24, 801 units will be built in 2026/27 and 787 in 2027/28. From 2028 onwards, 3,087 units are expected to be built. There are three large schemes, all located within Central Wrexham locality.

19.2 Current provision of pharmaceutical services within the locality's area

There are seven pharmacies in the locality operated by four different contractors. None of the GP practices dispense.

The map below shows the location of the pharmacies. It should be noted that where premises are close to each other the symbols will overlap.

Map 19.1 – location of pharmacies



[190] Wrexham County Borough Council, Notice of Withdrawal of the Wrexham County Borough Council Local Development Plan 2013-2028

© OpenStreetMap © CARTO  Pharmacy

In 2024/25, 81.3% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality.

In the first nine months of 2025/26 81.9% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality.

The map in chapter 5 indicates that all the locality is within a 20-minute drive of a pharmacy with most residents within ten minutes of a pharmacy. With regard to when the pharmacies are open:

- one opens Monday to Friday,
- four open Monday to Friday, and part of Saturday, and
- two open Monday to Saturday.

With regard to the times at which these pharmacies are open between Monday and Friday:

- all open at 09.00,
- Closing times vary between 17.30 and 18.00.

Four pharmacies close for lunch at varying times between 13.00 and 14.00. Three remain open all day.

On Saturday, five pharmacies open at 09.00, and one at 09.30. Three are open in the morning, one closes at 15.00, one at 16.30 and one at 17.30. Six have core opening hours on Saturday.

No pharmacies are open on Sundays.

The health board asks the pharmacies whether they will be open on public and bank holidays and Easter Sunday. The responses are collated, and the health board establishes whether or not there are any geographic gaps in provision. Where a gap exists, a pharmacy is either commissioned or directed to open.

Four pharmacies responded to the pharmacy contractor questionnaire and the following information is taken from those responses.

All four pharmacies are accessible by wheelchair and have a consultation area that is accessible by wheelchair. All four consultation areas are:

- closed rooms,
- a designated area where the patient and pharmacist can sit down together and talk at normal volumes without being overheard, and
- clearly designated as an area for confidential consultations distinct from the general public areas of the pharmacy.

Three pharmacies have Welsh speakers. One pharmacy confirmed that staff are also able to speak Gujarati, Bengali, Punjab and Hindi.

All four pharmacies dispense prescriptions for all types of appliances.

All four pharmacies collect prescriptions from GP practices. In relation to the delivery of dispensed items:

- two provide a free of charge delivery service on request, and
- two pharmacies restrict the service to elderly and vulnerable housebound patients.

There were no suggestions for a new service that is not currently available in the area.

One pharmacy was of the opinion that there is a requirement for an additional clinical service which is not currently available, namely blood pressure monitoring as it receives requests for the service from patients and also regularly finds people with high blood pressure when providing the pharmacist independent prescriber service. One pharmacy said it is open to any clinical services and would be prepared to open for longer hours if commissioned to do so.

Three pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide, with the fourth saying it doesn't but could make adjustments to manage any increase in demand. One pharmacy also has sufficient capacity in its staffing levels with the remaining three saying they don't but could make adjustments.

All four pharmacies have plans to develop or expand their premises or service provision:

- Relocation to new premises and installation of an automated collection point in the next 12 months.
- Addition of a third and fourth consultation room to meet increased demand. Second pharmacist due to start who will qualify as an independent prescriber in 2026. Two pharmacy technicians are providing services under patient group directions and certain private services.
- Expand the number of days the independent prescriber is available.
- Commence providing the pharmacist independent prescriber service in late 2026.

19.2.1 Clinical community pharmacy service

All the pharmacies had signed up to provide this service and in 2025/26 provided:

- 7,376 consultations for common ailments
- 125 consultations for contraception
- 2,156 emergency medicines supplies

19.2.2 Discharge medicines review

In 2025/26 six pharmacies provided this service and completed 264 reviews.

19.2.3 Pharmacist independent prescribing service

Four pharmacies were commissioned to provide this service in 2025/26 and provided a total of 5,129 consultations over the year.

19.2.4 Seasonal influenza vaccination service

All the pharmacies were commissioned to provide this service in 2025/26 and provided a total of 2,010 vaccinations.

19.2.5 Stoma appliance customisation

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

19.2.6 Appliance use reviews

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

19.2.7 Lateral flow test supply service

Five pharmacies were commissioned to provide this service in 2025/26.

19.2.8 Blood borne virus testing service

No pharmacies were commissioned to provide this service in 2025/26.

19.2.9 Covid-19 vaccination service

No pharmacies were commissioned to provide this service in 2025/26.

19.2.10 Help me quit @ pharmacy

Five pharmacies were commissioned to provide this service in 2025/26.

19.2.11 Inhaler review service

Six pharmacies were commissioned to provide this service in 2025/26.

19.2.12 Naloxone supply service

One pharmacy was commissioned to provide this service in 2025/26.

19.2.13 National care home support service

Two pharmacies were commissioned to provide this service in 2025/26.

19.2.14 Return of patients sharps boxes

All the pharmacies were commissioned to provide this service in 2025/26.

19.2.15 Smoking cessation service level 2 service

All the pharmacies were commissioned to provide this service in 2025/26.

19.2.16 Supervised administration service

Six pharmacies were commissioned to provide this service in 2025/26.

19.2.17 Needle and syringe programmes

One pharmacy was commissioned to provide this service in 2025/26.

19.2.18 Urgent medicines service

No pharmacies were commissioned to provide this service in 2025/26.

19.3 Current provision of pharmaceutical services outside the locality's area

Some residents choose to access contractors outside both the locality and the health board's area in order to access services:

- Offered by dispensing appliance contractors
- Which are located near to where they work, shop, or visit for leisure or other purposes.

Whilst the majority of prescriptions written by the GP practices in 2024/25 were dispensed by the pharmacies in the locality, 17.1% were dispensed outside the locality:

- 11.1% by pharmacies in South Wrexham,
- 3.2% by pharmacies in Central Wrexham,
- 1.9% by pharmacies in North East Flintshire,
- 0.6% by contractors in England,
- 0.2% in Cardiff and Vale University Health Board's area, and
- 0.1% by pharmacies in South Flintshire.

In the first nine months of 2025/26, the majority of prescriptions were dispensed by the pharmacies in the locality. 17.7% were dispensed outside the locality:

- 11.3% by pharmacies in South Wrexham,
- 3.3% by pharmacies in Central Wrexham,
- 1.5% by pharmacies in North East Flintshire,

- 1.2% by contractors in England,
- 0.2% in Cardiff and Vale University Health Board's area, and
- 0.1% by pharmacies in South Flintshire.

In addition, residents may have accessed one or more pharmaceutical services provided by another pharmacy outside of both the locality and the health board's area; however, it is not possible to quantify this activity from the recorded data.

19.4 Other NHS services

Details of the NHS services which affect the need for pharmaceutical services can be found in chapter six.

19.5 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 19.2 and 19.3, those living within the locality and registered with one of the GP practices generally choose to access one of the pharmacies in the locality in order to have their prescriptions dispensed or, if eligible, to be dispensed to by their practice. Those that look outside the locality usually do so either to access a neighbouring pharmacy or a dispensing appliance contractor outside of the health board's area.

In 2024/25 over 97 contractors dispensed items written by one of the GP practices in this locality, of which:

- seven were located within the locality,
- 76 were located elsewhere within the health board's area,
- 13 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

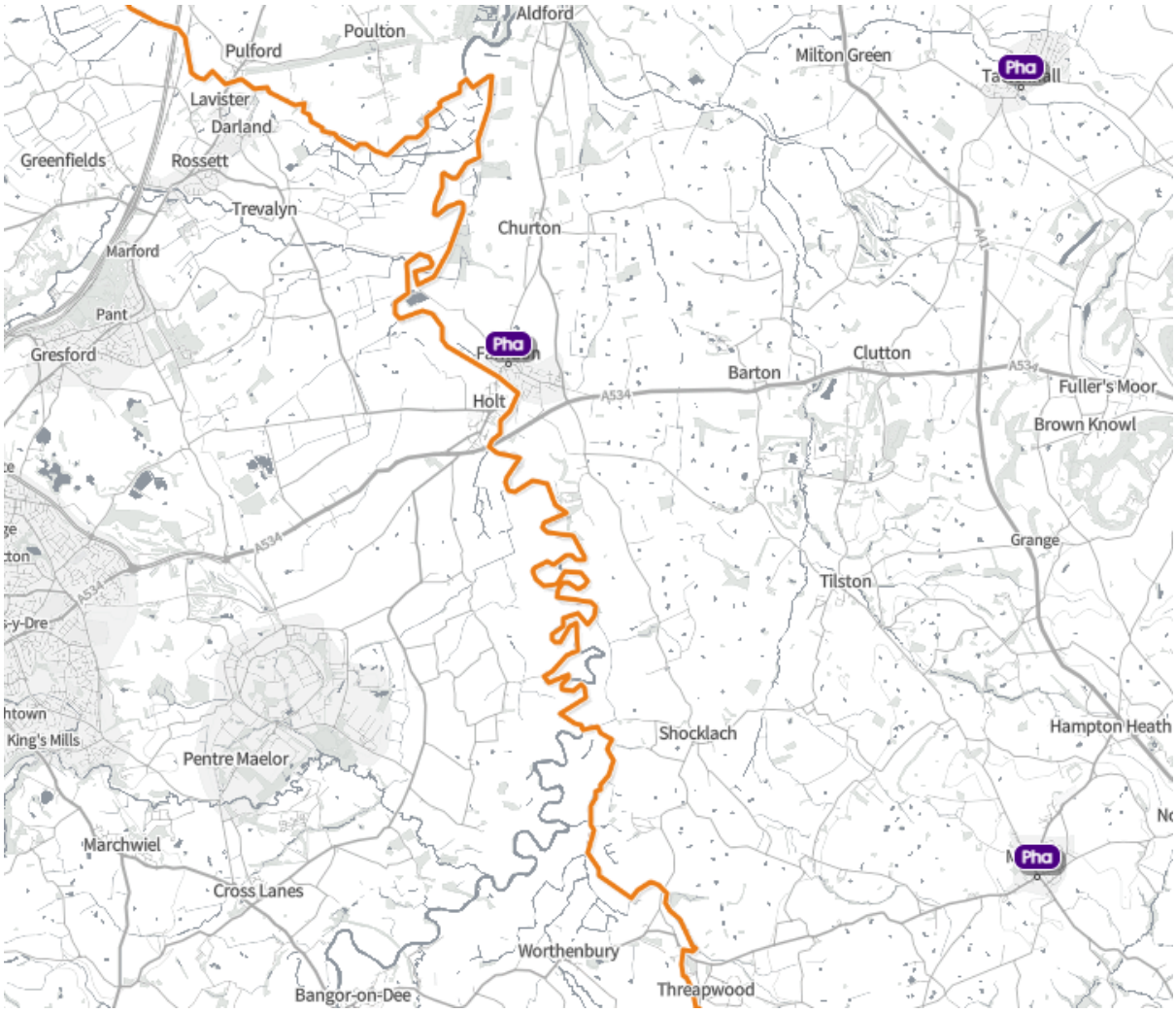
In the first nine months of 2025/26 over 90 contractors dispensed items written by one of the GP practices, of which:

- seven were located within the locality,
- 72 were located elsewhere within the health board's area,
- 10 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

19.6 Gaps in provision

Whilst not providers of either pharmaceutical services or other NHS services as defined in the regulations, the health board has taken account of the pharmacies over the border within England. The map below shows the location of pharmacies in England.

Map 19.2 –location of pharmacies in England



© Copyright Parallel 2026 | Ordnance Survey | Mapbox | OpenStreetMap contributors

When considering if there are any gaps in the provision of pharmaceutical services the health board has noted that three pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide, with a fourth saying it doesn't but could make adjustments to manage any increase in demand. One pharmacy also has sufficient capacity in its staffing levels with the remaining three saying they don't but could make adjustments.

19.6.1 Essential services

The health board has noted:

- The pharmacies are spread across the locality and are generally located in areas of greater population density and higher deprivation.

- All the locality is within a 20-minute drive of a pharmacy with most residents within ten minutes of a pharmacy.
- The level of housing projected to be built.
- There are no pharmacies open on Sundays.

The health board has not identified any current needs in relation to the provision of essential services in this locality.

The health board has identified that should there be a loss of essential services due to the withdrawal of a pharmacy from the pharmaceutical list there will be a future need for either:

- a new pharmacy in the same town/village providing essential services during, the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services for 40 core opening hours per week, or
- the GP dispensing service if the town/village is in a controlled locality,

unless there is another pharmacy in that town/village and then this future need will not arise.

The health board has identified that should there be a loss of supplementary opening hours on Saturdays from 1 October 2026 which results in less than three hours of provision of pharmaceutical services within a town/village there will be a future need for the provision of essential services for three core opening hours on Saturdays in the town/village or towns/villages where the reduction in supplementary opening hours has occurred, between 09.00 and 17.00, unless there is another pharmacy in that town/village and then the future need will not arise.

19.6.2 Clinical community pharmacy service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

19.6.3 Discharge medicines review

The health board has noted six pharmacies provided this service in 2025/26. It has not identified any current or future needs for this service within the locality.

19.6.4 Pharmacist independent prescribing service

The health board has noted:

- Four pharmacies were commissioned to provide this service in 2025/26.
- One pharmacy plans to commence providing the service in late 2026.
- The aspiration set out in Pharmacy: Delivering a Healthier Wales is for each pharmacy to have an independent prescriber by 2030 and has set interim targets of 50% of pharmacies to be providing this service in each locality by April 2027 and 70% by April 2029.

- From 2026 it is anticipated that all newly qualified pharmacists will also qualify as independent prescribers on completion of their undergraduate

Based on the above, the health board has not identified any current needs for this service within the locality.

Should the interim targets not be met there will be a future need for the provision of this service by sufficient pharmacies in the locality to meet the two targets.

19.6.5 Seasonal influenza vaccination service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has not identified any current or future needs for this service within the locality.

19.6.6 Stoma appliance customisation

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

It is therefore anticipated that these contractors will be customising stoma appliances as required before dispatching or delivering them to patients.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

19.6.7 Appliance use reviews

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

Individuals requiring the appliance use review service are likely to access this service from the contractor that dispenses their prescriptions for appliances or may access it from other healthcare providers such as stoma nurses.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

19.6.8 Lateral flow tests supply service

The health board has noted five pharmacies were commissioned to provide this service in 2025/26. It has also noted that this service is only available to specified patient groups. If one of the pharmacies that doesn't provide the service identified a need for it, the health board would commission the service from that pharmacy. As a result, the health board has not identified any current or future needs for this service within the locality.

19.6.9 Blood borne virus testing service

The health board has noted no pharmacies were commissioned to provide this service in 2025/26. However, there are other providers of the service, for example the health board's harm reduction team.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

19.6.10 Covid-19 vaccination service

The health board has noted no pharmacies were commissioned to provide this service in 2025/26. It has also noted that GP practices and the health board's vaccination team provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

19.6.11 Help me quit @ pharmacy

The health board has noted:

- Five pharmacies were commissioned to provide this service in 2025/26.
- Demand for the service is dictated by people wishing to stop smoking.
- There are other providers of the service for example Help me quit for baby, Help me quit in hospital, and the general Help me quit service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

19.6.12 Inhaler review service

The health board has noted:

- Six pharmacies were commissioned to provide this service in 2025/26.
- GP practices also provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

19.6.13 Naloxone supply service

The health board has noted:

- One pharmacy was commissioned to provide this service in 2025/26.
- There are other providers of the service such as the health board's harm reduction team and the 'click and deliver' service provided by DAN24/7.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

19.6.14 National care home support service

The health board has noted:

- Two pharmacies were commissioned to provide this service in 2025/26.
- The service is provided by pharmacies to the care homes that they provide services to, or where a care home has requested the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

19.6.15 Return of patients sharps boxes

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has not identified any current or future needs for this service within the locality.

19.6.16 Smoking cessation level 2 service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has not identified any current or future needs for this service within the locality.

19.6.17 Supervised administration service

The health board has noted six pharmacies were commissioned to provide this service in 2025/26. It has not identified any current or future needs for this service within the locality.

19.6.18 Needle and syringe programmes

The health board has noted:

- One pharmacy was commissioned to provide this service in 2025/26.
- There are other providers of the service, and a postal service is being established for those who are unable to use a pharmacy.
- If a pharmacy is asked to provide the service, they can approach the health board and asked to be commissioned to provide it.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

19.6.19 Urgent medicines service

The health board has noted no pharmacies were commissioned to provide this service in 2025/26. Due to the nature of the service, it is commissioned to ensure a good geographical spread of pharmacies providing it across the health board’s geography.

The health board has therefore not identified any current or future needs for this service within the locality.

20 Central Wrexham locality

20.1 Key facts[191]

- Wrexham Unitary Authority, in the north east of the region has the second largest population of the six unitary authorities at 138,245.
- The numbers of children and young people (aged 0 to 17 years) in the health board have declined by around 6,200 between 2013 and 2023. The largest decline has been in Wrexham Unitary Authority, with a decline of 1,350.
- Wrexham Unitary Authority has the lowest proportion of residents aged 65 years and over at 20.8%, which is lower than the Wales average (21.7%). The picture is similar for residents aged 85 years and over, with Wrexham having 2.6% which is the lowest across the six local authority areas and below the average for Wales (2.7%).
- The overall population of the health board is expected to increase by just over 50,000 residents (6.8%) between 2022 and 2047. At unitary authority level the smallest increase is predicted to be in Wrexham at 2.4% compared to the largest increases in Gwynedd (10.8%) and Denbighshire (10.4%).
- The number of children and young people aged 0 to 15 years in the health board area is expected to decline by 13.5% by 2047. At unitary authority level the largest decline is expected in Wrexham at 20.8% compared to the smallest decline predicted to be in Gwynedd (4.8%).
- The resident population aged 85 years in the health board area is expected to increase by almost 98%. Across the region, the largest percentage increases are expected in Wrexham (114.6%) and on the Isle of Anglesey (109.4%).
- 14.9% of the locality's population is aged 66-84 years, lower than the Wales average of 17.7%, and lower than the health board's average of 19.6%.
- 2.4% of the locality's population is aged 85+ years, lower than the health board's average of 3.1% and lower than the Wales average of 2.7%.
- 18.1% of the locality's population is aged 0-15 years, higher than the average for Wales (17.1%) and higher than the health board's average of 16.7%.
- One-person households in the locality make up 32.3% of total households; 13.3% of households are occupied by one person aged over 66. This is lower than the average for Wales (14.6%) and lower the health board's average of 15.8%.
- There has been a general increase in population density across North Wales between 2020 and 2023. The eastern area of the health board remains the most densely populated, with more persons per square kilometre compared to the Wales average (152.6). Wrexham is the second most densely populated local authority area at 270.3 persons per square kilometre.
- 23.8% of households in the locality have no car or .
- 17.1% of the cluster population live in the most deprived 20% of the Welsh Index of Multiple deprivation.[192]
- Life expectancy in Wrexham is 77.2 for males and 81.2 for females[193].

[191] Public Health Profiles - North West Collaborative profiles 2025
[192] Public Health Wales - Primary care clusters dashboard
[193] InfoBaseCymru data for an intelligent Wales - Life expectancy in males and females (2020 to 2022)

- Healthy life expectancy in Wrexham is 61.8 years for males and 61.5 years for females and the inequality gap for healthy life expectancy in Wrexham is 7.3 years for males and 7.5 years for females.
- 28.5% of four and five year olds in Central Wrexham locality have overweight or obesity.
- Healthy lifestyles and behaviour data for adults in Wrexham Unitary Authority show:

Area	Physically active for at least 60 minutes per day	Eat at least one portion of fruit or vegetable daily	Smoke tobacco at least weekly	Tried e-cigarettes at least weekly	Reporting drinking alcohol
Wrexham	16.1%	40.9%	3.2%	8.7%	34.7%
Betsi Cadwaladr University Health Board	18.3%	45.7%	3.3%	8.2%	36.8%
Wales	18.3%	46.5%	2.6%	6.9%	35.6%

- The Annual Population Survey in Wales records Welsh language ability and frequency. In 2025, almost 39% of residents in the health board reported being able to speak Welsh. In Wrexham, 26.1% of the population reported being able to speak Welsh. This is the second lowest percentage across North Wales.
- Numbers of patients with chronic conditions as reported on the Digital Health and Care Wales disease registers, April 2025, are shown below.

Disease register	Central Wrexham	Betsi Cadwaladr University Health Board	Wales
Asthma	7.1%	7.6%	7.1%
Atrial fibrillation	2.4%	2.8%	2.7%
Cancer	3.5%	4.3%	3.7%
Chronic obstructive pulmonary disease	2.4%	2.7%	2.3%
Diabetes	8.0%	8.3%	8.4%
Epilepsy	1.0%	0.9%	1.0%
Heart failure	1.5%	1.4%	1.4%
Hypertension	16.8%	17.9%	16.3%
Stroke transient ischaemic attack	2.2%	2.3%	2.2%
Secondary prevention of coronary heart disease	3.3%	3.6%	3.4%

The Wrexham Local Development Plan 2013 to 2028[194] identified the need for 8,525 housing units, equating to 568 houses per annum or 2,840 within the lifetime of this pharmaceutical needs assessment. However, it was withdrawn on 18 March 2026 by Welsh Ministers[195]. The development plan for Wrexham no comprises the Future Wales: the national plan 2024 and the Wrexham Unitary Development Plan 1996-2011 in order of legal hierarchy.

Based on development trajectory in the council's Annual Monitoring Report for 2023/24, 801 units will be built in 2026/27 and 787 in 2027/28. From 2028 onwards, 3,087 units are expected to be built. There are three large schemes, all located within Central Wrexham locality.

- 1,450 units (approximately 3,480 people) - land off Lower Berse Road, Wrexham. The majority of the units are expected from 2028 onwards.
- 600 units (approximately 1,440 people) – land off Holt Road, Wrexham.
- 900 units (approximately 2,160 people) – Esless Park (also referred to as Erlas Park), land east of Cefn Road. The majority of the units are expected from 2028 onwards.

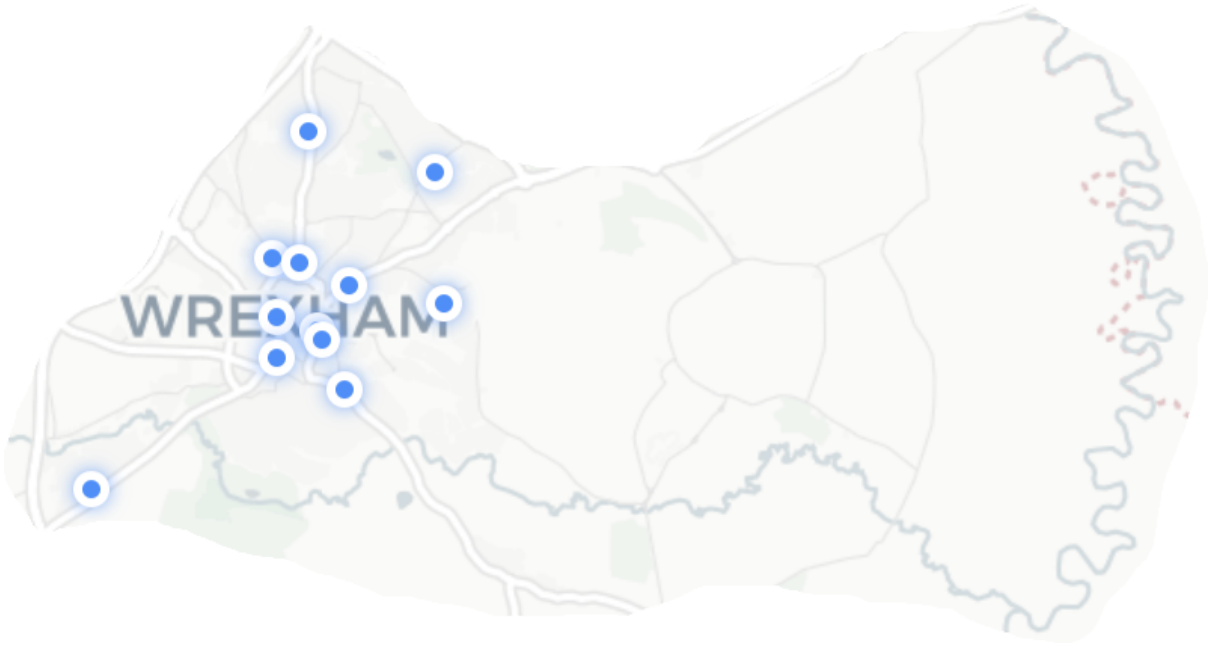
20.2 Current provision of pharmaceutical services within the locality's area

There are 12 pharmacies in the locality operated by five different contractors. None of the six GP practices dispense.

The map below shows the location of the pharmacies. It should be noted that where premises are close to each other the symbols will overlap.

[194] Wrexham Local Development Plan 2013 to 2028
[195] Wrexham County Borough Council, Notice of Withdrawal of the Wrexham County Borough Council Local Development Plan 2013-2028

Map 20.1 – location of pharmacies



© OpenStreetMap © CARTO

In 2025/26, 78.1% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality.

In the first nine months of 2025/26 79.2% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality.

The map in chapter 5 indicates that all the locality is within a 20-minute drive of a pharmacy, with most residents within ten minutes of a pharmacy. With regard to when the pharmacies are open:

- Three open Monday to Friday,
- Six open Monday to Friday, and part of Saturday,
- One opens Monday to Saturday, and
- Two open Monday to Sunday.

With regard to the times at which these pharmacies are open between Monday and Friday:

- Two open at 08.30, one opens at 08.45 and the remainder open at 09.00,
- Closing times vary between 17.30 and 18.00 with one pharmacy open until 20.00.

Ten pharmacies close for lunch at varying times between 13.00 and 14.00.

On Saturday, one pharmacy opens at 08.30 and eight at 09.00. Of the three pharmacies that open all day, one closes for lunch between 13.00 and 13.20. They

close between 17.30 and 18.00. Nine of the pharmacies have core opening hours on Saturdays, with two having them morning and afternoon.

The two pharmacies that open on Sunday between them cover the hours 10.00 to 16.00.

The health board asks the pharmacies whether they will be open on public and bank holidays and Easter Sunday. The responses are collated, and the health board establishes whether or not there are any geographic gaps in provision. Where a gap exists, a pharmacy is either commissioned or directed to open.

Ten pharmacies responded to the pharmacy contractor questionnaire and the following information is taken from those responses.

All ten pharmacies are accessible by wheelchair and have a consultation area that is accessible by wheelchair. Nine of the consultation areas are:

- closed rooms,
- a designated area where the patient and pharmacist can sit down together and talk at normal volumes without being overheard, and
- clearly designated as an area for confidential consultations distinct from the general public areas of the pharmacy.

The tenth is a closed room but does not meet the other two requirements. There are, however, alternative arrangements in place for confidential discussions.

Four pharmacies confirmed it they have Welsh speakers. Nine pharmacies reported other languages being spoken by staff.

- Polish, Gujarati, Urdu, Parsi, Hindi.
- Polish is spoken at three pharmacies.
- Spanish is spoken at two pharmacies.
- Polish and Urdu.
- Malay and Mandarin.
- Farsi.

All ten pharmacies dispense prescriptions for all types of appliances.

All ten pharmacies collect prescriptions from GP practices. In relation to the delivery of dispensed items:

- one provides a free of charge delivery service on request, and
- eight deliver to elderly and vulnerable housebound patients.

No pharmacies were of the opinion that there is a requirement for an existing additional clinical service, or a new service, that is not currently available.
All ten confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide. Two also have

sufficient capacity within its staffing levels, with eight saying they don't but could make adjustments.
Six pharmacies have plans to develop or expand their service provision.

- Second consultation room built with plans to build additional clinical rooms to the back of the pharmacy.
- Exploring providing the pharmacist independent prescriber service outside of normal working hours and a weekend service.
- No specific plans, but always reviewing the opportunity for services.
- Expand the independent prescriber to five days a week.
- Increase the volume of pharmacist independent prescriber service consultations.
- Two pharmacies plan to commence the provision of the pharmacist independent prescriber service.

20.2.1 Clinical community pharmacy service

All the pharmacies had signed up to provide this service and in 2025/26 provided:

- 10,373 consultations for common ailments771 consultations for contraception
- 2,393 emergency medicines supplies

20.2.2 Discharge medicines review

In 2025/26 nine pharmacies provided this and completed 208 reviews.

20.2.3 Pharmacist independent prescribing service

Seven pharmacies were commissioned to provide this service in 2025/26 and provided a total of 3,869 consultations over the year.

20.2.4 Seasonal influenza vaccination service

All the pharmacies were commissioned to provide this service in 2025/26 and provided a total of 2,168 vaccinations.

20.2.5 Stoma appliance customisation

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

20.2.6 Appliance use reviews

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

20.2.7 Lateral flow test supply service

All the pharmacies were commissioned to provide this service in 2025/26.

20.2.8 Blood borne virus testing service

Two pharmacies were commissioned to provide this service in 2025/26.

20.2.9 Covid-19 vaccination service

None of the pharmacies were commissioned to provide this service in 2025/26.

20.2.10 Help me quit @ pharmacy

11 pharmacies were commissioned to provide this service in 2025/26.

20.2.11 Inhaler review service

11 pharmacies were commissioned to provide this service in 2025/26.

20.2.12 Naloxone supply service

Three pharmacies were commissioned to provide this service in 2025/26.

20.2.13 National care home support service

Four pharmacies were commissioned to provide this service in 2025/26.

20.2.14 Return of patients sharps boxes

11 pharmacies were commissioned to provide this service in 2025/26.

20.2.15 Smoking cessation service level 2 service

11 pharmacies were commissioned to provide this service in 2025/26.

20.2.16 Supervised administration service

11 pharmacies were commissioned to provide this service in 2025/26.

20.2.17 Needle and syringe programmes

Eight pharmacies were commissioned to provide this service and provided it in 2025/26.

20.2.18 Urgent medicines service

One pharmacy was commissioned to provide this service in 2025/26.

20.3 Current provision of pharmaceutical services outside the locality's area

Some residents choose to access contractors outside both the locality and the health board's area in order to access services:

- Offered by dispensing appliance contractors
- Which are located near to where they work, shop or visit for leisure or other purposes.

Whilst the majority of prescriptions written by the GP practices in 2024/25 were dispensed by the pharmacies in the locality, 20.5% were dispensed outside the locality:

- 12.6% by pharmacies in North and West Wrexham,
- 3.4% by pharmacies in North East Flintshire,
- 2.5% by contractors in England,
- 1.7% in South Wrexham,
- 0.2% in Cardiff and Vale University Health Board's area, and
- 0.1% by pharmacies in South Flintshire.

In the first nine months of 2025/26, the majority of prescriptions were dispensed by the pharmacies in the locality. 20.4% was dispensed outside the locality:

- 12.2% by pharmacies in North and West Wrexham,3.2% in North East Flintshire,
- 3.1% in England,
- 1.6% in South Wrexham
- 0.2% in Cardiff and Vale University Health Board's area, and
- 0.1% in South Flintshire

In addition, residents may have accessed one or more pharmaceutical services provided by another pharmacy outside of both the locality and the health board's area; however, it is not possible to quantify this activity from the recorded data.

20.4 Other NHS services

Details of the NHS services which affect the need for pharmaceutical services can be found in chapter six.

20.5 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 20.2 and 20.3, those living within the locality and registered with one of the GP practices generally choose to access one of the pharmacies in the locality in order to have their prescriptions dispensed or, if eligible, to be dispensed to by their practice. Those that look outside the locality usually do so either to access a neighbouring pharmacy or a dispensing appliance contractor outside of the health board's area.

In 2024/25 over 118 contractors dispensed items written by one of the GP practices in this locality, of which:

- 12 were located within the locality,
- 77 were located elsewhere within the health board's area,

- 29 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

Similar figures were seen in the first nine months of 2024/25.

The health board has noted that there is a private pharmacy in Plas Coch Retail Park. Whilst not providing pharmaceutical services it will be able to provide support for self-care and sell medicines to those seeking advice. The pharmacy has a consultation room and provides a range of private services including vaccinations (both routine and travel), emergency contraception, and NHS prescription ordering.

20.6 Gaps in provision

20.6.1 Essential services

When considering if there are any gaps in the provision of pharmaceutical services the health board has noted that Ten pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide. Two also have sufficient capacity within its staffing levels, with eight saying they don't but could make adjustments.

The health board has noted:

- The pharmacies are located in the western side of the locality, generally in areas of greater population density and higher deprivation.
- All of the locality is within a 20-minute drive time of a pharmacy with many residents within ten minutes of a pharmacy.
- The three known developments in the locality that will start to deliver the expected number of houses from 2028 onwards.
- The opening hours of the pharmacies.

Based on the above, the health board has not identified any current needs for these services within the locality.

The health board has identified that should there be a loss of essential services due to the withdrawal of a pharmacy from the pharmaceutical list] there will be a future need for either:

- a new pharmacy in the same town/village providing essential services the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services for 40 core opening hours per week, or
- the GP dispensing service if the town/village is in a controlled locality,

unless there is another pharmacy in that town/village and then this future need will not arise.

The health board has identified that should there be a loss of supplementary opening hours on Saturdays from 1 October 2026 which results in less than three hours of provision of pharmaceutical services within a town/village there will be a future need

for the provision of essential services for three core opening hours on Saturdays in the town/village or towns/villages where the reduction in supplementary opening hours has occurred, between 09.00 and 17.00, unless there is another pharmacy in that town/village and then the future need will not arise.

20.6.2 Clinical community pharmacy service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

20.6.3 Discharge medicines review

The health board has noted nine pharmacies provided the service in 2025/26. It has not identified any current or future needs for this service within the locality.

20.6.4 Pharmacist independent prescribing service

The health board has noted:

- Seven pharmacies were commissioned to provide this service in 2025/26.
- Two pharmacies plan to commence the provision of this service
- The aspiration set out in Pharmacy: Delivering a Healthier Wales is for each pharmacy to have an independent prescriber by 2030 and has set interim targets of 50% of pharmacies to be providing this service in each locality by April 2027 and 70% by April 2029.
- From 2026 it is anticipated that all newly qualified pharmacists will also qualify as independent prescribers on completion of their undergraduate

Based on the above, the health board has not identified any current needs for this service within the locality.

Should the interim targets not be met there will be a future need for the provision of this service by sufficient pharmacies in the locality to meet the two targets.

20.6.5 Seasonal influenza vaccination service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

20.6.6 Stoma appliance customisation

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

It is therefore anticipated that these contractors will be customising stoma appliances as required before dispatching or delivering them to patients.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

20.6.7 Appliance use reviews

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

Individuals requiring the appliance use review service are likely to access this service from the contractor that dispenses their prescriptions for appliances or may access it from other healthcare providers such as stoma nurses.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

20.6.8 Lateral flow tests supply service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

20.6.9 Blood borne virus testing service

The health board has noted two pharmacies were commissioned to provide this service in 2025/26. However, there are other providers of the service, for example the health board's harm reduction team.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

20.6.10 Covid-19 vaccination service

The health board has noted none of the pharmacies were commissioned to provide this service in 2025/26. It has also noted that GP practices and the health board's vaccination team provide the service.
Based on the above, the health board has not identified any current or future needs for this service within the locality.

20.6.11 Help me quit @ pharmacy

The health board has noted:

- 11 of the pharmacies were commissioned to provide this service in 2025/26.
- Demand for the service is dictated by people wishing to stop smoking.
- There are other providers of the service for example Help me quit for baby, Help me quit in hospital, and the general Help me quit service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

20.6.12 Inhaler review service

The health board has noted:

- 11 of the pharmacies were commissioned to provide this service in 2025/26.
- GP practices also provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

20.6.13 Naloxone supply service

The health board has noted:

- Three pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service such as the health board's harm reduction team and the 'click and deliver' service provided by DAN24/7.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

20.6.14 National care home support service

The health board has noted:

- Four of the pharmacies were commissioned to provide this service in 2025/26.
- The service is provided by pharmacies to the care homes that they provide services to, or where a care home has requested the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

20.6.15 Return of patients sharps boxes

The health board has noted 11 pharmacies were commissioned to provide this service in 2025/26. It has not identified any current or future needs for this service within the locality.

20.6.16 Smoking cessation level 2

The health board has noted:

- 11 of the pharmacies were commissioned to provide this service in 2025/26.
- Demand for the service is dictated by people wishing to stop smoking.

It has not identified any current or future needs for this service within the locality.

20.6.17 Supervised administration service

The health board has noted 11 of the pharmacies were commissioned to provide this service in 2025/26. It has not identified any current or future needs for this service within the locality.

20.6.18 Needle and syringe programmes

The health board has noted:

- Eight of the pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service, and a postal service is being established for those who are unable to use a pharmacy.
- If a pharmacy is asked to provide the service, they can approach the health board and asked to be commissioned to provide it.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

20.6.19 Urgent medicines service

The health board has noted one of the pharmacies was commissioned to provide this service in 2025/26. Due to the nature of the service, it is commissioned to ensure a good geographical spread of pharmacies providing it across the health board’s geography.

The health board has therefore not identified any current or future needs for this service within the locality.

21 South Wrexham locality

21.1 Key facts[196]

- Wrexham Unitary Authority, in the north east of the region has the second largest population of the six unitary authorities at 138,245.
- The numbers of children and young people (aged 0 to 17 years) in the health board have declined by around 6,200 between 2013 and 2023. The largest decline has been in Wrexham Unitary Authority, with a decline of 1,350.
- Wrexham has the lowest proportion of residents aged 65 years and over at 20.8%, which is lower than the Wales average (21.7%). The picture is similar for residents aged 85 years and over, with Wrexham having 2.6% which is the lowest across the six unitary authority areas and below the average for Wales (2.7%).
- The overall population of the health board is expected to increase by just over 50,000 residents (6.8%) between 2022 and 2047. At unitary authority level the smallest increase is predicted to be in Wrexham at 2.4% compared to the largest increases in Gwynedd (10.8%) and Denbighshire (10.4%).
- The number of children and young people aged 0 to 15 years in the health board area is expected to decline by 13.5% by 2047. At unitary authority level the largest decline is expected in Wrexham at 20.8% compared to the smallest decline predicted to be in Gwynedd (4.8%).
- The resident population aged 85 years in the health board area is expected to increase by almost 98%. Across the region, the largest percentage increases are expected in Wrexham (114.6%) and on the Isle of Anglesey (109.4%).
- 18.9% of the locality's population is aged 66-84 years, higher than the Wales average of 17.7%, and higher than the health board's average of 19.6%.
- 2.9% of the locality's population is aged 85+ years, lower than the health board's average of 3.1% and similar to the Wales average of 2.7%.
- 17.2% of the locality's population is aged 0-15 years, similar to the average for Wales (17.1%) and higher than the health board's average of 16.7%.
- One-person households in the locality make up 30.4% of total households; 15.1% of households are occupied by one person aged over 66. This is higher than the average for Wales (14.6%) but lower than the health board's average of 15.8%.
- There has been a general increase in population density across North Wales between 2020 and 2023. The eastern area of the health board remains the most densely populated, with more persons per square kilometre compared to the Wales average (152.6). Wrexham is the second most densely populated local authority area at 270.3 persons per square kilometre.
- 16.9% of households in the locality have no car or van.
- 8.48 of the cluster population live in the most deprived 20% of the Welsh Index of Multiple deprivation.[197]
- Life expectancy in Wrexham is 77.2 for males and 81.2 for females[198].

[196] Public Health Profiles - North West Collaborative profiles 2025
[197] Public Health Wales - Primary care clusters dashboard
[198] InfoBaseCymru data for an intelligent Wales - Life expectancy in males and females (2020 to 2022)

- Healthy life expectancy in Wrexham is 61.8 years for males and 61.5 years for females and the inequality gap for healthy life expectancy in Wrexham is 7.3 years for males and 7.5 years for females.
- 33.4% of four and five year olds in South Wrexham locality have overweight or obesity, the highest in the region.
- Healthy lifestyles and behaviour data for adults in Wrexham Unitary Authority show:

Area	Physically active for at least 60 minutes per day	Eat at least one portion of fruit or vegetable daily	Smoke tobacco at least weekly	Tried e-cigarettes at least weekly	Reporting drinking alcohol
Wrexham	16.1%	40.9%	3.2%	8.7%	34.7%
Betsi Cadwaladr University Health Board	18.3%	45.7%	3.3%	8.2%	36.8%
Wales	18.3%	46.5%	2.6%	6.9%	35.6%

- Over 89,600 health board patients are registered by their GP as having obesity; this is almost 15% of the population. At cluster level the highest proportions are in North and West Wrexham (17.4%) and South Wrexham (16.8%).
- The Annual Population Survey in Wales records Welsh language ability and frequency. In 2025, almost 39% of residents in the health board reported being able to speak Welsh. In Wrexham, 26.1% of the population reported being able to speak Welsh. This is the second lowest percentage across North Wales.
- Numbers of patients with chronic conditions as reported on the Digital Health and Care Wales disease registers, April 2025, are shown below.

Disease register	South Wrexham	Betsi Cadwaladr University Health Board	Wales
Asthma	8.1%	7.6%	7.1%
Atrial fibrillation	2.9%	2.8%	2.7%
Cancer	4.1%	4.3%	3.7%
Chronic obstructive pulmonary disease	2.7%	2.7%	2.3%
Diabetes	8.2%	8.3%	8.4%
Epilepsy	1.0%	0.9%	1.0%
Heart failure	1.3%	1.4%	1.4%
Hypertension	18.8%	17.9%	16.3%
Stroke transient ischaemic attack	2.3%	2.3%	2.2%
Secondary prevention of coronary heart disease	3.8%	3.6%	3.4%

The Wrexham Local Development Plan 2013 to 2028[199] identified the need for 8,525 housing units, equating to 568 houses per annum or 2,840 within the lifetime of this pharmaceutical needs assessment. However, it was withdrawn on 18 March 2026 by Welsh Ministers[200]. The development plan for Wrexham no comprises the Future Wales: the national plan 2024 and the Wrexham Unitary Development Plan 1996-2011 in order of legal hierarchy.

Based on development trajectory in the council's Annual Monitoring Report for 2023/24, 801 units will be built in 2026/27 and 787 in 2027/28. From 2028 onwards, 3,087 units are expected to be built. There are three large schemes, all located within Central Wrexham locality.

21.2 Current provision of pharmaceutical services within the locality's area

There are ten pharmacies in the locality operated by four different contractors. One pharmacy is covered by the essential small pharmacy scheme. Of the eight GP practices, two dispense from a total of two premises. The level of dispensing ranges from 71.8% to 86.4% of the practices' registered populations.

The map below shows the location of the pharmacies and dispensing practice premises. It should be noted that where premises are close to each other the symbols will overlap.

Map 21.1 – location of pharmacies and dispensing doctor premises



© OpenStreetMap © CARTO Dispensing doctor premises Pharmacy

[199] Wrexham County Borough Council, Wrexham Local Development Plan 2013 to 2028
[200] Wrexham County Borough Council, Notice of Withdrawal of the Wrexham County Borough Council Local Development Plan 2013-2028

In 2024/25, 73.8% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practices dispensed or personally administered 6.5% of the prescribed items. Whilst the data available doesn't show the percentage split between dispensed and personally administered items, based on the level of personal administration elsewhere in Wales it can be assumed that less than 2% of items were personally administered.

In the first nine months of 2025/26 72.2% of prescriptions written by the GP practices in the locality were dispensed by a pharmacy within the locality, and the dispensing practices dispensed or personally administered 9.5% of the prescribed items. Less than 2% of items were personally administered.

The map in chapter 5 indicates that not all the locality is within a 20-minute drive of a pharmacy. The area to the west of Pentre is hilly countryside with a few scattered houses/farms. The area in the east that is south of Bronington is occupied by Fenn's, Whixall & Bettisfield Mosses National Nature Reserve.
With regard to when the pharmacies are open:

- three open Monday to Friday, and
- seven open Monday to Friday and Saturday morning.

With regard to the times at which these pharmacies are open between Monday and Friday:

- five open at 08.30 and five open at 09.00,
- closing times vary between 17.00 and 18.30, although one pharmacy closes at 12.30 on Wednesdays.

All bar one close for lunch at varying times between 12.00 and 14.00.

On Saturday, seven pharmacies open at 09.00, with one closing at 12.00 and the remainder at 13.00. Six of these pharmacies have core opening hours on Saturday mornings.

No pharmacies open on Sundays.

The health board asks the pharmacies whether they will be open on public and bank holidays and Easter Sunday. The responses are collated, and the health board establishes whether or not there are any geographic gaps in provision. Where a gap exists, a pharmacy is either commissioned or directed to open.

Nine pharmacies responded to the pharmacy contractor questionnaire and the following information is taken from those responses.

Eight pharmacies are accessible by wheelchair, and of these eight have a consultation area that is accessible by wheelchair. The pharmacy that is not wheelchair accessible, does have a consultation area that is wheelchair accessible. All nine consultation areas are:

- closed rooms,
- a designated area where the patient and pharmacist can sit down together and talk at normal volumes without being overheard, and
- clearly designated as an area for confidential consultations distinct from the general public areas of the pharmacy.

Five pharmacies have Welsh speakers. Five pharmacies reported staff speaking other languages.

- Romanian.
- Hindi, Gujarati, Urdu and Polish.
- Polish.
- Asante Twi.
- Urdu.

All nine pharmacies dispense prescriptions for all types of appliances.

All nine pharmacies collect prescriptions from GP practices. In relation to the delivery of dispensed items:

- three provide a free of charge delivery service on request, and
- six restrict the service to elderly and vulnerably housebound patients.

No pharmacies were of the opinion that there is a requirement for an existing additional clinical service, or new service, in the area.

Eight pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide, with the nineth able to make adjustments. One pharmacy confirmed it has sufficient capacity within its staffing levels, and eight said they don't but could make adjustments to manage an increase in demand.

Eight pharmacies have plans to develop or expand their premises or service provision.

- Two plan to commence providing the pharmacist independent prescriber service in 2026.
- One is exploring the option of extending its opening hours.
- One pharmacy has a pharmacist who plans to commence their independent prescriber training in 2027 if they can find a designated prescribing practitioner.
- One needs an additional consultation room but needs to secure funding for it.

There were no responses to the dispensing doctor questionnaire.

21.2.1 Clinical community pharmacy service

All the pharmacies had signed up to provide this service and in 2025/26 provided

- 7,633 consultations for common ailments235 consultations for contraception
- 1,346 emergency medicines supplies

21.2.2 Discharge medicines review

In 2025/26 seven pharmacies provided this service and completed 292 reviews.

21.2.3 Pharmacist independent prescribing service

Four pharmacies were commissioned to provide this service in 2025/26 and provided a total of 1,943 consultations over the year.

21.2.4 Seasonal influenza vaccination service

Nine pharmacies were commissioned to provide this service in 2025/26 and provided a total of 910 vaccinations.

21.2.5 Stoma appliance customisation

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

21.2.6 Appliance use reviews

None of the pharmacies in the locality provide this service despite dispensing prescriptions for appliances.

21.2.7 Lateral flow test supply service

Nine of the pharmacies were commissioned to provide this service in 2025/26.

21.2.9 Blood borne virus testing service

One pharmacy was commissioned to provide this service in 2025/26.

21.2.10 Covid-19 vaccination service

No pharmacies were commissioned to provide this service in 2025/26.

21.2.7 Help me quit @ pharmacy service

Nine pharmacies were commissioned to provide this service in 2025/26.

21.2.13 Inhaler review service

Nine pharmacies were commissioned to provide this service in 2025/26.

21.2.16 Naloxone supply service

One pharmacy was commissioned to provide this service in 2025/26.

21.2.17 National care home support service

One pharmacy was commissioned to provide this service in 2025/26.

21.2.18 Return of patients sharps boxes

All the pharmacies were commissioned to provide this service in 2025/26.

21.2.19 Smoking cessation service level 2 service

In 2025/26 all the pharmacies were commissioned to provide this service.

21.2.21 Supervised administration service

Nine pharmacies were commissioned to provide this service in 2025/26.

21.2.22 Needle and syringe programmes

Five of the pharmacies were commissioned to provide this service in 2025/26.

21.2.23 Urgent medicines service

None of the pharmacies were commissioned to provide this service in 2025/26.

21.3 Current provision of pharmaceutical services outside the locality's area

Some residents choose to access contractors outside both the locality and the health board's area in order to access services:

- Offered by dispensing appliance contractors
- Which are located near to where they work, shop, or visit for leisure or other purposes.

Whilst the majority of prescriptions written by the GP practices in 2024/25 were dispensed by either the pharmacies in the locality or the dispensing practices, 19.7% were dispensed outside the locality:

- 10.2% in Central Wrexham,
- 6.7% in England,
- 1.1% were personally administered by GP practices,
- 1.0% in North and West Wexham,
- 0.3% in North East Flintshire,
- 0.2% in Central and South Denbighshire,
- 0.2% in Cardiff and Vale University Health Board's area, and
- 0.1% in South Flintshire.

In the first nine months of 2025/26, the majority of prescriptions were dispensed by either the pharmacies or dispensing practices in the locality. 18.0% was dispensed outside the locality:

- 10.2% in Central Wrexham,
- 5.9% in England,
- 0.9% in North and West Wexham,
- 0.3% in North East Flintshire,
- 0.2% in Central and South Denbighshire,
- 0.2% in Cardiff and Vale University Health Board's area,
- 0.1% in Conwy East,
- 0.1% in North Denbighshire, and
- 0.1% in South Flintshire.

In addition, residents may have accessed one or more pharmaceutical services provided by another pharmacy outside of both the locality and the health board's area; however, it is not possible to quantify this activity from the recorded data.

21.4 Other NHS services

Details of the NHS services which affect the need for pharmaceutical services can be found in chapter six.

21.5 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 21.2 and 21.3, those living within the locality and registered with one of the GP practices generally choose to access one of the pharmacies in the locality in order to have their prescriptions dispensed or, if eligible, to be dispensed to by their practice. Those that look outside the locality usually do so either to access a neighbouring pharmacy or a dispensing appliance contractor outside of the health board's area.

In 2024/25, over 124 contractors dispensed items written by one of the GP practices in this locality, of which:

- ten were located within the locality,
- 98 were located elsewhere within the health board's area
- 26 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England

In the first ten months of 2025/26over 115 contractors dispensed items written by one of the GP practices in this locality, of which:

- ten were located within the locality,
- 92 were located elsewhere within the health board's area,
- 21 were located elsewhere in Wales, and
- a number of prescriptions were dispensed in England.

21.6 Gaps in provision

Whilst not providers of either pharmaceutical services or other NHS services as defined in the regulations, the health board has taken account of the pharmacies over the border within England. The map below shows the location of those pharmacies.

Map 21.2 – location of pharmacies in England



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When considering if there are any gaps in the provision of pharmaceutical services the health board has noted that eight pharmacies confirmed that they have sufficient capacity within their existing premises to manage an increase in demand for the services they provide, with the nineth able to make adjustments. One pharmacy confirmed it has sufficient capacity within its staffing levels, and eight said they don't but could make adjustments to manage an increase in demand.

21.6.1 Essential services

The health board has noted:

- The pharmacies are spread across the locality and are generally located in areas of higher deprivation. The dispensing practices are generally located in areas of lower deprivation.
- Some parts of the locality are not within a 20-minute drive time of a pharmacy however there is either no resident population or a few scattered properties in those areas. When taking into account the pharmacy over the border with England in Whitchurch, the areas in the east are within a 20-minute drive of a pharmacy in England.
- The known housing developments.
- The opening hours of the pharmacies.

Based on the above, the health board has not identified any current needs for these services.

The health board has identified that should there be a loss of essential services due to the withdrawal of a pharmacy from the pharmaceutical list in a town/ there will be a future need for either:

- a new pharmacy in the same town/village providing essential services the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services for 40 core opening hours per week, or
- the GP dispensing service if the town/village is in a controlled locality,

unless there is another pharmacy in that town/village and then this future need will not arise.

The health board has identified that should there be a loss of supplementary opening hours on Saturdays from 1 October 2026 which results in less than three hours of provision of pharmaceutical services within a town/village there will be a future need for the provision of essential services for three core opening hours on Saturdays in the town/village or towns/villages where the reduction in supplementary opening hours has occurred, between 09.00 and 17.00, unless there is another pharmacy in that town/village and then the future need will not arise.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and
    - the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

21.6.2 Clinical community pharmacy service

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

21.6.3 Discharge medicines review

The health board has noted seven of the pharmacies provided this service in 2025/26. It has not identified any current or future needs for this service within the locality.

21.6.4 Pharmacist independent prescribing service

The health board has noted:

- Four pharmacies were commissioned to provide this service in 2025/26.
- Two plan to commence providing this service in 2026.
- The aspiration set out in Pharmacy: Delivering a Healthier Wales is for each pharmacy to have an independent prescriber by 2030 and has set interim targets of 50% of pharmacies to be providing this service in each locality by April 2027 and 70% by April 2029.
- From 2026 it is anticipated that all newly qualified pharmacists will also qualify as independent prescribers on completion of their undergraduate

Based on the above, the health board has not identified any current needs for this service within the locality.

Should the interim targets not be met there will be a future need for the provision of this service by sufficient pharmacies in the locality to meet the two targets.

21.6.5 Seasonal influenza vaccination service

The health board has noted:

- Nine of the pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service, for example the GP practices.

It has not identified any current or future needs for this service within the locality.

21.6.6 Stoma appliance customisation

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

It is therefore anticipated that these contractors will be customising stoma appliances as required before dispatching or delivering them to patients.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

21.6.7 Appliance use reviews

Although no pharmacies provide this service the health board has noted that prescriptions for appliances are dispensed by contractors elsewhere in Wales and also in England.

Individuals requiring the appliance use review service are likely to access this service from the contractor that dispenses their prescriptions for appliances or may access it from other healthcare providers such as stoma nurses.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

21.6.8 Lateral flow tests supply service

The health board has noted nine pharmacies were commissioned to provide this service in 2025/26. It has also noted that this service is only available to specified patient groups. If one of the pharmacies that doesn't provide the service identified a need for it, the health board would commission the service from that pharmacy. As a result, the health board has not identified any current or future needs for this service within the locality.

21.6.9 Blood borne virus testing service

The health board has noted one pharmacy was commissioned to provide this service in 2025/26. However, there are other providers of the service, for example the health board's harm reduction team.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

21.6.10 Covid-19 vaccination service

The health board has noted none of the pharmacies were commissioned to provide this service in 2025/26. It has also noted that GP practices and the health board's vaccination team provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

21.6.11 Help me quit @ pharmacy

The health board has noted:

- Nine pharmacies were commissioned to provide this service in 2025/26.
- Demand for the service is dictated by people wishing to stop smoking.

- There are other providers of the service for example Help me quit for baby, Help me quit in hospital, and the general Help me quit service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

21.6.12 Inhaler review service

The health board has noted:

- Nine pharmacies were commissioned to provide this service in 2025/26.
- GP practices also provide the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

21.6.13 Naloxone supply service

The health board has noted:

- One pharmacy was commissioned to provide this service in 2025/26.
- There are other providers of the service such as the health board's harm reduction team and the 'click and deliver' service provided by DAN24/7.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

21.6.14 National care home support service

The health board has noted:

- One pharmacy was commissioned to provide this service in 2025/26.
- The service is provided by pharmacies to the care homes that they provide services to, or where a care home has requested the service.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

21.6.15 Return of patients sharps boxes

The health board has noted all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

21.6.16 Smoking cessation level 2

The health board has noted that all the pharmacies were commissioned to provide this service in 2025/26. It has therefore not identified any current or future needs for this service within the locality.

21.6.17 Supervised administration service

The health board has noted nine pharmacies were commissioned to provide this service in 2025/26. The health board has not identified any current or future needs for this service within the locality.

21.6.18 Needle and syringe programmes

The health board has noted:

- Five pharmacies were commissioned to provide this service in 2025/26.
- There are other providers of the service, and a postal service is being established for those who are unable to use a pharmacy.
- If a pharmacy is asked to provide the service, they can approach the health board and asked to be commissioned to provide it.

Based on the above, the health board has not identified any current or future needs for this service within the locality.

21.6.19 Urgent medicines service

The health board has noted none of the pharmacies were commissioned to provide this service in 2025/26. Due to the nature of the service, it is commissioned to ensure a good geographical spread of pharmacies providing it across the health board's geography.

The health board has therefore not identified any current or future needs for this service within the locality.

21.6.20 GP dispensing service

The health board has not identified any current needs in relation to this service.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum providing:
    - all the essential services, and
    - the clinical community pharmacy service, patient sharps, smoking cessation level 2, and help me quit @ pharmacy services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

22 Conclusions

The pharmaceutical needs assessment has considered the current provision of pharmaceutical services across the health board's area alongside the demography and health needs of the population. It has analysed whether current provision meets the needs of the population and whether there are any gaps in the provision of pharmaceutical service either now or within the lifetime of this document.

22.1 Current provision

The health board has identified the following services as those that are necessary to meet the need for pharmaceutical services in its area:

- Essential and the additional clinical services provided at premises included in the pharmaceutical list.
- The dispensing service provided by those GP practices included in the dispensing doctor list.

Preceding sections of this document have set out the provision of these services in each locality.

It has also identified the provision of the above services by contractors outside of its area, whether that is elsewhere in Wales or England, as contributing towards meeting the need for pharmaceutical services in its area.

22.2 Other NHS services

In undertaking this pharmaceutical needs assessment the health board considers the following other NHS services as affecting the need for pharmaceutical services and has taken them into account:

- Hospital services
- Provision of drugs, medicines and appliances for immediate treatment or personal administration by GPs
- The GP out of hours service
- Minor injury units
- Urgent primary care centres
- Prescribing by dentists and optometrists
- HMP Berwyn pharmacy service
- Substance misuse services
- Help Me Quit
- Services provided by GPs under their General Medical Services contract
- The alternative treatment scheme
- Hospices
- Sexual health services, and
- Other services provided in a community setting.

Further details on these can be found in chapter 6.

22.3 Current gaps in provision

22.3.1 Current access to essential services

In order to assess the provision of essential services against the needs of the population the health board considered access (travelling times and opening hours) as the most important factor in determining the extent to which the current provision of essential services meets the needs of the population.

A travel time standard of 20 minutes by car was agreed and travel times for the population to a pharmacy were mapped against that standard. The health board has noted that the vast majority of its population is within a 20-minute drive of a pharmacy.

The health board has identified one current need in relation to the provision of essential services, in Conwy West locality.

There is a current need for a pharmacy in Betws-y-Coed which, as a minimum, has core opening hours of:

- 09.00 to 17.00 Monday to Friday, and
- Six hours on Saturdays.

The pharmacy must provide all essential services.

22.3.2 Current access to additional clinical services

The health board has identified one current need in relation to the provision of additional clinical services, in Conwy West locality.

There is a current need for a pharmacy in Betws-y-Coed that provides the following additional clinical services from the point it is included in the pharmaceutical list:

- clinical community pharmacy service,
- return of patient sharps,
- smoking cessation level 2, and
- help me quit @ pharmacy service.

22.3.3 Current access to the GP dispensing service

The health board has noted the dispensing service provided by 34 of the GP practices to eligible patients and has not identified any current needs in relation to the provision of this service.

22.4 Future gaps in provision

The health board has taken into account the following matters:

- the forecasted population growth,
- the ageing population,

- the known housing developments, and
- the direction of travel set out in Pharmacy: delivering a healthier Wales.

22.4.1 Future access to essential services

The health board has identified the following future needs for essential services in relation to all the localities.

The health board has identified that should there be a loss of supplementary opening hours on Saturdays from 1 October 2026 which results in less than three hours of provision of pharmaceutical services within a town/village there will be a future need for the provision of essential services for three core opening hours on Saturdays in the town/village or towns/villages where the reduction in supplementary opening hours has occurred, between 09.00 and 17.00, unless there is another pharmacy in that town/village and then the future need will not arise.

The health board has identified that should there be a loss of essential services due to the withdrawal of a pharmacy from the pharmaceutical list there will be a future need for either:

- a new pharmacy in the same town/village providing essential services, the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services for 40 core opening hours per week, or
- the GP dispensing service if the town/village is in a controlled locality,

unless there is another pharmacy in that town/village and then this future need will not arise.

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum, providing:
    - all the essential services, and
    - the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

The health board has identified one specific future need in relation to the provision of additional clinical services, in North Denbighshire locality.

Should the pharmacy in Bodelwyddan withdraw from the pharmaceutical list there will be a future need for a new pharmacy in the town providing essential services during the following core opening hours:

- At least ten core opening hours per day Monday to Friday,
- Six core opening hours on Saturdays, and
- Six core opening hours on Sundays.

22.4.2 Future access to additional clinical services

The health board has identified the following future need in relation to the provision of the pharmacist independent prescribing service, in relation to all the localities.

The health board has adopted the aspiration set out in Pharmacy: Delivering a Healthier Wales for each pharmacy to have an independent prescriber by 2030 and the interim targets of 50% of pharmacies to be providing this service in each locality by April 2027 and 70% by April 2029.

Should the interim targets not be met in a locality there will be a future need for the provision of this service by sufficient pharmacies in that locality to meet the two targets.

The health board has identified one future need in relation to the provision of the clinical community pharmacy service, in the North Denbighshire locality.

The health board will work with the only pharmacy that does not provide this service. However, should this gap not be closed, then from 1 April 2027 there will be a future need for this service to be provided in Bodelwyddan, seven days a week for:

- eight hours a day Monday to Friday,
- six hours on Saturdays to include 13.00 to 15.00, and
- three hours on Sundays after 12 noon.

22.4.3 Future access to the GP dispensing service

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or
- a pharmacy that is open Monday to Friday as a minimum, providing:
    - all the essential services, and
    - the clinical community pharmacy service, patient sharps, smoking cessation level 2, and help me quit @ pharmacy services

unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise.

Appendix A – policy context and background papers

Welsh Government establishes the overall structure in which community pharmacies, dispensing appliance contractors and dispensing doctors operate by providing the legislative and policy framework. Within the framework, the responsibility for planning and providing pharmaceutical services is vested in health boards who must plan health services to meet the needs of their resident populations. This includes determining the number and location of pharmacies and dispensing appliance contractors in their areas.

The general duty to ensure the provision of pharmaceutical services, as with other aspects of NHS primary care services, is conferred directly on health boards under the NHS (Wales) Act 2006 (the 2006 Act). Health boards manage local lists of approved providers, referred to as pharmaceutical lists, and the inclusion of pharmacy and dispensing appliance contractor premises on pharmaceutical lists entitles contractors to provide NHS pharmaceutical services at those premises.

These arrangements govern the provision of pharmaceutical services and not the right to open and conduct a pharmacy business in Wales. That is dealt with under separate UK-wide legislation, the Medicines Act 1968.

The Welsh Ministers have extensive powers and duties to make regulations and to issue directions to health boards, which govern the detail of the pharmaceutical services system in Wales. This includes specifying the terms of service for pharmacies and dispensing appliance contractors and the application of the control of entry test, which is the test that until 1 October 2021 had to be satisfied before a health board would grant an application for entry, or amend an entry, on the pharmaceutical list.

Under the NHS (Pharmaceutical Services) (Wales) Regulations 2013 (the 2013 Regulations), and preceding regulations, those persons wishing to provide pharmaceutical services submitted an application to the health board in accordance with the 2013 Regulations. The health board then decided whether or not the application satisfied the relevant test. The 2013 Regulations allowed for the health board’s decision to be challenged by lodging an appeal with the Welsh Ministers.

The previous system of pharmaceutical services delivery was therefore driven by those who wished to provide pharmaceutical services. It was they who decided which services they wished to provide and from what location.

That meant that the system was reactive to applications and health boards were not able to plan where pharmacies or dispensing appliance contractors were located, or direct which services must be provided from those locations.

Rationale for change

In 2010 the then Minister for Health and Social Services established a Task and Finish Group to review the regulatory framework, to consider Welsh Government policy on control of entry and the provision of pharmaceutical services by health professions other than pharmacists (eg doctors) and to make recommendations for

changes to legislation, if appropriate, to bring about a long term, cost effective and sustainable system which would afford patients appropriate access to pharmaceutical services.

In 2011 Welsh Government consulted on the recommendations of the Task and Finish group. The consultation “Proposals to reform and modernise the National Health Service (Pharmaceutical Services) Regulations 1992” sought views on proposals to deliver a new approach for determining applications to provide pharmaceutical services in Wales based more on an assessment of local needs by health boards. However, it was recognised that to make such a change required the creation and inclusion of appropriate powers in the 2006 Act.

Following the consultation, the 2013 Regulations came into force on 10 May 2013 but did not contain provisions to introduce pharmaceutical needs assessments.

The Public Health (Wales) Act 2017 (the 2017 Act) inserted section 82A into the 2006 Act which makes provision for a new duty for health boards in Wales to prepare and publish an assessment of need for pharmaceutical services. Section 82A gave the Welsh Ministers powers to make regulations setting out the requirements for pharmaceutical needs assessments in Wales.

Intended effect and beneficial outcomes

The intended effect of introducing pharmaceutical needs assessments is to improve the planning and delivery of pharmaceutical services by ensuring the health boards robustly consider the pharmaceutical needs of their populations and align services more closely with them. This requires health boards to take a more integrated approach to identifying the pharmaceutical needs of populations, including considering the contribution of all pharmaceutical services providers (eg pharmacies and dispensing doctors). Health boards use these assessments to identify where additional premises are required, where existing providers are adequately addressing pharmaceutical needs, and where additional services are required from existing premises.

The change provides contractors with increased certainty, reducing business risk and allowing them to invest in the delivery of wider services than they did previously. Importantly, pharmacies in particular will also become more responsive to the needs of the populations they serve and provide services effectively to address identified pharmaceutical needs.

Policy, legislative framework and regulation

Section 80 of the 2006 Act places a duty on health boards to make arrangements for the provision of the pharmaceutical services that are set out in subsections 80(3)(a) to (d). These core pharmaceutical services are the essential services now set out in Part 2 of the NHS (Pharmaceutical Services) (Wales) Regulations 2020. There is a duty on Welsh Ministers to make regulations governing the way in which health boards make these arrangements.

Section 81 of the 2006 Act sets out the arrangements that Welsh Ministers may make for the provision of additional pharmaceutical services. 'Additional pharmaceutical services' are defined as services of a kind that do not fall within section 80 ie the national community pharmacy and appliance contractor services (previously referred to as the 'advanced services', and the community pharmacy additional clinical services (previously referred to as the 'enhanced services').

Section 81 gives Welsh Ministers the power to give directions to a health board:

(i) requiring it to arrange for the provision of additional pharmaceutical services, or
(ii) authorising the health board to arrange for the provision of pharmaceutical services if it wishes.

Section 83 of the 2006 Act contains the core of the Welsh Ministers' regulation making powers in relation to the provision of the pharmaceutical services and, amongst other things, sets out the requirement for regulations to require a health board to prepare and publish a pharmaceutical list, and sets out the tests which those persons wishing to provide pharmaceutical services must pass in order to do so (known as the 'control of entry test').

Section 84 sets out a requirement for Welsh Ministers to provide for rights of appeal against decisions that are made by health boards in exercise of powers conferred upon them by regulations made under section 83.

Part 7 of the 2017 Act made provision to amend the 2006 Act in respect of pharmaceutical services. Section 111 of the 2017 Act inserted a new section 82A into the 2006 Act conferring powers on the Welsh Ministers to make regulations in respect of pharmaceutical needs assessments. The Public Health (Wales) Act 2017 (Commencement No.4) Order 2019 brought Part 7 of the 2017 Act into force on 1 April 2019. As a result, the Welsh Ministers made subordinate legislation setting out requirements for pharmaceutical needs assessments in Wales.

The 2013 Regulations were revoked and replaced by the NHS (Pharmaceutical Services) (Wales) Regulations 2020. Part 2 of the NHS (Pharmaceutical Services) (Wales) Regulations 2020 imposes the legal requirements on health boards to complete pharmaceutical needs assessments.

The NHS (Pharmaceutical Services) (Wales) Regulations 2020 came into force on 1st October 2020 and health boards had until 1 October 2021 to publish their first pharmaceutical needs assessment.

In summary the NHS (Pharmaceutical Services) (Wales) Regulations 2020 set out the:

- Services that are to be covered by the pharmaceutical needs assessment,
- Information that must be included in the pharmaceutical needs assessment (it should be noted that health boards are free to include any other information that they feel is relevant),

- Date by which health boards must publish their first pharmaceutical needs assessment,
- Requirement on health boards to publish further pharmaceutical needs assessments on a five yearly basis,
- Requirement to publish a revised assessment sooner than on a five yearly basis in certain circumstances,
- Requirement to publish supplementary statements in certain circumstances
- Requirement to consult with certain people and organisations at least once during the production of the pharmaceutical needs assessment, for at least 60 days, and
- Matters the health board is to have regard to when producing its pharmaceutical needs assessment.

Once a health board has published its first pharmaceutical needs assessment it is required to produce a revised pharmaceutical needs assessment within five years or sooner if it identifies changes to the need for pharmaceutical services which are of a significant extent. The only exception to this is where the health board is satisfied that producing a revised pharmaceutical needs assessment would be a disproportionate response to those changes.

In addition, a health board may publish a supplementary statement where it identifies changes to the availability of pharmaceutical services which are relevant to the granting of applications referred to in Section 83 of the 2006 Act, and

- It is satisfied that making a revised assessment would be a disproportionate response to those changes, or
- It is in the course of making a revised assessment and is satisfied that immediate modification of its pharmaceutical needs assessment is essential in order to prevent detriment to the provision of pharmaceutical services in its area.

Developing the detailed requirements

A working group was established in November 2015 to develop the detailed requirements for conducting a pharmaceutical needs assessment and to review and amend the tests and procedures as they apply to the provision of NHS pharmaceutical services. The group, which met on a number of occasions, consisted health board pharmacy leads with knowledge of the previous control of entry system and expertise in community pharmacy, NHS Shared Services Partnership primary care (pharmacy) leads, who have expertise in the process of determining control of entry applications, and Welsh Government staff. The group made a significant contribution to the development of Welsh Government's policy on pharmaceutical needs assessments, including the resultant proposals contained within the NHS (Pharmaceutical Services) (Wales) Regulations 2020.

Review of the NHS (Pharmaceutical Services) (Wales) Regulations 2020

From May to July 2024 Welsh Government undertook a review of the regulations to evaluate the introduction of pharmaceutical needs assessments in order to assess

whether their introduction is working as intended and to identify any unintended consequences of the policy.

Appendix B – essential services

1. Dispensing of prescriptions

Service description

The supply of medicines and appliances ordered on NHS prescriptions, together with information and advice, to enable safe and effective use by patients, and maintenance of appropriate records.

Aims and intended outcomes

To ensure patients receive ordered medicines and appliances safely and appropriately by the pharmacy:

- Performing appropriate legal, clinical and accuracy checks
- Having safe systems of operation, in line with clinical governance requirements
- Having systems in place to guarantee the integrity of products supplied
- Maintaining a record of all medicines and appliances supplied which can be used to assist future patient care
- Maintaining a record of advice given, and interventions and referrals made, where the pharmacist judges it to be clinically appropriate.

To ensure patients are able to use their medicines and appliances effectively by pharmacy staff:

- Providing information and advice to the patient or their representative on the safe use of their medicine or appliance
- Providing when appropriate broader advice to the patient on the medicine, for example its possible side effects and significant interactions with other substances.

2. Dispensing of repeatable prescriptions

Service description

The management and dispensing of repeatable NHS prescriptions for medicines and appliances in partnership with the patient and the prescriber.

This service includes requirements additional to those for dispensing, such that the pharmacist ascertains the patient's need for a repeat supply and communicates any clinically significant issues to the prescriber.

Aims and intended outcomes

- To increase patient choice and convenience, by allowing them to obtain their regular prescribed medicines and appliances directly from a community pharmacy for a period agreed by the prescriber

- To minimise wastage by reducing the number of medicines and appliances dispensed which are not required by the patient
- To reduce the workload of general medical practices, by lowering the burden of managing repeat prescriptions.

3. Disposal of unwanted drugs

Service description

Acceptance by community pharmacies, of unwanted medicines which require safe disposal from private households and people living in a residential care home. The health board is required to arrange for the collection and disposal of waste medicines from pharmacies.

Aims and intended outcomes

- To ensure the public has an easy method of safely disposing of unwanted medicines
- To reduce the volume of stored unwanted medicines in people's homes by providing a route for disposal thus reducing the risk of accidental poisonings in the home and diversion of medicines to other people not authorised to possess them
- To reduce the risk of exposing the public to unwanted medicines which have been disposed of by non-secure methods
- To reduce environmental damage caused by the inappropriate disposal methods for unwanted medicines.

4. Promotion of healthy lifestyles

Service description

The provision of opportunistic healthy lifestyle and public health advice to patients receiving prescriptions who appear to be suffering from, or at risk of development, an adverse health issue and pro-active participation in national/local campaigns, to promote public health messages to general pharmacy visitors during specific targeted campaign periods

Aims and intended outcomes

- To increase patient and public knowledge and understanding of key healthy lifestyle and public health messages so they are empowered to take actions which will improve their health.
- To target the 'hard to reach' sectors of the population who are not frequently exposed to health promotion activities in other parts of the health or social care sector.

5. Signposting

Service description

The provision of information to people visiting the pharmacy, who require further support, advice or treatment which cannot be provided by the pharmacy but is available from other health and social care providers or support organisations who may be able to assist the person. Where appropriate, this may take the form of a referral.

Aims and intended outcomes

- To inform or advise people who require assistance, which cannot be provided by the pharmacy, of other appropriate health and social care providers or support organisations
- To enable people to contact and/or access further care and support appropriate to their needs
- To minimise inappropriate use of health and social care services.

6. Support for self-care

Service description

The provision of advice and support by pharmacy staff to enable people to derive maximum benefit from caring for themselves or their families.

Aims and intended outcomes

- To enhance access and choice for people who wish to care for themselves or their families
- People, including carers, are provided with appropriate advice to help them self-manage a self-limiting or long-term condition, including advice on the selection and use of any appropriate medicines
- People, including carers, are opportunistically provided with health promotion advice when appropriate, in line with the advice provided in essential service – promotion of healthy lifestyles service
- People, including carers, are better able to care for themselves or manage a condition both immediately and in the future, by being more knowledgeable about the treatment options they have, including non-pharmacological ones
- To minimise inappropriate use of health and social care services.

Appendix C – national community pharmacy and appliance contractor services

1. The clinical community pharmacy service

Service description

The clinical community pharmacy service comprises three components.

- A common ailments service,
- An urgent contraception service, and
- An emergency medicine supply service.

In order to provide the service, pharmacy contractors must provide all three components.

Aims and intended outcomes

- To deliver prudent healthcare using a ‘community pharmacy first’ model of care, for patients who can be appropriately managed in the community pharmacy setting, thereby increasing access to timely care from an appropriate healthcare professional.
- To help tackle health inequalities through increasing access (both temporally and geographically) to services that meet patient need for unplanned care, contraception, or advice on sexually transmitted infections.

Common ailments service

Under this service, patients register with the pharmacy of their choice in order to receive advice and treatment on a specified list of common ailments which includes urinary tract infection and sore throat. This may include the supply of one or more medicines listed on the national formulary.

Contraception service

This service is for patients aged 13 to 54 years old, are of childbearing potential and either:

- have had unprotected sexual intercourse in the past five days, or
- wish to QuickStart contraception using a progestogen-only contraceptive.

Where the patient is aged 13, 14 or 15 years old the service will be offered in accordance with Gillick competence, Fraser guidance and any guidance issued by the Welsh Government in relation to the provision of confidential sexual health advice and/or treatment for patients aged 13 years or over.

Where assessment determines that it is appropriate to supply emergency contraception, the relevant medicine will be supplied via a patient group direction for immediate consumption on the premises.

Emergency medicines supply

This service will normally only be provided where the pharmacy contractor believes that it would not be practicable for the patient to obtain the previously prescribed medicines they require in a clinically appropriate timeframe via the usual route.

In order to make a supply, the pharmacy contractor must interview the patient and be satisfied that:

- that there is an immediate need for the medicine supplied, and
- that it is impracticable to obtain a prescription without undue delay; and
- that treatment with the medicine has on a previous occasion been prescribed by a relevant prescriber for the person requesting it; and
- as to the dose which in the circumstances it would be appropriate for that person to take.

2. Discharge medicines review service

Service description

The discharge medicines review service will provide support to patients recently discharged between care settings by ensuring that changes to patients' medicines made in one care setting (eg during a hospital admission) are enacted as intended in the community helping to reduce the risk of preventable medicines related problems and supporting adherence with newly prescribed medication.

The service comprises two stages.

- The first stage requires the pharmacist or pharmacy technician at the pharmacy to check the medicines prescribed in one care setting match those prescribed by the patient's GP or relevant primary care team when the patient moves to another care setting, which may be their home. If there are any discrepancies these are raised with the GP practice, relevant primary care team, care setting patient or carer as applicable.
- The second stage provides an opportunity for the patient to have a discussion with a pharmacist and/or pharmacy technician to establish a picture of the patient's use of their medicines or onward referral to an appropriate setting for further review. The review will also help patients understand their medicines and will identify any problems they are experiencing along with possible solutions.

Aims and intended outcomes

The underlying purpose of this service is, with the patient's agreement, to contribute to a reduction in risk of medication errors and adverse drug events by, in particular –

- Increasing the availability of accurate information about a patient's medicines,
- Improving communication between healthcare professionals and others involved in the transfer of patient care, and patients and their carers,

- Increasing patient involvement in their own care by helping them to develop a better understanding of their medicines, and
- Reducing the likelihood of unnecessary or duplicated prescriptions being dispensed and reducing wastage of medicines.

3. Pharmacist independent prescribing service

Service description

Any pharmacy contractor wishing to provide this service must also be providing the clinical community pharmacy service. It comprises three components:

- The prescribing of routine contraception,
- The management of common ailments, not normally managed by the national common ailment service, and
- The provision of a prescribing service agreed by the relevant local health board.

Aims and intended outcomes

The underlying purposes of this service are:

- to provide access to prescription only medicines for the treatment of common ailments that require treatment with prescription only medicines that are not available under the clinical community pharmacy service,
- to provide access to emergency or regular contraception where those needs cannot be met under the clinical community pharmacy service; and
- for the provision of any other service which the pharmacy contractor agrees with the relevant local health board to provide.

4. Seasonal influenza vaccination service

Service description

Any pharmacy contractor wishing to provide this service must also be providing the clinical community pharmacy service.

Aims and intended outcomes

The underlying purpose of the service is for the registered pharmacist or pharmacy technician to administer an influenza vaccination to a patient under a patient group direction or administer an influenza vaccination to a patient under a protocol authorised by the Welsh Ministers in accordance with regulation 247A of the Human Medicines Regulations 2012 (Protocols relating to coronavirus and influenza vaccinations and immunisations).

5. Stoma appliance customisation

Service description

Stoma appliance customisation is the customisation of a quantity of more than one stoma appliance, where:

- The stoma appliance to be customised is listed in Part IXC of the Drug Tariff
- The customisation involves modification to the same specification of multiple identical parts for use with an appliance; and
- Modification is based on the patient's measurement or record of those measurements and if applicable, a template.

Aims and intended outcomes

The underlying purpose of the service is to:

- Ensure the proper use and comfortable fitting of the stoma appliance by a patient; and
- Improve the duration of usage of the appliance, thereby reducing wastage of such appliances.

6. Appliance use review

Service description

An appliance use review is about helping patients use their appliances more effectively. Recommendations made to prescribers may also relate to the clinical or cost effectiveness of treatment.

Aims and intended outcomes

The underlying purpose of the service is, with the patient's agreement, to improve the patient's knowledge and use of any specified appliance by, in particular:

- Establishing the way the patient uses the specified appliance and the patient's experience of such use
- Identifying, discussing, and assisting in the resolution of poor or ineffective use of the specified appliance by the patient
- Advising the patient on the safe and appropriate storage of the specified appliance
- Advising the patient on the safe and proper disposal of the specified appliances that are used or unwanted.

7. Lateral flow test supply service

Service description

This service is only for patients who are potentially eligible for Covid-19 treatments. Under the service, pharmacy contractors make a supply of lateral flow tests to eligible patients or their representatives for the tests to be self-administered by the patient away from the pharmacy.

Aims and intended outcomes

To offer access to lateral flow tests for patients who have a health condition that makes them eligible for Covid-19 treatment, to enable testing at home for Covid-19, following symptoms of infection. A positive lateral flow test result will be used to inform a clinical assessment to determine whether the patient is suitable for and will benefit from NICE recommended Covid-19 treatments.

Appendix D – additional clinical services

1. An anticoagulant monitoring service, the underlying purpose of which is for the pharmacy contractor to test the patient's blood clotting time, review the results and adjust (or recommend adjustment to) the anticoagulant dose accordingly.

2. A care home service, the underlying purpose of which is for the pharmacy contractor to provide advice and support to residents and staff in a care home relating to—

- The proper and effective ordering of drugs and appliances for the benefit of residents in the care home
- The clinical and cost effective use of drugs
- The proper and effective administration of drugs and appliances in the care home
- The safe and appropriate storage and handling of drugs and appliances, and
- The recording of drugs and appliances ordered, handled, administered, stored, or disposed of.

3. A disease specific management service, the underlying purpose of which is for the pharmacy contractor to advise on, support and monitor the treatment of patients with specified conditions, and where appropriate to refer the patient to another health care professional.

4. An emergency pandemic treatment and prophylaxis supply service-

- The underlying purpose of which is for the pharmacy contractor to administer a vaccination to a patient under a patient group direction or protocol authorised by the Welsh Ministers in accordance with regulation 247A of the Human Medicines Regulations 2012 (Protocols relating to coronavirus and influenza vaccinations and immunisations), and
- If a pharmacy contractor arranges to provide this service, it must provide it for the duration of the arrangement it has agreed with the local health board.

5. An emergency pandemic vaccination service-

- The underlying purpose of which is for the pharmacy contractor to administer a vaccination to a patient under a patient group direction or protocol authorised by the Welsh Ministers in accordance with regulation 247A of the Human Medicines Regulations 2012 (Protocols relating to coronavirus and influenza vaccinations and immunisations), and
- If a pharmacy contractor arranges to provide this service, it must provide it for the duration of the arrangement it has agreed with the local health board.

6. A gluten free food supply service, the underlying purpose of which is for the pharmacy contractor to supply gluten free foods to patients.

7. A home delivery service, the underlying purpose of which is for the pharmacy contractor to deliver to patients' homes-

- Drugs, and
- Appliances, other than specified appliances within the meaning of regulation 2(1) of the NHS (Pharmaceutical Services) (Wales) Regulations 2020.

8. A language access service, the underlying purpose of which is for the pharmacy contractor to provide, either orally or in writing, advice and support to patients in a language understood by them relating to—

- Drugs which they are using
- Their health,
- General health matters relevant to them, and
- where appropriate referral to another health care professional.

9. A medication review service, the underlying purpose of which is for the pharmacy contractor to —

- Conduct a review of the drugs used by a patient on the basis of information and test results included in the patient's patient care record, with the objective of considering the continued appropriateness and effectiveness of the drugs for the patient,
- Advise and support the patient regarding the use of their drugs, including encouraging the active participation of the patient in decision making relating to their use of drugs, and
- Where appropriate, to refer the patient to another health care professional.

10. A medicines assessment and compliance support service, the underlying purpose of which is for the pharmacy contractor to —

- Assess the knowledge of, compliance with, and use of, drugs by vulnerable patients and patients with additional learning needs, and
- Offer advice, support and assistance to vulnerable patients and patients with additional learning needs regarding the use of drugs with a view to improving their knowledge of, compliance with, and use of, such drugs.

11. A needle and syringe supply service, the underlying purpose of which is for the pharmacy contractor to —

- Provide sterile needles, syringes, and associated materials to drug misusers
- Receive from drug misusers used needles, syringes, and associated materials, and
- Offer advice to drug misusers and where appropriate refer the drug misuser to another health care professional or a specialist drug treatment centre.

12. An on demand availability of specialist drugs service, the underlying purpose of which is for the pharmacy contractor to ensure that patients or health care professionals have prompt access to specialist drugs.

13. Out of hours services, the underlying purpose of which is for the pharmacy contractor to dispense drugs and appliances in the out of hours period (whether or not for the whole of the out of hours period).

14. A patient group direction service, the underlying purpose of which is for the pharmacy contractor to supply or administer prescription only medicines to patients under patient group directions.

15. A prescriber support service, the underlying purpose of which is for the pharmacy contractor to support health care professionals who prescribe drugs, and in particular to offer advice on—

- The clinical and cost effective use of drugs
- Prescribing policies and guidelines, and
- Repeat prescribing.

16. A schools service, the underlying purpose of which is for the pharmacy contractor to provide advice and support to children and staff in schools relating to—

- The clinical and cost effective use of drugs in the school
- The proper and effective administration and use of drugs and appliances in the school
- The safe and appropriate storage and handling of drugs and appliances, and
- The recording of drugs and appliances ordered, handled, administered, stored, or disposed of.

17. A screening service, the underlying purpose of which is for the pharmacy contractor to —

- Identify patients at risk of developing a specified disease or condition
- Offer advice regarding testing for a specified disease or condition
- Carry out such a test with the patient's consent, and
- Offer advice following a test and refer to another health care professional as appropriate.

18. A stop smoking service, the underlying purpose of which is for the pharmacy contractor to—

- Advise and support patients wishing to give up smoking, and
- Where appropriate, to supply appropriate drugs and aids.

19. A supervised administration service, the underlying purpose of which is for the pharmacy contractor to supervise the administration of prescribed medicines at their premises.

20. A prescribing service, the underlying purpose of which is for the pharmacy contractor who is an independent prescriber, or who employs or engages an

independent prescriber, to prescribe medicines in circumstances specified by the relevant local health board.

21. An antiviral collection service, the underlying purpose of which is for the pharmacy contractor to supply antiviral medicines, in accordance with regulation 247 of the Human Medicines Regulations 2012 (Exemption for supply in the event of or in anticipation of pandemic disease), to patients for treatment or prophylaxis.

22. A waste minimisation service, the underlying purpose of which is to identify prescribed medicines or appliances which are not required by the patient at the point of supply.

Appendix E – terms of service for dispensing appliance contractors

1. Dispensing of prescriptions

Service description

The supply of appliances ordered on NHS prescriptions, together with information and advice and appropriate referral arrangements in the event of a supply being unable to be made, to enable safe and effective use by patients, and maintenance of appropriate records.

Aims and intended outcomes

To ensure patients receive ordered appliances safely and appropriately by the dispensing appliance contractor:

- Performing appropriate legal, clinical and accuracy checks
- Having safe systems of operation, in line with clinical governance requirements
- Having systems in place to guarantee the integrity of products supplied
- Maintaining a record of all appliances supplied which can be used to assist future patient care
- Maintaining a record of advice given, and interventions and referrals made, where the dispensing appliance contractor judges it to be clinically appropriate
- Providing the appropriate additional items such as disposable bags and wipes
- Delivering the appropriate items if required to do so in a timely manner and in suitable packaging that is discreet.

To ensure patients are able to use their appliances effectively by staff providing information and advice to the patient or carer on the safe use of their appliance(s).

2. Dispensing of repeatable prescriptions

Service description

The management and dispensing of repeatable NHS prescriptions appliances in partnership with the patient and the prescriber.

This service includes the requirements that are additional to those for dispensing, such that the dispensing appliance contractor ascertains the patient's need for a repeat supply and communicates any clinically significant issues to the prescriber.

Aims and intended outcomes

- To increase patient choice and convenience, by allowing them to obtain their regular prescribed appliances directly from a dispensing appliance contractor for a period agreed by the prescriber
- To minimise wastage by reducing the number of appliances dispensed which are not required by the patient

- To reduce the workload of GP practices, by lowering the burden of managing repeat prescriptions.

3. Home delivery service

Service description

To provide a home delivery service in respect of certain appliances.

Aims and intended outcomes

To preserve the dignity of patients by ensuring that certain appliances are delivered:

- With reasonable promptness, at a time agree with the patient
- In a package that displays no writing or other markings which could indicate its content; and
- In such a way that it is not possible to identify the type of appliance that is being delivered.

4. Supply of appropriate supplementary items

Service description

The provision of additional items such as disposable wipes and disposal bags in connection with certain appliances.

Aims and intended outcomes

To ensure that patients have a sufficient supply of wipes for use with their appliance and are able to dispose of them in a safe and hygienic way.

5. Provide expert clinical advice regarding the appliances

Service description

The provision of expert clinical advice by a suitably trained person who has relevant experience in respect of certain appliances.

Aims and intended outcomes

To ensure that patients are able to seek appropriate advice on their appliance to increase their confidence in choosing an appliance that suits their needs as well as gaining confidence to adjust to the changes in their life and learning to manage an appliance.

6. Where a telephone care line is provided, during the period when the dispensing appliance contractor is closed, advice is either to be provided via the care line or callers are directed to NHS Direct Wales

Service description

Provision of advice on certain appliances via a telephone care line outside of the dispensing appliance contractor's contracted opening hours. The dispensing appliance contractor is not required to staff the care line all day, every day, but when it is not staffed callers must be given a telephone number or website contact details for NHS Direct Wales who may be consulted for advice.

Aims and intended outcomes

Callers to the telephone care line are able to access advice 24 hours a day, seven days a week on certain appliances in order to manage their appliance.

7. Signposting

Service description

Where a patient presents a prescription for an appliance which the dispensing appliance contractor does not supply the prescription is either:

- With the consent of the patient, passed to another provider of appliances, or
- If the patient does not consent, they are given contact details for at least two other contractors who are able to dispense it.

Aims and intended outcomes

To ensure that patients are able to have their prescription dispensed.

Appendix F – pharmaceutical needs assessment steering group membership

Role	Organisation
Associate director primary care	Betsi Cadwaladr University Health Board
Chief finance officer	Betsi Cadwaladr University Health Board
Head of engagement	Betsi Cadwaladr University Health Board
Head of health strategy and planning	Betsi Cadwaladr University Health Board
Head of pharmacy primary care and community services (Central)	Betsi Cadwaladr University Health Board
Head of primary care contracting	Betsi Cadwaladr University Health Board
Project support	Betsi Cadwaladr University Health Board
Senior cluster co-ordinator	Betsi Cadwaladr University Health Board
Senior public health practitioner	Betsi Cadwaladr University Health Board
Strategic lead for community pharmacy	Betsi Cadwaladr University Health Board
Associate director contractor engagement	Community Pharmacy Wales
Welsh representative, director	Dispensing Doctors' Association
Head of engagement and complaints advocacy	Llais
Head of service North Wales GP out of hours service	North Wales GP out of hours service
Deputy chair	North Wales Local Medical Committee

Appendix G – patient and public engagement questionnaire

We are inviting you to tell us about pharmacy services in your area.

The services we are looking at include local services that you receive from pharmacies (or chemists). To do a good job, we need to regularly review what services we have, what our local people need, and how things might change in the future. This process is called a 'pharmaceutical needs assessment' or PNA and we are preparing our second one for the area covered by Betsi Cadwaladr University Health Board with the help of a company called Primary Care Commissioning Community Interest Company (PCC) who specialise in this kind of work. The feedback you provide will be shared with PCC but will only be used for the purpose of this survey and developing the PNA. Any personal data you provide will be held in accordance with our privacy policy.

Many people call them chemists but in this questionnaire, we use the word pharmacy. By a pharmacy, we mean a place you would use to get a prescription dispensed, buy medicines which you can only buy from a pharmacy, or to talk to a pharmacist for advice about an illness that you may have or medicines that you take. We don't mean the pharmacy at a hospital or the part of a pharmacy where you buy beauty products or any shops where you can buy medicines.

Some people are given their medicines by their doctor's surgery instead of being given a prescription to take to a pharmacy, or having their prescription sent to a pharmacy, and collecting their medicines from the pharmacy. Staff at the doctor's surgery will dispense the medicines and have them ready for collection. If your doctor's surgery gives you your medicines, we would like your views on that service. You may use a pharmacy for other services and so you may wish to complete the questions about using a pharmacy.

Your views are important to us so please spare some time to complete this questionnaire. We anticipate it will take you around five to 15 minutes to complete, depending on how much additional information you would like to give us.

We really would like and value your input, but if you don't want to take part, please just ignore this questionnaire; your decision will not affect the care you receive from the NHS or your pharmacy or doctor's surgery in any way.

The questionnaire is anonymous; please do not give your name and address. Any information you do give will not be linked to you.

The results of our questionnaire will be published in the draft pharmaceutical needs assessment and a 60-day consultation on that document will take place in the summer. Please keep an eye on our website and social media pages for further details.

If you would like more information about the questionnaire or have questions on how to complete it, please email BCU.GetInvolved@wales.nhs.uk with "PNA questionnaire" in the subject header.

If you would like to complete this questionnaire in Welsh, please click here.

About you

Please tell us your postcode.

By providing us with the first four digits of your postcode, you are consenting for us to use this information to understand which part of North Wales you live in. This information will only be used for the purposes of this questionnaire so that we can identify whether we have received responses from across North Wales or from particular areas. Please do not provide us with your full postcode.

For example, if your postcode is LL17 0JG just type LL17 in the box below.

The Welsh Language Standards are a set of statutory requirements which are relevant to the health board. They state clearly our responsibilities to provide bilingual services to patients and the public. Please could you therefore tell us your preferred language when you access services at a pharmacy or GP practice?

- Welsh
- English
- Other (as this is an anonymous questionnaire, please do not include any information that would identify yourself or any other individual) [text box]

Do you collect your medicines from:

- a pharmacy
- your doctor's surgery

Collecting your medicines from your doctor's surgery

The area in your doctor's surgery where staff dispense your prescriptions is called a dispensary.

1. What time is the most convenient for you to use your doctor's dispensary?

- 8am to 12pm
- 12pm to 2.30pm
- 2.30pm to 6.30pm
- I don't have a preference

2. What day is the most convenient for you to use your doctor's dispensary?

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday

- Weekdays in general
- I don’t have a preference

3. Has there been a time recently when you were not able to use your doctor’s dispensary?

- Yes – please go to question 4
- No – please go to question 5
- Not applicable - please go to question 5

4. If you answered ‘yes’ to question 3, can you tell us what you did? Please tick all statements that apply.

- I went to a pharmacy
- I waited until the dispensary was open
- I went to A&E/casualty
- I went to a minor injury unit
- I called NHS 111 Wales
- Other [text box]

Travelling to your doctor’s surgery for your medicines

5. How do you usually get to your surgery to pick up your medicines?

- On foot
- By bus
- By car
- By bike
- By taxi
- By mobility scooter
- Other [text box]
- Not applicable - please go to question 7

6. ...and how long does it usually take to get there?

- Less than 5 minutes
- Between 5 and 15 minutes
- More than 15 minutes but less than 20 minutes
- 20 minutes or more

7. Would you say that you have difficulty in getting to the dispensary at your doctor’s surgery?

- Yes
- No - please go to question 9
- Not applicable - please go to question 9

8. If you have difficulty getting to the dispensary at your doctor's surgery please tell us why. As this is an anonymous questionnaire, please do not include any information that would identify yourself or anyone else.

[Text box]

9. Is there anything else you would like to tell us about your experience of the dispensary at your doctor's surgery? As this is an anonymous questionnaire, please do not include any information that would identify yourself or anyone else

[Text box]

10. Are there any barriers to you accessing services at your doctor's dispensary that you have not mentioned? As this is an anonymous questionnaire, please do not include any information that would identify yourself or anyone else.

[Text box]

11. Do you also use a pharmacy?

- Yes
- No

How you use your pharmacy - either in person or by having someone else go there for you

12. Why do you usually visit a pharmacy? Please tick any or all that apply.

- To get a prescription for myself
- To buy medicines for myself
- To get advice for myself
- To get a prescription for someone else
- To buy medicines for someone else
- To get advice for someone else
- I don't visit a pharmacy as I use an online/internet pharmacy
- I don't go to a pharmacy; someone goes on my behalf
- Other (as this is an anonymous questionnaire, please do not include any information that would identify yourself or any other individual) [text box]

13. How often do you use a pharmacy?

- Daily
- Weekly
- Fortnightly
- Monthly/every four weeks
- Quarterly
- As and when
- I don't use a pharmacy

- Other (as this is an anonymous questionnaire, please do not include any information that would identify yourself or any other individual) [text box]

14. What time is the most convenient for you to use a pharmacy?

- Before 7 am
- 7am to 9am
- 9am to 12 noon
- 12 noon to 3pm
- 3pm to 6pm
- 6pm to 9pm
- 9pm to midnight
- I don’t have a preference

15. What day is the most convenient for you to use a pharmacy?

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday
- Sunday
- Weekdays in general
- Weekends in general
- I don’t have a preference

16. Has there been a time recently when you were not able to use your normal pharmacy?

- Yes
- No
- Not applicable

17. If you answered ‘yes’ to question 16, can you tell us what you did? Please tick all statements that apply.

- I went to another pharmacy
- I waited until the pharmacy was open
- I went to my GP
- I went to the general hospital
- I went to a minor injury unit
- I contacted the GP Out of Hours (OOH) service
- I called NHS Direct Wales or NHS 111 Wales
- Other (as this is an anonymous questionnaire, please do not include any information that would identify yourself or any other individual) [text box]

Your choice of pharmacy

18. Please could you tell us whether you:

- Always use the same pharmacy
- Use different pharmacies but I prefer to visit one most often
- Always use different pharmacies
- Rarely use a pharmacy
- Never use a pharmacy

19. We would like to know what influences your choice of pharmacy. Please could you tell us why you use this pharmacy? Please tick all the statements that apply to you.

- Close to my home
- Close to where I work
- Close to my doctor
- Close to children's school or nursery
- Close to other shops
- The pharmacy delivers my medicines
- The location of the pharmacy is easy to get to
- It is easy to park at the pharmacy
- I just like the pharmacy
- I can speak to the staff in my preferred language
- I trust the staff who work there
- The staff know me and look after me
- The staff don't know me
- I've always used this pharmacy
- The service is quick
- They usually have what I need in stock
- The pharmacy has good opening hours
- The pharmacy collects my prescription and delivers my medicines
- The pharmacy was recommended to me
- The pharmacy provides good advice & information
- The customer service
- It is very accessible i.e. wheelchair/baby buggy friendly
- It's a well-known big chain
- It's not one of the big chains
- There is a private area if I need to talk to the pharmacist
- It's an online/internet pharmacy
- It's not an online/internet pharmacy and so I can visit it and talk to the staff face-to-face
- I can order my repeat medicines using their app
- Other (as this is an anonymous questionnaire, please do not include any information that would identify yourself or any other individual) [text box]

20. Is there a more convenient and/or closer pharmacy that you don't use?

- Yes
- No (go to question 22)
- Don’t know (go to question 22)

21. ...and if you have answered yes to question 20, please could you tell us why you do not use that pharmacy?

- It is not easy to park at the pharmacy
- I have had a bad experience in the past
- The service is too slow
- The staff are always changing
- The staff don’t know me
- I know the staff and would prefer them not to know what medicines I am taking
- They don’t have what I need in stock
- The pharmacy does not deliver medicines
- There is not enough privacy
- It’s not open when I need it
- It’s not wheelchair/baby buggy friendly
- Other (as this is an anonymous questionnaire, please do not include any information that would identify yourself or any other individual) [text box]

Travelling to a pharmacy

22. If you go to the pharmacy by yourself or with someone, how do you usually get there?

- On foot
- By bus
- By car
- By bike
- By taxi
- By mobility scooter
- Other (as this is an anonymous questionnaire, please do not include any information that would identify yourself or any other individual) [insert text box]

23. ...and how long does it usually take to get there?

- Less than 5 minutes
- Between 5 and 15 minutes
- More than 15 minutes but less than 20 minutes
- More than 20 minutes

24. Would you say that you have difficulty in getting to a pharmacy?

- Yes
- No

25. If you have difficulty getting to a pharmacy please tell us why. As this is an anonymous questionnaire, please do not include any information that would identify yourself or any other individual.

[Text box]

Pharmacy services in general

26. We would like to know how you find out information about a pharmacy such as opening times or the service being offered. Please tick any or all that apply.

- I would call them
- I would call NHS 111 Wales or use its website
- I would search the internet
- I would use social media
- I would ask a friend
- I would just pop in and ask them
- I would look in the window
- I would find out from reading the local newspaper or magazine
- Not applicable
- Other (as this is an anonymous questionnaire, please do not include any information that would identify yourself or any other individual) [text box]

27. Do you feel able to discuss something private with your pharmacist?

- Yes
- No
- Never needed to
- Don’t know

28. Are you aware that you may be able to access the following services from pharmacies as part of the NHS? Please select those that you are aware of.

- Flu vaccinations (for those who are in one of the at risk groups)
- Discharge medicines review service – this service is for people whose medicines have changed during a hospital stay, to help them understand the changes that have been made and to make sure future prescriptions are for the right medicines.
- Appliance use review service - this is an opportunity to discuss appliances such as those for stomas and colostomies with a pharmacist or a specialist nurse to ensure your appliances are doing what you need them to do.
- Emergency hormonal contraception, also referred to as the ‘morning after pill’
- Help to stop smoking
- Common ailments scheme – pharmacists can provide you with advice and free treatment for common minor illnesses and ailments so that you do not need to see a GP.

29. Is there anything else you would like to tell us about your experience of your local pharmacy? As this is an anonymous questionnaire, please do not include any information that would identify yourself or any other individual.

[Text box]

30. Are there any barriers to you accessing services at your pharmacy that you have not mentioned? As this is an anonymous questionnaire, please do not include any information that would identify yourself or any other individual.

[Text box]

Equality monitoring

The information you provide in answer to this set of questions which are about you as a person will help us to better understand and analyse the range of response we get; they will not be used for any other purposes.

The information is collected anonymously and cannot be used to identify you personally.

Please help us by completing this as fully as you feel able. This is a purely voluntary submission; you do not have to provide an answer to any questions.

Ethnic group: what is your ethnic group?

Choose one option that best describes your ethnic group or background.

White

- British
- English
- Northern Irish
- Scottish
- Welsh
- Irish
- Gypsy or Irish Traveller
- Prefer not to say
- Other (please specify): [Text box]

Mixed/Mixed British

- White/Black Caribbean
- White/Black African
- White/Asian
- Any other Mixed background

Black/Black British

- Caribbean
- African
- Any other Black Background

Asian/Asian British

- Indian
- Bangladeshi
- Pakistan
- Chinese
- Asian other

Other/Other British

- Arab
- Prefer not to say
- Other (state if required) [Text box]

Age: please indicate your age by ticking the appropriate box.

- 0 -15 years
- 16 – 24 years
- 25 – 34 years
- 35 – 44 years
- 45 – 54 years
- 55 – 64 years
- 65 – 74 years
- 75 and above

What do you consider to be your first language?

- Welsh
- English
- Other, please state: [Text box]

How would you best describe your employment status?

- Employed - full time
- Employed - part time
- Unemployed
- Retired

Sex:

- Male
- Female
- Prefer not to say
- Other

Sexual orientation: which of the following options best describes how you think of yourself?

- Heterosexual/straight
- Gay man
- Gay woman/lesbian
- Bisexual

- Prefer not to say
- Other (please specify):

Religion or belief: what is your religion?

- Christian (all denominations)
- No religion
- Buddhist
- Muslim
- Jewish
- Hindu
- Sikh
- Prefer not to say
- Other (please specify):

Marital status: are you married or in a same-sex civil partnership?

- Yes
- No
- Prefer not to say

Disabled: Section 6(1) of the Equality Act 2010 states that a person has a disability if:

a) **That person has a physical or mental impairment, and**
b) **The impairment has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.**

Using this definition do you consider yourself to be disabled?

- Yes
- No
- Prefer not to say

Gender identity: has your gender identity changed from that assigned at birth?

- Yes
- No
- Prefer not to say

Caring responsibilities: o you look after or give help or support to family members, friends, neighbours or others because of either:

a) **Long term physical or mental ill-health/disability; or**
b) **Problems related to old age**

- Yes
- No
- Prefer not to say

Betsi Cadwaladr University Health Board aims to promote equality in everything we do, please let us know below if you have any comments (positive or negative) in relation to your protected characteristics (such as issues relating to age, disability,

race, pregnancy, religion, marriage/civil partnership, gender, sexual orientation and gender reassignment).

[Text box]

Appendix H – full results of the patient and public questionnaire

Please note that all responses are verbatim and have not been edited other than to anonymise pharmacies, GP practices and locations.

Postcode of responders	Number of responses
CH5	1
CH6	3
CH7	8
CH73	1
CH8	2
LL11	5
LL12	3
LI13	3
LL13	1
LL14	2
LL16	2
LL16	2
LL18	12
LL19	3
LL21	1
LL22	6
LL26	1
LL27	1
LL28	2
LL29	6
LL30	5
LL31	5
LL32	7
LL33	3
LL36	2
LL40	1
LL41	1
LL45	2
LL46	1
LL52	1
LL53	1
LL53	1
LL54	1
LL55	5
LL57	4
LL58	1
LL59	2
LL60	3
LL63	1

LL64	1
LL65	3
LL65	1
LL67	1
LL77	5
Chose not to provide	3

The Welsh Language Standards are a set of statutory requirements which are relevant to the health board. They state clearly our responsibilities to provide bilingual services to patients and the public. Please could you therefore tell us your preferred language when you access services at a pharmacy or GP practice?

Answer options	Number of responses
Welsh	15
English	109
Other	1
Chose not to answer	1

The person who selected “Other” did not expand upon their answer.

Do you collect your medicines from:

Answer options	Number of responses
A pharmacy	116
My doctor’s surgery	10

The following questions were answered by those who collect their medicines from their doctor’s surgery.

What time is the most convenient for you to use your doctor’s dispensary?

Answer options	Number of responses
8am to 12pm	0
12pm to 2.30pm	1
2.30pm to 6.30pm	2
I don’t have a preference	7

What day is the most convenient for you to use your doctor’s dispensary?

Answer options	Number of responses
Monday	0
Tuesday	0
Wednesday	1
Thursday	2
Friday	1
Weekdays in general	2
I don’t have a preference	4

Has there been a time recently when you were not able to use your doctor's dispensary?

Answer options	Number of responses
Yes	2
No	7
Not applicable	1

Can you tell us what you did? Please tick all statements that apply.

Answer options	Number of responses
I went to a pharmacy	1
I waited until the dispensary was open	1

How do you usually get to your surgery to pick up your medicines?

Answer options	Number of responses
On foot	0
By bus	0
By car	10
By bike	0
By taxi	0
By mobility scooter	0

...and how long does it usually take to get there?

Answer options	Number of responses
Less than five minutes	2
Between five and 15 minutes	5
More than 15 minutes but less than 20 minutes	1
More than 20 minutes	2

Would you say that you have difficulty in getting to the dispensary at your doctor's surgery?

Answer options	Number of responses
Yes	1
No	9
Not applicable	0

If you have difficulty getting to the dispensary at your doctor's surgery, please tell us why.

- Work full time so always have to get a family member to collect my repeat prescription

Is there anything else you would like to tell us about your experience of the dispensary at your doctor's surgery?

- Limited opening hours
- Excellent service every time
- I would prefer that registered pharmacy professionals were involved in the dispensing of my prescription.
- They go above and beyond at [practice]
- Excellent service. I'm on monthly repeat prescriptions never had any issues.
- My surgery dispensary is excellent
- They only use limited features i the NHS app
- On line ordering - efficient for repeat prescriptions. Prescription always available. Reception staff excellent and efficient. prompt
- There have been periods when no prescription medication was received in earlier months

Are there any barriers to you accessing services at your doctor's dispensary that you have not mentioned?

- Unable to collect prescriptions unless I am off work due to the hours they are open.

Do you also use a pharmacy?

Answer options	Number of responses
Yes	6
No	4

Why do you usually visit a pharmacy?

Answer options	Number of responses
To get a prescription for myself	104
To get a prescription for someone else	55
To buy medicines for myself	46
To get advice for myself	39
To buy medicines for someone else	23
To get advice for someone else	12
I don't go to a pharmacy; someone goes on my behalf	2
Other	2
I don't visit a pharmacy as I use an online/internet pharmacy	0
Chose not to answer	4

Where "Other" was selected the following additional information was provided.

- They Deliver To Me
- Collect return sharps box

How often do you use a pharmacy?

Answer options	Number of responses
Daily	0
Weekly	7
Fortnightly	14
Monthly/every four weeks	76
Quarterly	4
As and when	17
I don’t use a pharmacy	0
Other	4
Chose not to answer	4

Where “Other” was selected the following additional information was provided:

- Occasionally for advice
- 8 weeks
- Just gone to 3 months but prior to this it was monthly
- When I have to collect medication ordered from surgery.

What time is the most convenient for you to use a pharmacy?

Answer options	Number of responses
Before 7am	0
7am to 9am	3
9am to 12 noon	31
12 noon to 3pm	14
3pm to 6pm	19
6pm to 9pm	15
9pm to midnight	0
I don’t have a preference	39
Chose not to answer	5

What day is the most convenient for you to use a pharmacy?

Answer options	Number of responses
Monday	1
Tuesday	1
Wednesday	2
Thursday	4
Friday	4
Saturday	4
Sunday	0
Weekdays in general	35
Weekends in general	16
I don’t have a preference	55
Chose not to answer	4

Has there been a time recently when you were not able to use your normal pharmacy?

Answer options	Number of responses
Yes	31
No	81
Not applicable	10
Chose not to answer	4

Can you tell us what you did?

Answer options	Number of responses
I went to another pharmacy	19
I waited until the pharmacy was open	7
I went to my GP	1
I went to the general hospital	0
I went to a minor injury unit	0
I contacted the GP Out of Hours (OOH) service	1
I called NHS Direct Wales or NHS 111 Wales	3
Other	4
Chose not to answer	95

Where 'Other' was selected the following additional information was provided:

- Asked a friend
- Waited till the next day
- Other pharmacy on Sunday 2hrs away
- Was out of area (Scotland) Had to call GP surgery for an emergency prescription to be sent to Scotland.

Please could you tell us whether you:

Answer options	Number of responses
Always use the same pharmacy	99
Use different pharmacies but I prefer to visit one most often?	20
Always use different pharmacies?	2
Rarely use a pharmacy?	1
Never use a pharmacy	0
Chose not to answer	4

We would like to know what influences your choice of pharmacy. Please could you tell us why you use this pharmacy? Please tick all the statements that apply to you.

Answer options	Number of respondents
Close to my home	85
Close to my doctor	51
The location of the pharmacy is easy to get to	41
There is a private area if I need to talk to the pharmacist	37
I've always used this pharmacy	35
I trust the staff who work there	34
It is easy to park at the pharmacy	30
The staff know me and look after me	29
The customer service	27
The pharmacy provides good advice & information	26
The pharmacy has good opening hours	25
They usually have what I need in stock	24
I just like the pharmacy	21
The service is quick	20
Close to where I work	17
It's a well-known big chain	16
It's not one of the big chains	15
It's not an online/internet pharmacy and so I can visit it and talk to the staff face-to-face	12
Close to other shops	10
I can speak to the staff in my preferred language	8
I can order my repeat medicines using their app	7
Other	6
The pharmacy collects my prescription and delivers my medicines	5
The pharmacy was recommended to me	4
It is very accessible i.e. wheelchair/baby buggy friendly	3
Close to children's school or nursery	2
The pharmacy delivers my medicines	2
The staff don't know me	1
It's an online/internet pharmacy	1
Chose not to answer	4

Where "Other" was selected the following additional information was provided.

- Stop trying to make pharmacys open more hours they work harder than the surgeries
- Collection service set up
- None of the pharmacies in town open on bank holidays
- [Following a change in the provision of services], the service deteriorated. There were always queues of 20,30 mins. The staff shouted questions in front of the room, which was embarrassing and technically sometimes a data breach. I became so angry I began going to a pharmacy in the next village. It's a drive away but the staff are more courteous, there are no queues, and the

service is way better. Basically, pharmacy provision has rapidly got worse, since Brexit it seems, when some medicines were harder to get, and with issues in GP surgeries. There seem to be so many locum staff now, they don't care, they don't know the patients, they move on so aren't accountable. I want fast, discrete service close to home
- Staff are friendly and I know some.
- I can order repeat prescriptions by phone

Is there a more convenient and/or closer pharmacy that you don't use?

Answer options	Number of responses
Yes	30
No	90
Don't know	2
Chose not to answer	4

Please could you tell us why you do not use that pharmacy?

Answer options	Number of responses
The service is too slow	7
Other	6
I have had a bad experience in the past	5
It is not easy to park at the pharmacy	3
There is not enough privacy	3
They don't have what I need in stock	2
The staff don't know me	1
It's not open when I need it	1
It's not wheelchair/baby buggy friendly	1
The staff are always changing	0
I know the staff and would prefer them not to know what medicines I am taking	0
The pharmacy does not deliver medicines	0

Where "Other" was selected the following additional information was provided.

- They never have all the drugs
- My GP surgery don't use this pharmacy
- Very slow service, 2 weeks for repeat, rude pharmacist. This q needs to be multiple choice as so many reasons
- Prescription goes to other place

If you go to the pharmacy by yourself or with someone, how do you usually get there?

Answer options	Number of responses
On foot	30
By bus	5

By car	82
By bike	1
By taxi	1
By mobility scooter	1
Other	2
Chose not to answer	4

Where ‘Other’ was selected the following additional information was provided.

- Don’t visit
- Car and foot

...and how long does it usually take to get there?

Answer options	Number of responses
Less than 5 minutes	37
Between 5 and 15 minutes	71
More than 15 minutes but less than 20 minutes	7
More than 20 minutes	6
Chose not to answer	5

Would you say that you have difficulty in getting to a pharmacy?

Answer options	Number of responses
Yes	8
No	113
Chose not to answer	5

If you have difficulty getting to a pharmacy, please tell us why.

- Physical disabilities.
- I am housebound
- Parking
- I have difficulty in getting to another pharmacy
- I have ME. Sometimes I can't drive and rely on my husband
- I dont drive
- Mobility issues

We would like to know how you find out information about a pharmacy such as opening times or the service being offered. Please tick any or all that apply.

Answer options	Number of responses
I would search the internet	85
I would call them	37
I would just pop in and ask them	23
I would use social media	18
I would look in the window	15
I would call NHS 111 Wales or use its website	6
Not applicable	5
I would ask a friend	4
Other	2
I would find out from reading the local newspaper or magazine	0

Where 'Other' was selected the following additional information was provided.

- Pharmacy services are better than the surgeries
- Use the NHS website to look for services offered near me (like sore throat testing)

Do you feel able to talk about something private with your pharmacist?

Answer options	Number of responses
Yes	69
No	18
Never needed to	27
Don't know	8
Chose not to answer	4

Are you aware that you may be able to access the following services from pharmacies as part of the NHS? Please select those that you are aware of.

Answer options	Number of responses
Flu vaccinations (for those who are in one of the at risk groups)	101
Discharge medicines review service – this service is for people whose medicines have changed during a hospital stay, to help them understand the changes that have been made and to make sure future prescriptions are for the right medicines.	32
Appliance use review service - this is an opportunity to discuss appliances such as those for stomas and colostomies with a pharmacist or a specialist nurse to ensure your appliances are doing what you need them to do.	15
Emergency hormonal contraception, also referred to as the 'morning after pill'	44
Help to stop smoking	48
Common ailments scheme – pharmacists can provide you with advice and free treatment for common minor illnesses and ailments so that you do not need to see a GP.	95
Chose not to respond	16

Is there anything else you would like to tell us about your experience of your local pharmacy?

- Service is slow, not confidential. Very disorganised.
- Some pharmacists are not able to check ears
- [Name] pharmacy [location] is shocking. Staff cannot be bothered to serve the customer and would rather carry on chatting when they can clearly see a queue forming. The worst pharmacy [location]
- Does common ailments scheme but difficult to get appointment nearly as difficult as GP appointment.
- Wonderful, knowledgeable staff. Always helpful
- I feel forced to seek advise from a local pharmacy as getting a GP appointment is impossible and illnesses get worse
- Prescribing service very helpful
- The staff at [name] pharmacy in [location] are outstanding and deliver a great service at all times. [Staff] at some of the best members of staff that could work for [name] and the NHS.
- [Name] pharmacy has always been fantastic, always caring and always a great service
- Very helpful staff
- I prefer to visit my local pharmacy than to try & get an appointment with the Doctor.
- Why is the pharmacy next to WEMC not open at the weekend when the OOH is based there?

- Excellent service
- "I used to leave my repeat prescription at the pharmacy for the next month. They would send the prescription request to the Dr and then txt me when it was ready. On occasions I found it had been sent to the wrong gp. It came to a point when I was frequently without medication because of this now I keep my repeat prescription and take it to the doctors now myself.
- The time it takes to get the prescription to the chemist and the medication ready now takes more than 7 days.
- I find that if the pharmacy has not got the medication their go to excuse is to blame the gp. When you speak to the gp they state they have sent it. You end up going back and to trying to sort it out.
- On one occasion they gave me completely the wrong medication. I took it back and spoke to the manager who didn't seem really bothered. She did say she would fill in an incident form."
- I wish they were open longer on Saturdays and evenings
- They do inhaler technique review, which I think is a waste of nhs funding as this should be covered when initially prescribed and during annual reviews with respiratory nurse in the gp surgery. There are more services which are better suited to pharmacy such as ip, DMR and cas service for when you can not get into a gp.
- The parking is atrocious
- Our local pharmacy is open early to late 7 days a week and provides a good service for a wide area. I worry that the pharmacist is under strain however as sometimes get told that meds aren’t ready or the prescription hasn’t been sent but waiting for these meds could have serious issues
- Local pharmacies work harder than the local surgeries and get no support from the health board. Stop trying to dump more on them
- "I've had to change my paramancy to another one due to long waiting times.. 50mins waiting time was the last time I had to stand and wait...no explanation, no communication, by time I received my prescription there was 7 others also waiting and 5 where elderly with not even a chair to sit on...
- 3 member's of staff in a very busy establishment.
- With only one as the dispenser.
- Totally unacceptable.
- Due to this issue I have changed my prescriptions from my GP to be delivered to another paramancy."
- Current pharmacist is stored is lazy and wont speak to you without an appointment
- They are great, especially when ordering prescription milk for my little one, within a couple of days it’s ready to collect.
- No local pharmacy open on Sunday
- Absolutely wonderful service
- My local, village pharmacy [name] is excellent also the pharmacy in [location]. However [name] in [location] say they can offer a lot of services but when you get there they can't (checking ears is one of those).
- My pharmacy is very good
- Being notified prescription is ready even though they have contact number they don’t notify, prescription is never ready and often not available that day

- Always issue with stock. Waiting time for prescription to be dispensed. Lack of space.
- I have to say that the Pharmacy I use is great the staff are great and so helpful, They know me and we have good banter. If I have a problem they are very good and explain everything.
- there should be wider access to prescription deliveries. I support a lot of people in a professional capacity who struggle to access pharmacies. More pharmacists available so that I am able to speak to a pharmacist, in private not in the main area without feeling guilty or like a hinderence.
- Very helpful
- Unable to answer phone. Can be very long queues
- Repeat prescription service is inconsistent
- I can’t quite believe how it’s run. No stock, disorderly. You will drop a prescription off, go back in a couple of days and still not done. Then they’ll pay don’t have it in. Ignore you when you walk in. Appalling customer service. As usual all opening times are for the convenience of staff, not the customer.
- I have a repeat prescription for medication I will be on for the rest of my life. I put my prescription in at the doctors who then authorise it and send it across to the pharmacy. I cannot say how many times my prescription cannot be found at the pharmacy. Almost every time not all of the drugs I need are available which necessitates another walk down to the pharmacy. There is always a problem sometimes the prescription has vanished into a blackhole between the doctors and the pharmacy. I have been wholly dissatisfied with the service. If there was another pharmacy nearer that was reliable I would change.
- Staff are very helpful & always pleasant
- [Name] order my prescription monthly and text me when it arrives. It is fine when things work well, but I often have delays in receiving my monthly prescription, it is unclear where the problem lies, but it doesn't help that they rely on a courier driver to pick up and deliver prescriptions from the surgery in [location]. I often have to go back two or three times before I get my prescription which by then is late and I have run out of tablets. There needs to be a better system.
- Long waiting times to collect medication often requiring multiple visits. Medication frequently not in stock. I can’t change pharmacy as they have the best opening hours as I work full time.
- Have to wait a long for my tablets and sometimes my subscription is not tjere
- We used to have 2 branches and since we now only have one it is always busy, long waiting time and mistakes can be made
- Always very busy and often long waits to be served. Opening hours are now so restricted that I have to take time off work each month to get to the pharmacy to collect my repeat prescription.
- The service I get with a terminal illness is second to none excellent when I go there
- Long queues & back to & fro from Dr surgery as prescriptions not always correct’
- Pharmacy itself is very good. The problem I'd the attached GP surgery [name]. That's what you need to be sorting out! On more than 1 occasion a pharmacist had needed to intervene to ensure access to a repeat prescription

for critical medication which would run out but surgery wouldn't prescribe without med review but wouldn't make an appointment for a med review and we weren't lucky on the daily 10 minute lottery at 0830 to try and get an appointment

- Prescription not ordered in time for a doctors appointment which I then had to rearrange, very frustrating
- My pharmacy is a vital part of our community especially for the young and elderly and like myself those that don't drive or have any means of transport.
- Parking nearby is now charged for
- No they have been helpful
- My local pharmacy is getting worse and worse. Always long delays for medication and often left without medication due to mistakes of the staff.
- Need a regular WELSH prescribing pharmacist
- I had to ring around pharmacies to get an appointment, it would be so much better to book online. I've also experienced rudeness when trying to collect changed medication at short notice
- [Name] pharmacy are just incredible. Wonderful team, very quick to dispense. A model service
- I have excellent service from my chosen pharmacy
- At times they are overwhelmed with too few staff trying to serve, advise and put together prescriptions. One [pharmacy] we used could not dispense prescriptions over a certain number of items on site…they had to be put together offsite and delivered back to the pharmacy ..is that progress…the items needed were common items and not unusual. I worry about people making trips to collect prescriptions that are either not ready either in part or full. Especially if they are paying taxi or bus fares for effective wasted trips. It amazes me to see shelves and drawers full of items…but still items are not available.
- very poor service
- Our pharmacy is excellent , great staff , approachable and knowledgeable pharmacists. Repeat prescriptions can be ordered by phone , and you get a text message once they are ready for collection
- Lack.of stock
- Pharmacy receives my prescriptions from doctors surgery but usually takes 4/5days to process, this is far too long. Its usually because of no stock of my medication but surely if its prescribed every month for me they know that they need a stock of the medication.
- I feel the my prescriptions take too long to be processed
- Fabulous IP SERVICE
- Problem accessing pharmacy on Saturday afternoon and Sunday as closed.
- Very disorganised. Long waiting time from prescription to collection. Fantastic locker collection system never working so have to wait unacceptable length of time in long queue with unwell people. No privacy Expected to recite name and address in earshot of a shop full of customers. Never enough staff. For the population and elderly demographic of [location], this small pharmacy is totally inadequate
- Friendly staff. Always ready to help.. They go out of their way to help us every time

Are there any barriers to you accessing services at your pharmacy that you have not mentioned?

- My usual pharmacy along with most pharmacies in the area close for an hour or so over lunch, at the weekends, aren't open before work and are very often either closed of queuing out the door after work - when do you suppose the working population are meant to get our scripts without taking leave?
- Not knowing which Pharmacy has a prescriber available
- I can't believe that the pharmacy still closes for an hour at lunch time. This is so out dated. Who gets an hour for lunch?
- If one works mondays to fridays 9-6' it's difficult to get to the pharmacy...
- Yes I'm housebound and they won't deliver my meds
- Stop this open the surgeries more!!!!
- Pharmacist in store forces appointment based system for advice, for services I tend to use different pharmacy that easier to access the pharmacist, they also close for lunch with makes asking questions difficult
- The need to collect a prescription from the surgery in order to have my prescription processed at the local pharmacy. I have to physically go and collect my prescription from the surgery, when it used to be taken to the pharmacy and you would get a notification to say your prescription was ready - none of that happens anymore, it's all guess work.
- yes. My pharmacy get irritated when we ask, and often do not give people the option to access a private room. it is uncomfortable.
- Disable parking space often used by able body persons who get aggressive when challenged.
- Access after working hours. Confirmation that prescriptions are ready (don't send them half the time)
- Doesn't open on bank holidays
- Opening hours, closed at lunchtime
- Closed sunday, evenings and bank holidays.
- English pharmacist unable to provide commin ailments scheme - no regular pharmacist in store
- some staff are are arrogant
- I suffer with anxiety and using the pharmacy exasperates my condition. I no longer drive and depend on my daughter to get me there. I would like to see them offering a delivery service
- Closed during lunchtime

Equality monitoring

Ethnic group	Number of responses
British	57
Welsh	52
English	10
Scottish	2
Irish	1
Prefer not to say	1
Other – non-British European	1
White and Black African	1
Chose not to answer	1

Age	Number of responses
0-15 years	0
16-24 years	0
25-34 years	10
35-44 years	18
45-54 years	22
55-64 years	36
65-74 years	34
75 and above	5
Chose not to answer	1

What do you consider to be your first language?	Number of responses
Welsh	28
English	96
Other – French	1
Chose not to answer	1

How would you best describe your employment status?	Number of responses
Employed – full time	47
Employed – part time	22
Unemployed	7
Retired	48
Chose not to answer	2

Sex	Number of responses
Male	20
Female	103
Prefer not to say	2
Other	0
Chose not to answer	1

Sexual orientation: which of the following options best describes how you think of yourself?	Number of responses
Heterosexual/straight	113
Gay man	1
Gay woman/lesbian	1
Bisexual	3
Prefer not to say	4
Other	1
Chose not to answer	3

Religion or belief: what is your religion?	Number of responses
Christian (all denominations)	60
No religion	55
Prefer not to say	8
Other (state)	2
Chose not to answer	1

Where “Other” was selected the following additional information was provided.

- Pagon
- Jehovah’s Witness

Marital status: are you married or in a same-sex civil partnership?	Number of responses
Yes	76
No	40
Prefer not to say	8
Chose not to answer	2

Disabled: Section 6(1) of the Equality Act 2010 states that a person has a disability if:

a) That person has a physical or mental impairment, and
b) The impairment has a substantial and long-term adverse effect on that person’s ability to carry out normal day-to-day activities.

Using this definition do you consider yourself to be disabled?	Number of responses
Yes	24
No	91
Prefer not to say	7
Chose not to answer	4

Gender identity: has your gender identity changed from that assigned at birth?	**Number of responses**
Yes	5
No	116
Prefer not to say	2
Chose not to answer	3

Caring responsibilities: do you look after or give help or support to family members, friends, neighbours or others because of either: • **Long term physical or mental ill-health/disability, or** • **Problems related to old age?**	**Number of responses**
Yes	39
No	79
Prefer not to say	5
Chose not to answer	3

Betsi Cadwaladr University Health Board aims to promote equality in everything we do, please let us know below if you have any comments (positive or negative) in relation to your protected characteristics (such as issues relating to age, disability, race, pregnancy, religion, marriage/civil partnership, gender, sexual orientation and gender reassignment).

- I am not always treated with respect
- Widower living alone with family close by if needed.

Appendix I – pharmacy contractor questionnaire

Betsi Cadwaladr University Health Board is preparing its next pharmaceutical needs assessment or PNA which is due to be published by 1 October 2026 and we need your help to gather some information to supports its development.

In developing the questionnaire, we are only asking for information that is needed but is not routinely held or collected. As you will see we have kept the questionnaire as short as possible.

While available until Monday 6 April 2026 we would encourage you to complete the questionnaire now.

For queries relating to the information requested or the answers required please email BCU.CommunityPharmacy@wales.nhs.uk with a subject title of 'BCUHB PNA contractor questionnaire'.

Premises details

Contractor code (ODS code)	
Name of contractor (ie name of individual, partnership or company owning the pharmacy business)	
Trading name	
Address of pharmacy	
Pharmacy email address	
Pharmacy telephone	
Pharmacy fax (if applicable)	
Pharmacy website address (if applicable)	
Can the health board store the above information and use it to contact you?	☐ Yes ☐ No

Consultation facilities

Are the premises accessible by wheelchair? ☐ Yes ☐ No

Is a consultation area:

- not available ☐
- available (including wheelchair access), or ☐ Yes
- available (without wheelchair access), or ☐ Yes
- planned within the next 12 months, or ☐ Yes
- other (specify)

(Please select one option.)

Where there is a consultation area:

- is it a closed room? ☐ Yes ☐ No
- is it a designated area where both the patient and the pharmacist can sit down together? ☐ Yes ☐ No
- are the patient and pharmacist able to talk at normal volumes without being overheard by pharmacy staff or visitors to the pharmacy? ☐ Yes ☐ No
- is it clearly designated as an area for confidential consultations, distinct from the general public areas of the pharmacy? ☐ Yes ☐ No

If there is no consultation area are there alternative arrangements for confidential discussions? ☐ Yes ☐ No

Do you have Welsh speakers in your staff? ☐ Yes

Are any other languages spoken by staff (in addition to English)?

If yes, please say which ones below. [text box]

Services

Does the pharmacy dispense appliances?

- Yes, all types ☐ Yes
- Yes, excluding stoma appliances ☐ Yes
- Yes, excluding incontinence appliances ☐ Yes
- Yes, excluding stoma and incontinence appliances ☐ Yes
- Yes, just dressings ☐ Yes
- Other [text box]
- None ☐ Yes

Non-commissioned services

Does the pharmacy provide any of the following?

- Collection of prescriptions from GP practices ☐ Yes
- Delivery of dispensed medicines – free of charge on request ☐ Yes
- Delivery of dispensed medicines – selected patient groups (list criteria) [text box] ☐ Yes
- Delivery of dispensed medicines – selected areas (list areas) [text box] ☐ Yes
- Delivery of dispensed medicines – chargeable ☐ Yes
- Automated collection point at the premises ☐ Yes

In your opinion is there a requirement for an existing additional clinical service which is not currently provided in your area? If so, what is the particular requirement and why.

In your opinion is there a requirement for a new service that is currently not available? If so, what is the particular requirement and why.

Capacity

The demand for pharmaceutical services in general is increasing. Thinking of your pharmacy do you:

	Premises	**Staffing levels**
We have sufficient capacity to manage the increase in demand in our area.	☐ Yes	☐ Yes
We don't have sufficient capacity at present but could make adjustments to manage the increase in demand in our area.	☐ Yes	☐ Yes
We don't have sufficient capacity and would have difficulty in managing an increase in demand.	☐ Yes	☐ Yes

Business development

Do you have any plans to develop or expand your premises or service provision?

☐ Yes ☐ No

If yes, please can you provide details?

Details of the person completing this form:

Contact name of the person completing the questionnaire, in case we need to discuss your response with you.

……..

Contact email address

……..

Appendix J – dispensing practice questionnaire

Betsi Cadwaladr University Health Board is preparing its next pharmaceutical needs assessment (PNA) which is due to be published by 1 October 2026 and we need your help to gather some information to support its development.

In developing the questionnaire, we are only asking for information that is needed but is not routinely held or collected. As you will see we have kept the questionnaire as short as possible.

While available until Monday 6 April 2026 we would encourage you to complete the questionnaire now.

For queries relating to the information requested or the answers required please email BCU.CommunityPharmacy@wales.nhs.uk with a subject title of 'BCUHB PNA dispensing practice survey'.

Please insert the name of the practice you are completing the questionnaire on behalf of:
……

Please insert the address or addresses of the premises for which the practice has premises approval to dispense from:
……

Please complete the table below in respect of the times at which the dispensary is open using the 24 hour clock.

	Address -	**Address –**	**Address -**
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Are appliances dispensed from the premises?

- Yes, all types ☐ Yes
- Yes, excluding stoma appliances ☐ Yes
- Yes, excluding incontinence appliances ☐ Yes

- Yes, excluding stoma and incontinence appliances ☐ Yes
- Yes, just dressings ☐ Yes
- Other [text box]
- None ☐ Yes

Delivery of dispensed items

Does the dispensary provide any of the following?

- Delivery of dispensed medicines – free of charge on request ☐ Yes
- Delivery of dispensed medicines – selected patient groups (list criteria)
  [text box] ☐ Yes
- Delivery of dispensed medicines – selected areas (list areas)
  [text box] ☐ Yes
- Delivery of dispensed medicines – chargeable ☐ Yes
- Automated collection point at the premises ☐ Yes

Languages spoken

Do you have Welsh speakers in your staff? ☐ Yes

Are any other languages spoken by staff (in addition to English)?

If yes, please say which ones below.

[text box]

Capacity

The demand for health services in general is increasing. Thinking of your dispensing service only, do you:

	Premises	**Staffing levels**
We have sufficient capacity to manage the increase in demand in our area.	☐ Yes	☐ Yes
We don't have sufficient capacity at present but could make adjustments to manage the increase in demand in our area.	☐ Yes	☐ Yes
We don't have sufficient capacity and would have difficulty in managing an increase in demand.	☐ Yes	☐ Yes

Other dispensing related services

Please can you provide details of any other activities that you provide related to your dispensing service, for example MARs charts, 'just in case packs' and patient sharps.

[text box]

Details of the person completing this form:

Contact name of the person completing the questionnaire in case we need to discuss your response with you.

……

Contact email address

……

Appendix K – consultation report

1 Introduction

As part of the pharmaceutical needs assessment process the health board is required to undertake a consultation of at least 60 days with certain organisations. The purpose of the consultation is to establish if the pharmaceutical providers and services supporting the population of the health board's area are accurately reflected in the final pharmaceutical needs assessment document. This report outlines the considerations and responses to the consultation and describes the overall process by which the consultation was undertaken.

2 Consultation process

In order to complete this process, the health board has consulted with those parties identified under regulation 7 of the NHS (Pharmaceutical Services) (Wales) Regulations 2020, to establish if the draft pharmaceutical needs assessment addresses issues that they considered relevant to the provision of pharmaceutical services:

- Community Pharmacy Wales
- North Wales Local Medical Committee
- Contractors included in the pharmaceutical list
- GPs included in the dispensing doctor list
- GP practices
- Llais
- North Wales Regional Partnership Board
- Isle of Anglesey County Council
- Gwynedd Council
- Conwy County Borough Council
- Denbighshire County Council
- Flintshire County Council
- Wrexham County Borough Council
- Hywel Dda University Health Board
- Powys Teaching Health Board

An email was sent to the above organisations, inviting them to submit their views on the pharmaceutical needs assessment. Web links to the pharmaceutical needs assessment and online questionnaire were included in the email.

Consultees were given the opportunity to respond by completing a set of questions and/or submitting additional comments. All documents were bilingual, although no responses were received in Welsh.

The questions were design to assess the current provision of pharmaceutical services, have regard to any specified future circumstance where the current position may materially change, and identify any current and future gaps in pharmaceutical services.

The consultation ran from 10 June to 9 August 2026.

This report outlines the considerations and responses to the consultation. It should be noted that participants in the consultation were not required to complete every question.

The consultation received five responses, including an off-system response by Community Pharmacy Wales.

Answer options	Response percent	Response count
On behalf of a pharmacy/dispensing appliance contractor/dispensing practice	20.0%	1
On behalf of an organisation	40.0%	2
Personal response	40.0%	2
Answered question		**5**

3 Summary of online questions, responses, and the health board's considerations

All comments made as part of the consultation are included verbatim.

In asking "**Has the purpose of the pharmaceutical needs assessment been explained**", the health board is pleased to note that four respondents said "Yes".

One person expanded upon their response by saying the "explanation is clear".

Community Pharmacy Wales commented as follows.

"The draft PNA provides a helpful explanation of the relationship between the PNA, population health needs and pharmaceutical service provision. Consideration should be given to more explicitly recognising the PNA's statutory function within the market entry framework. In particular, the PNA provides the evidential basis against which applications to join a pharmaceutical list or dispensing doctor list, and certain relocation applications, are assessed under the National Health Service (Pharmaceutical Services) (Wales) Regulations 2020. Explicit recognition of this role is important because the conclusions reached within the PNA will directly influence future market entry decisions. Any deficiencies in the evidence base or assessment methodology therefore have the potential to affect the robustness of those decisions."

The health board has considered this comment and notes that the link between the pharmaceutical needs assessment and market entry is made in section 1.1 and is explained in legislation. It is satisfied that no amendment needs to be made to the pharmaceutical needs assessment.

The next question asked, "**Does the pharmaceutical needs assessment reflect the current provision of pharmaceutical services within your area?**" and the health board is pleased to note that no-one said "No".

Community Pharmacy Wales commented as follows.

“The draft PNA broadly reflects current community pharmacy provision across the BCUHB area. It draws on an appropriate mix of contractual data, dispensing and service activity data, local Health Board intelligence and self-declared pharmacy contractor questionnaire returns, providing a reasonable high-level overview of current provision.

The pharmacy contractor questionnaire provides valuable insight into current services and operating conditions across the network. However, the capacity reported is a point-in-time assessment. Pharmaceutical services provision remains closely linked to available funding, which directly affects contractor capacity, workforce resilience and service delivery. Without significant additional investment in the community pharmacy contractual framework, the level of provision described in the PNA will not be sustainable over its lifetime.”

The health board has noted Community Pharmacy Wales’ concerns regarding funding of pharmaceutical services. It is of the opinion that this is outside the scope of the pharmaceutical needs assessment, and that remuneration for the majority of the pharmaceutical services provided by pharmacy contractors is not within the control of the health board.

The health board recognises that the responses to the capacity question are based on circumstances at the time the question was answered and that there may continue to be withdrawals of pharmacies from the pharmaceutical list. It is cognisant of its duty to monitor service provision and the needs of its residents so that it can consider whether it needs to produce a new pharmaceutical needs assessment within the usual five-year lifespan of the document in order to identify new current needs for one or more pharmaceutical services. It is of the opinion that the ongoing risk of withdrawals from the pharmaceutical list strengthens the need to future-proof the document so that it responds should that happen.

When asked “**Are there any gaps in service provision, ie when, where and which services are available that have not been identified in the pharmaceutical needs assessment?**”, three people said “No” and one person said, “Don’t know”.

Community Pharmacy Wales commented as follows.

“The when (i.e. opening hours), where (location of the pharmacies, appliance contractors and dispensing doctors) and which services they provide have been identified by BCUHB for the purposes of the PNA using data available from various sources. CPW is not in a position to verify this information.”

The health board is pleased to note that it has fully identified the provision of pharmaceutical services within the pharmaceutical needs assessment.

When asked “**Does the draft pharmaceutical needs assessment reflect the needs of the population?**” one person said “Yes” and three said “Don’t know”. Two comments were left, expanding on the responses given.

- “Neighbouring Health Board response”
- “We would question the need identified for a pharmacy in Betws-y-Coed. There is no detail why a pharmacy is needed here. A previous application by Boots UK Ltd in 2013 was rejected in this locality and there has been no significant change to this locality since then.”

In response to this comment, the health board notes that the application received in 2013 was determined in line with the test in the NHS (Pharmaceutical Services) (Wales) Regulations 2013, as amended. The basis for applications for inclusion in the pharmaceutical list has changed, and previous decisions have no bearing on decisions made under the NHS (Pharmaceutical Services) (Wales) Regulations 2020, as amended.

The health board identified a current need for a pharmacy in Betws-y-Coed in the 2021 pharmaceutical needs assessment. It has noted that the volume of tourism in North Wales has increased, and the number of items prescribed per head of population increased by 5.5% between 2015 and 2025. In addition, a wider range of pharmaceutical services are provided by pharmacy contractors. Residents and tourists in Betws-y-Coed do not currently have reasonable access to the wider range of pharmaceutical services provided by pharmacy contractors. The health board remains of the opinion that this is a gap in the provision of pharmaceutical services.

Community Pharmacy Wales commented as follows.

“BCUHB has identified unmet needs in relation to the following:

- Current provision of Essential Services in Betws-y-Coed
- Current provision of Additional Clinical Services in Betws-y-Coed

BCUHB has made statements in relation to the speculative loss of:

- Essential Services on Saturdays due to changes to supplementary hours.
- Essential Services due to pharmacy closures in towns or villages where there is only one pharmacy
- Doctor Dispensing Services
- Essential services due to the closure of the pharmacy in Bodelwyddan
- BCUHB has made statements in relation to future provision of:
    - Pharmacist Independent Prescriber Services
    - Clinical Community Pharmacy Services in Bodelwyddan

CPW comments in more detail on the aforementioned identified needs and speculative needs below.

a) SECTION 22.3.1 and 22.3.2 - NEED FOR A PHARMACY TO PROVIDE ESSENTIAL SERVICES AND SPECIFC ADDITIONAL CLINICAL SERVICES IN BETWS-Y-COED

Betws-y-Coed is a very rural area. As required by the NHS (Pharmaceutical Services) (Wales) Regulations 2020 and advised by non-statutory guidance:

…. *unless the Health Board is able to provide evidence by way of a delineated map of their controlled areas the Health Board will not be able to take any action on any application it receives until it has been determined that the application is in a controlled area or not*…

We welcome the identification that a pharmacy may be required in Betws-y-Coed and, we trust that the underpinning regulations will be observed, including the necessity for the determination of a controlled locality to have been undertaken and evidenced on a delineated map kept by the Health Board in advance of determining an application to open a new pharmacy. See Q5(b)"

The health board is pleased to note that Community Pharmacy Wales is supportive of this identified current need. It can confirm that should an application be received, it will be determined in accordance with the relevant regulations. This may include a review of the current controlled locality for the area which would be undertaken in line with the relevant regulations.

"b) SECTION 22.4.1 - THE SPECULATIVE LOSS OF: ESSENTIAL SERVICES ON SATURDAYS DUE TO CHANGES TO SUPPLEMENTARY HOURS; ESSENTIAL SERVICES DUE TO PHARMACY CLOSURES IN TOWNS OR VILLAGES WHERE THERE IS ONLY ONE PHARMACY AND THE CLOSURE OF THE PHARMACY IN BODELWYDDAN.

Within the PNA, BCUHB has identified needs as described in the table below

i. **The health board has identified that should there be a Loss of supplementary opening hours on Saturdays** from 1 October 2026 which results in less than three hours of provision of pharmaceutical services within a town/village there will be a future need for the provision of essential services for three core opening hours on Saturdays in the town/village or towns/villages where the reduction in supplementary opening hours has occurred, between 09.00 and 17.00, unless there is another pharmacy in that town/village and then the future need will not arise.

ii. **The health board has identified that should there be a loss of essential services due to the withdrawal of a pharmacy** from the pharmaceutical list there will be a future need for either:

- a new pharmacy in the same town/village providing essential services, the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services for 40 core opening hours per week,
  or
- the GP dispensing service if the town/village is in a controlled locality,

  unless there is another pharmacy in that town/village and then this future need will not arise.

iii. **Should the pharmacy in Bodelwyddan withdraw from the pharmaceutical list** there will be a future need for a new pharmacy in the town providing essential services during the following core opening hours:

- At least ten core opening hours per day Monday to Friday,
- Six core opening hours on Saturdays, and
- Six core opening hours on Sundays

CPW wishes to make several points regarding the inclusion of statements (i) to (iii) in the PNA.

Future Need Must Be Real and Demonstrable

The NHS (Pharmaceutical Services) (Wales) Regulations 2020 non-statutory guidance states:

Only needs which immediately require meeting or will arise within the lifetime of the PNA are to be included in the PNA.

The Health Board's statements are contingent upon events which may or may not occur during the lifetime of the PNA. They do not represent identified needs which currently exist or which the Health Board can reasonably conclude will arise; rather, they are speculative assessments of the potential consequences of future changes to service provision.

Community Pharmacy Wales considers that the statements set out in sections (i)–(iii) are conjectural and fall outside the intended purpose of the PNA. The PNA is intended to assess and describe existing and demonstrable future need, not to anticipate hypothetical market changes that may occur if providers withdraw services or alter opening hours. Accordingly, these statements should be removed.

Regulatory Framework

The regulatory framework provides a mechanism for future change

• Revision of the PNA

The regulations (Regulation 6) and the non-statutory guidance recognise that changes to the availability of pharmaceutical services may arise during the five-year life of a PNA and provides a mechanism for Health Boards to respond to such changes. The non-statutory guidance, based on the relevant provisions of the NHS (Pharmaceutical Services) (Wales) Regulations 2020, states:

"*If there are changes either to the needs for pharmaceutical services or to the availability of pharmaceutical services within the five-year cycle, and those changes are relevant to market entry applications, the LHB will need to consider whether or not to go through the process of revising its PNA*..."

Should any of the circumstances described in sections (i)–(iii) actually occur, the Health Board would at that point be required to consider whether the change was sufficiently significant to warrant either a revised PNA or, where appropriate, a supplementary statement. It is therefore unnecessary and inappropriate to include speculative assessments of such scenarios within the current PNA.

• Additional Hours

Most importantly, the Health Board should recognise that the circumstance described in paragraph (i), the loss of supplementary Saturday opening hours, does not, of itself, establish a pharmaceutical need or justify the creation of a new pharmacy contract. A determination that additional opening hours may be beneficial is not the same as a determination that additional pharmaceutical service provision is necessary within the meaning of the Regulations and need would need to be demonstrated.

Where a gap in access at particular times is identified, existing regulatory and contractual mechanisms are already available to address it, namely the commissioning the Community Pharmacy Out-of-Hours Additional Clinical Service or, where appropriate, directing opening hours under the NHS (Pharmaceutical Services) (Wales) Regulations 2020. These measures should be explored before any conclusion is reached that new pharmaceutical service provision is required solely to provide additional hours on a particular day or at a particular time.

The Health Board should therefore undertake a robust assessment of demand and access before identifying any need for additional opening hours following the withdrawal of supplementary hours. The PNA should also make clear that, where any unmet need relates only to access outside existing core opening hours, the proportionate response will ordinarily be to secure additional access through established commissioning or contractual arrangements, rather than identifying a need for new pharmaceutical service provision.

Without prejudice to CPW's primary position that these speculative future-need statements should be removed, if the Health Board retains them it must ensure that any future need identified is supported by a robust and proportionate assessment of accessibility and patient need for each individual location.

Assessment of Gaps

In identifying future need in statements (ii) and (iii), the Health Board appears to assume that the loss of an existing pharmacy or dispensing practice would automatically create a need for replacement provision in the same town or village. However, as part of any future assessment, the Health Board would be required to apply the relevant criteria and undertake a full assessment of pharmaceutical need having regard to the circumstances prevailing at the time.

The existence of a pharmacy or dispensing practice today does not, in itself, demonstrate that replacement provision will be required in the future. The

appropriate question is not whether a provider has ceased operating, but whether its withdrawal has resulted in an unmet need for pharmaceutical services. Such an assessment would need to take account of factors including patient access, travel times, the availability of alternative providers, service use, population and the wider pharmaceutical network.

Accordingly, paragraphs (ii) and (iii) risk prejudging the situation by assuming that replacement provision would automatically be required. In practice, the Health Board would need to undertake a fresh assessment against the relevant criteria at the time of any withdrawal before determining whether a need exists and, if so, the most appropriate means of addressing that need.

Over-provision of Essential Services

BCUHB should be particularly mindful of the significant risks associated with identifying alleged "needs" that do not relate to essential pharmaceutical services, particularly where the apparent objective is to facilitate the provision of additional clinical services. Opening a market entry gap on this basis risks creating unnecessary over-provision of essential services, resulting in the establishment of additional pharmacies where there is insufficient demand to support them sustainably.

This is not a theoretical concern. In the current funding environment, where many community pharmacies are already operating under considerable financial pressure, creating additional contracts without a demonstrable need for essential services may simply result in existing activity being divided between multiple providers. The consequence could be the creation of two financially unviable pharmacies, increasing the risk of contractor failure and service closures. In such circumstances, the outcome could be a net reduction in access and resilience, contrary to the objectives of the PNA. The Health Board should therefore exercise considerable caution before identifying pharmaceutical needs that are directed towards securing additional clinical services

Community Pharmacy vs Dispensing Doctor Pharmaceutical services

CPW is concerned that paragraphs (ii) and (iii) appear to assume that a pharmacy and a dispensing practice are interchangeable forms of pharmaceutical service provision. This is not the case. Community pharmacies provide open-access pharmaceutical services and may dispense to any patient presenting a valid prescription, or presenting for a clinical service, regardless of which GP practice they are registered with. In contrast, dispensing practices are only permitted to provide dispensing services to eligible patients on their own practice list and must do so within the context of their GMS obligations and the controlled locality framework. Accordingly, the withdrawal of a pharmacy from the pharmaceutical list does not automatically create a need that could be met by a dispensing practice.

Travel-time

The Health Board has adopted a uniform driving **travel-time** standard of 20 minutes across its entire area. CPW questions whether a single access standard can

reasonably be applied to a Health Board area encompassing both densely populated urban communities and some of the most rural areas in Wales.

In rural communities residents routinely travel considerably further to access a range of services and amenities, including healthcare. Similarly, outside normal weekday opening hours, patients may reasonably be expected to travel longer distances to access pharmaceutical services than would be acceptable during core daytime periods.

The PNA does not explain why a 20-minute standard has been adopted in all circumstances, nor does it appear to consider whether different access expectations may be appropriate:

- in rural and urban settings;
- during normal weekday hours and outside those hours; or

In summary:

CPW recommends that paragraph i) and similar references in other parts of the document are removed. A reduction in supplementary opening hours does not, of itself, create an unmet need for pharmaceutical services. If such a change occurs during the lifetime of the PNA, the Health Board would need to assess the impact at that time and determine, based on the evidence available, whether an unmet need exists. Furthermore, where a gap in access outside core opening hours is identified, this can be addressed through existing commissioning and contractual mechanisms, including rota arrangements or the direction of opening hours where appropriate. It should not be presumed that a reduction in supplementary hours would create a need for additional pharmaceutical service provision.

CPW recommends that paragraphs (ii) and (iii), and similar references in other parts of the document, are removed. These statements risk opening gaps by assuming that the withdrawal of a pharmacy would automatically create a need for replacement provision. The existence of a pharmacy or dispensing practice today does not, of itself, demonstrate that replacement provision would be required in the future. Any such change would require a fresh assessment of need at the time against the relevant criteria and evidence then available. Furthermore, community pharmacies and dispensing practices are not interchangeable forms of provision.

CPW recommends that the Health Board reviews and justifies the travel-time assumptions used within the PNA and considers whether different access standards may be appropriate based on geography, population density, time of day and day of the week.

It should be noted that within section 22.4.1 which pertains to access to future essential services the following sentence which refers to additional service is included *The health board has identified one specific future need in relation to the provision of additional clinical services, in North Denbighshire locality*.

In addition, there is a section replicating 22.4.3 which pertains to *Future Access to the GP dispensing service"*

The health board's response

The health board is of the opinion that it is appropriate to future-proof the pharmaceutical needs assessment, based on changes that have happened over the lifetime of the 2021 version. In its comments, Community Pharmacy Wales has highlighted the fragility of service provision in light of funding pressures experienced by contractors and the continued risk of pharmacies closing. Whilst the health board has the ability to produce a new pharmaceutical needs assessment where it identifies changes which are relevant to the granting of applications referred to in section 83 of the NHS (Wales) Act 2006, it needs to take into account the length of time that would take. Firstly, it would need to reconvene the steering group, it would then need to undertake engagement with contractors and the public, then draft a new pharmaceutical needs assessment, consult on it for a minimum of 60 days, review comments, consider whether any further changes are required, finalise, and then publish the new document. This is likely to take a minimum of six months during which time no applications could be successfully made. In the meantime, residents in a specific area or areas face difficulty in accessing pharmaceutical services.

By future-proofing the document the health board is minimising the amount of time between a change occurring and service provision recommencing. It has chosen not to adopt a "like for like" approach and state that if a pharmacy withdraws from the pharmaceutical list, then there will be a future need for a new pharmacy providing specified services, at specified times, on specified days. It has adopted a proportionate approach and has taken the view that if there is another pharmacy in that town or village then no gap would be created, and this has been informed by the responses to the contractor questionnaire.

Whilst the health board has the ability to issue supplementary statements, the review of the regulations by Welsh Government (published in 2026) clearly stated that supplementary statements cannot identify a gap and therefore a need. If the pharmaceutical needs assessment is not future-proofed, then there would be a considerable delay before any applications could be successfully submitted.

The health board has noted the non-statutory guidance but is conscious that its pharmaceutical needs assessment must comply with the regulations. Paragraph 3(b), Schedule 1 requires the health board to include a statement of the pharmaceutical services that it has identified as services that are not provided in its area but which it is satisfied will, in specified future circumstances, need to be provided in order to meet a future need for one or more pharmaceutical services. The health board is therefore satisfied that the regulations permit it to future-proof its pharmaceutical needs assessment whether that be in relation to known housing developments, changes to the demographics of the population, or changes to service provision.

The health board has noted Community Pharmacy Wales' concerns regarding the over-provision of essential services due to needs being identified for services other than essential services. It is the health board's preference for existing contractors to

meet those needs, but if that should not happen it will consider applications for inclusion in the pharmaceutical list offering to secure an identified need in line with the relevant regulations. It may be directed to refuse an application by virtue of a specific regulation despite the need being identified in the pharmaceutical needs assessment.

The health board is not of the opinion that the range of services that can be provided by a pharmacy is interchangeable with the dispensing service that can be provided by a dispensing practice. However, it is conscious that much of its area is very rural and a pharmacy would not be financially viable in such areas, particularly if a reserved location was determined in connection with an application for inclusion in the pharmaceutical list. As applications for inclusion in a dispensing doctor list can only be granted if they meet a need identified in the pharmaceutical needs assessment the health board is of the opinion that it is appropriate to also identify needs for the dispensing service that GP practices can provide in order to ensure that residents in controlled localities are able to access their dispensed items.

With regard to the 20-minute travel time that has been adopted, this is consistent with the current pharmaceutical needs assessment and the approach taken across England and Wales. In addition, this travel time echoes a global climate/planning goal of creating “20-minute neighbourhoods”, the concept of which is that there are benefits to public health if people live in communities where their daily needs can be met within a short distance of where they live.

When it was discussed at the steering group no concerns were raised by representatives of the contractors or the public. The health board has noted that there appears to be some text missing from this part of Community Pharmacy Wales’ representations, but in the absence of any information to demonstrate why a 20-minute travel time is not appropriate, or any suggestion of a different travel time that should be adopted, it is satisfied that 20 minutes is appropriate.

“c) SECTION 22.4.3 BCUHB THE SPECULATIVE LOSS OF DISPENSING DOCTOR SERVICES

As part of the assessment BCUHB has made the following statement:

The health board has identified that should a GP practice cease to dispense to an area for which it has outline consent there will be a future need for either:

- *the GP dispensing service to be provided to that area whilst it remains a controlled locality and is more than 1.6km in a straight line from a pharmacy, or*
- *a pharmacy that is open Monday to Friday as a minimum, providing:*
    - *all the essential services, and*
    - *the clinical community pharmacy service, return of patient sharps boxes, supervised administration service, Help me quit @ pharmacy, and smoking cessation level 2 services.*

Where a dispensing practice ceases to dispense, it cannot be assumed that replacement dispensing provision will be required. Any assessment would need to

consider the controlled locality arrangements in force at the time, including the relevant controlled locality maps, together with the availability of alternative pharmaceutical services and the applicable regulatory requirements."

Health board response

The health board has reflected on this point and has amended this identified need to add "unless residents in that area are within a 20-minute drive of a pharmacy and then this future need will not arise" at the end of the sentence on each occasion.

"d) SECTION 22.4.2 -FUTURE NEED IN RELATION TO THE PROVISION OF THE PHARMACIST INDEPENDENT PRESCRIBING SERVICE (PIPS)

As part of its assessment of future need BCUHB has made the following statement.

> *The health board has adopted the aspiration set out in Pharmacy: Delivering a Healthier Wales for each pharmacy to have an independent prescriber by 2030 and the interim targets of 50% of pharmacies to be providing this service in each locality by April 2027 and 70% by April 2029.*
>
> *Should the interim targets not be met in a locality there will be a future need for the provision of this service by sufficient pharmacies in that locality to meet the two targets.*

The Health Board has identified a future need for PIPS in localities where the interim targets set out in *Pharmacy: Delivering a Healthier Wales* are not met. However, *Pharmacy: Delivering a Healthier Wales* is not a Welsh Government-authored policy document, statutory guidance, or formal statement of Government policy. Rather, it is a profession-led vision developed by the Welsh Pharmaceutical Committee to support the long-term development of community pharmacy services. While it aligns with the broader ambitions of *A Healthier Wales* and has been supported by Welsh Government, the targets it contains are aspirational service development objectives rather than assessments of pharmaceutical need. Consequently, failure to achieve those targets does not demonstrate an unmet pharmaceutical need or provide a sufficient basis for identifying a future need within the PNA

Any assessment of future need should be based on the relevant statutory criteria, including the reasonable requirements of the population, accessibility of services, service use and the availability of alternative providers. In the case of prescribing services, patients may be able to access equivalent care through a range of providers, including GP practices and other NHS services. The PNA cannot demonstrate that a locality would have an unmet need simply because a specified proportion of pharmacies are not providing PIPS by a particular date."

Health board response

Whilst "Pharmacy: Delivering a Healthier Wales" sets out the profession's aspirations, one of the performance measures in quadruple aim 2 of Welsh Government's "NHS Wales Performance Framework 2026-27" is the percentage of pharmacies providing the pharmacist independent prescribing service. The health

board has been set a target for achieving this performance measure and is therefore satisfied that it is appropriate to include these needs in the pharmaceutical needs assessment. It is anticipated that increasing numbers of the existing pharmacies will provide the service during the lifetime of the pharmaceutical needs assessment and as noted above it is the health board's hope that existing contractors will step up to meet and exceed these targets.

"e) SECTION 22.4.2 - FUTURE NEED IN RELATION TO THE PROVISION OF THE CLINICAL COMMUNITY PHARMACY SERVICE (CCPS) IN NORTH DENBIGHSHIRE

As part of its assessment of future need BCUHB has made the following statement.

> *The health board has identified one future need in relation to the provision of the clinical community pharmacy service, in the North Denbighshire locality.*
>
> *The health board will work with the only pharmacy that does [NOT] provide this service. However, should this gap not be closed, then from 1 April 2027 there will be a future need for this service to be provided in Bodelwyddan, seven days a week for:*
>
> - *eight hours a day Monday to Friday,*
> *six hours on Saturdays to include 13.00 to 15.00, and*
> - *three hours on Sundays after 12 noon*

Firstly, it is likely that the word NOT is missing from the above statement

The PNA identifies that one pharmacy in North Denbighshire does not currently provide the Clinical Community Pharmacy Service and concludes that, if this position remains unchanged, a future need will arise for the service to be provided in Bodelwyddan for specified hours seven days a week. Bodelwyddan has numerous pharmacies providing CCPS within a 20-minute drive-time, including on Saturdays and Sundays hence, the access time criteria is met and it is difficult to understand how a need could be identified.

Whilst CPW supports the Health Board in its ambition to have the key clinical services delivered by all pharmacies and wishes to work with contractors and BCUHB to achieve this, the Health Board is reminded that the PNA is an official document to establish Market Entry arrangements; It was not designed to be a process to 'encourage' contractors to improve service delivery and it is not appropriate for it to be used as such.

As explained in the answer to Q8 b) BCUHB should be mindful that identifying pharmaceutical needs to secure additional clinical services, such as PIPS and CCPS, risks creating unnecessary over-provision of essential services.

We would suggest that the PNA is reworded to reflect the need for existing providers of pharmaceutical services and the Health Board to work together to increase the availability and uptake of PIPS and CCPS in Bodelwyddan, rather

than identify a formal gap in the provision of pharmaceutical services."

Health board response

The health board has noted the typographical error and has amended the pharmaceutical needs assessment accordingly.

The health board wishes to see a core range of pharmaceutical services offered by contractors. This ensures that pharmacy users are provided with a consistent service offer irrespective of which pharmacy they choose to use. Where the health board identified the need for specific services in the previous pharmaceutical needs assessment it is pleased to note that contractors met some of those needs which meant that there was no need to grant any applications for inclusion in the pharmaceutical list offering to meet that need.

Identifying the need for specific services in specific locations will also support the primary care model for Wales which focusses on place-based care, care closer to home, and multi-professional working.

Respondents were then asked for their views on **whether the pharmaceutical needs assessment has provided information to inform decisions made by the health board in relation to applications for new pharmacies and dispensing appliance contractor premises, and applications from dispensing doctors**. The health board notes that two respondents said "Yes", two said they didn't know, and Community Pharmacy Wales said "No" for the following reasons.

"a) As outlined in Question 4, the needs identified have not been robustly evidenced and as such there is a question over whether these are needs in terms of Market Entry. To identify non-provision of a service as an unmet need creates a gap and a consequent invitation for applications to provide that service. The PNA is intended to provide the evidential basis for market entry decisions. Where gaps in service provision are identified without sufficient supporting evidence and the correct application of the regulatory framework there is a risk that the PNA could influence market entry decisions on the basis of flawed or inadequately substantiated conclusions. CPW therefore considers that the issues identified in Question 4 must be addressed before the PNA can be relied upon as a sound basis for determining market entry applications.

b) CPW is concerned that the PNA does not provide sufficient information regarding controlled localities.

The PNA acknowledges that dispensing doctor provision depends upon patients residing within controlled localities and practices holding the relevant consent and premises approvals. However, it does not identify current controlled locality determinations, dispensing doctor outline consent areas, or provide controlled locality maps (or signposting to them). In a significantly rural Health Board area where dispensing doctors form an important part of pharmaceutical service provision, this information is fundamental to a transparent and robust market entry system.

CPW draws the Health Board's attention to the Welsh Government’s non-statutory guidance accompanying the NHS (Pharmaceutical Services) (Wales) Regulations 2020, which states that PNAs should include information on dispensing doctor outline consent areas and suggests that controlled locality maps, or links to those maps, should be provided. The guidance also highlights the importance of maintaining accurate controlled locality boundaries, particularly where development or changing settlement patterns may affect previous determinations.

The Welsh Government's non-statutory guidance correctly recognises that, unless a Health Board is able to evidence the boundaries of its controlled localities by way of a delineated map, it will be unable to determine whether the controlled locality provisions in Part 5 of the NHS (Pharmaceutical Services) (Wales) Regulations 2020 apply to an application. This reflects the statutory requirement in Regulation 13 and Schedule 4 for controlled localities to be formally determined before the Health Board can lawfully apply the controlled locality and reserved location provisions when considering market entry applications.

Further to correspondence earlier in 2026 requesting information and maps relating to controlled locality determinations, CPW notes the Health Board's confirmation that controlled locality maps exist but will not be included within the October 2026 PNA. The Health Board has advised that it intends to undertake a comprehensive review of controlled localities following publication of the PNA and that, given the scale and complexity of the work required, it would not be feasible to complete this exercise before the October deadline.

Notwithstanding this, CPW seeks assurance that any application submitted before that review is completed, including any future application in the Betws-y-Coed area, will be assessed in accordance with the Regulations and supported by an accurate and up-to-date controlled locality map produced as part of the application assessment process.

Without a current controlled locality determination, there can be no certainty as to whether patients are entitled to receive dispensing services from a doctor or whether the area falls within a reserved location, both of which are material considerations in determining pharmaceutical applications.”

Health board response

The health board has responded above to the points raised by Community Pharmacy Wales in its reply to the previous question.

In response to the point raised in relation to controlled localities, the health board has noted the regulatory requirement to publish in such manner as it sees fit and make available for inspection at its offices copies of a map delineating the boundaries of any controlled localities. There is no regulatory requirement to publish such that map in the pharmaceutical needs assessment and indeed there would be a risk in doing so where subsequent determinations are made and the version included in the pharmaceutical needs assessment becomes out of date.

The health board can confirm it a controlled locality map and Community Pharmacy Wales is welcome to inspect it at the health board's offices if it so wishes.

Where an application is received for inclusion in the pharmaceutical or dispensing doctor list and the premises are, or appear to be in, a controlled locality, the health board can confirm that it is aware that it has the ability to make a controlled locality determination in line with the regulations where that is appropriate.

The health board has noted reference to the non-statutory guidance which says that controlled locality maps "should" be included. It has noted that neither the guidance nor the regulations say they "must" be included.

The health board has decided that it will not include the controlled locality map in its pharmaceutical needs assessment.

The survey then asked whether the document has **provided information to inform how pharmaceutical services may be commissioned in the future**. The health board has noted that four people said it has. Community Pharmacy Wales commented as follows.

"The purpose of the PNA is to assess and set out how the provision of pharmaceutical services can meet the health needs of the population of a health board's area for a period of up to five years. There is no provision within the PNA to look beyond a five-year period.

As outlined in Question 4 there are concerns in relation to the current and future needs identified."

The health board has responded above to the points raised by Community Pharmacy Wales.

Turning to whether or not the pharmaceutical needs assessment has **provided enough information for contractors to plan future pharmaceutical services provision** the health board has noted that two respondents said "Yes", one said "Don't know" and one respondent said "No". They expanded upon their response as follows.

- "Where pharmacies have closed and an explanation given that there remains an existing pharmacy there is no insight into the existing pharmacy's capacity. Are existing staff simply expected to work under increased stress and pressure with perhaps no increase space or resources?"

Community Pharmacy Wales commented as follows.

"The draft Pharmaceutical Needs Assessment provides a reasonable level of information to inform future pharmaceutical service provision and planning. It has considered pharmacy contractors' ability to increase capacity in response to rising demand, drawing on evidence from the contractor questionnaire, and has also taken account of wider factors such as planned housing developments and anticipated

population changes. This helps to build a forward-looking picture of potential service need.

However, the conclusions regarding capacity should be viewed in the context of the current financial pressures facing the sector. Any suggestion of available or scalable capacity is heavily dependent on the availability of sustainable funding and an adequate workforce. In practice, there is clear evidence across the network that financial pressures are affecting service delivery. For some contractors, ongoing funding constraints are now affecting viability, with a small but growing number reaching a point where the sustainability of their businesses is in question. As such, while the PNA provides a useful evidence base for planning, the extent to which any identified capacity can be realised will depend on meaningful and sustained investment alongside contractual support. CPW would welcome the Health Board's support in recognising that the assumptions underpinning the PNA's conclusions depend on sustainable recurrent funding and sufficient workforce capacity."

The health board sought the views of contractors as to whether they have capacity to manage an increase in demand for services and has taken them into account when coming to the conclusions set out in this document. Having reviewed them again, no contractors said their response was contingent on sustainable recurrent funding. In addition, only one pharmacy contractor responded to the consultation but did not raise the same points as Community Pharmacy Wales.

The health board has noted the statement that for some contractors, ongoing funding constraints are now affecting viability. As noted above, the vast majority of payments made to contractors are set by Welsh Government and are therefore outside the control of the health board. However, the fact that some pharmacies may close further justifies the health board's decision to future-proof the pharmaceutical needs assessment.

The consultation then asked **whether there are any pharmaceutical services that could be provided in the future by pharmacies that have been not highlighted**. The health board has noted that no respondents identified such services. Community Pharmacy Wales commented as follows.

"Yes. Chapter 3 identifies a number of significant health needs within the BCUHB population that could potentially be addressed through community pharmacy additional clinical services. For example, Section 3.9 highlights the growing prevalence of obesity among adults in Wales, an area where pharmacy-based weight management services could make a meaningful contribution.

However, the delivery of services such as weight management and other clinically focused interventions **would require significant additional investment beyond the current Community Pharmacy Contractual Framework (CPCF)**. It is suggested that the Health Board considers these identified health needs in greater detail, develops services in line with Community Pharmacy by Design principles, and secures appropriate recurrent funding to support their sustainable delivery through the community pharmacy network."

The health board has noted the comment regarding the need for a weight management service, however this was not a service identified by any of the contractors.

The health board will continue to review the needs of its residents and where there is a need for one or more new services, pharmacy contractors will be considered alongside other potential providers.

In order to ensure that the pharmaceutical needs assessment had identified any needs that may arise within its five-year lifetime, respondents were asked if **any developments, for example housing developments, regeneration projects or new premises for the provision of NHS services, had been missed**. The health board has noted that no respondents said “Yes”. Community Pharmacy Wales commented as follows.

“We are not aware of any developments that may arise within the lifetime of this PNA that have not been identified. However, individual pharmacy contractors, members of the public and others with local knowledge may well alert the health board of any developments they are aware of.”

The health board is pleased to note that no developments have been missed in the writing of this pharmaceutical needs assessment.

The consultation then asked whether respondents agreed **with the conclusions of the pharmaceutical needs assessment** and the health board has noted that two said “Yes”, one said “Don’t know”, and one said “No”. One of the respondents who said “Yes” and the respondent who said “Don’t know”, expanded upon their response.

- “I believe that it's wrong that when an existing pharmacy closes the door is also closed for a new contractor applicant to apply to take their place (eg Coedpoeth, Rhos on Sea)”
- “We would question the need for a pharmacy in Betws -y- Coed”

Community Pharmacy Wales commented as follows.

“CPW cannot agree with the conclusions of the pharmaceutical needs assessment as it is felt that unmet needs have not been sufficiently demonstrated for reasons outlined in Question 4. “

The health board has noted the first comment and the view of Community Pharmacy Wales in respect to the future proofing of the document. Balancing both views, it is of the opinion that no changes need to be made to the pharmaceutical needs assessment.

Finally, those responding to the consultation were asked whether they had **any further comments**. Four people said “No”.

Community Pharmacy Wales commented as follows.

“Page 131 does not show a pharmacy at Benllech on the Anglesey locality Map 8.1. It is recommended that the PNA is checked for Data quality / mapping issues before publication

Page 269 refers to a pharmacy premises relocating in August 2026. CPW is not aware of any consultation regarding a relocation application to meet a business need, nor does the PNA identify a gap in pharmaceutical services that could be addressed through the relocation of an existing pharmacy. Any relocation of pharmacy premises would need to be considered and determined through the appropriate regulatory processes set out in the NHS (Pharmaceutical Services) (Wales) Regulations 2020. As drafted, the reference appears to anticipate a future outcome that has neither been assessed within the PNA nor approved through the relevant statutory procedures.

Part 3: Conclusion

CPW welcomes the work undertaken to produce this PNA but remains concerned that several identified “needs” are either speculative or relate to service development objectives rather than demonstrable pharmaceutical need. Given the PNA’s statutory role in informing market entry decisions, it is essential that conclusions are evidence-based, proportionate and consistent with the NHS (Pharmaceutical Services) (Wales) Regulations 2020.

CPW therefore recommends that the identified concerns are addressed before the PNA is finalised.”

In response to the pharmacy in Benllech, it is included in the map (as can be seen in map 5.2). Unfortunately, due to its proximity to a dispensing doctor it was hidden on maps 5.1 and 8.1. This has been corrected.

In relation to the relocation of a pharmacy that was due to take place in August 2026, this information was taken from a response to the contractor questionnaire. The health board has checked its records and has not received an application from this contractor to relocate its pharmacy. As and when such an application is received it will be determined in accordance with the regulations. Regulation 19(2) of the NHS (Pharmaceutical Services) (Wales) Regulations 2020 permits relocations in two specific scenarios and the health board waits to see under which provision this contractor will apply.

4 Summary conclusions

The health board is pleased to note that the majority of respondents are in agreement with the conclusions of the pharmaceutical needs assessment. It has reviewed the responses and has set out above where the document will be amended.

It would like to thank those who took the time to read the document and to respond to the consultation.

5 Equalities monitoring

Two of the responses were personal responses. Of these:

- One said they are Welsh, and the other British.
- One is aged 35-44 years old, and the other is 55-64 years old.
- Both consider English to be their first language.
- Both are employed full-time, male, and heterosexual/straight.
- One has no religion; the other is Christian.
- Both are married.
- Neither considers themselves to be disabled.
- Their gender identity has not changed from that assigned at birth.
- Neither has caring responsibilities.
- Neither had any comments in relation to their protected characteristics.

6 Amendments

The following amendments have been made to the pharmaceutical needs assessment:

- A symbol has been added to maps 5.1 and 8.1 to represent the pharmacy in Benllech.
- Sections 8.6.1, 8.6.20, 9.6.1, 9.6.20, 10.6.1, 10.6.20, 11.6.1, 11.6.20, 12.6.1, 12.6.20, 13.6.1, 13.6.20, 15.6.1, 15.6.20, 16.6.1, 16.6.20, 18.6.1, 18.6.20, 21.6.1, 21.6.20, 22.4.1, and 22.4.3 have been amended to reflect the amended future need should a GP practice cease to dispense to an area for which it has outline consent. Reference to this future need in section 19.6.1 has been deleted as there are no dispensing doctors in this locality.
- Section 22.4.2 has been amended to insert the word “not” into the sentence “The health board will work with the only pharmacy that does provide this service”.

Appendix L – pharmacy opening hours



BCUHB PNA 2026 appendix L v1 Final.:

Betsi Cadwaladr University Health Board (BCUHB)
UNCONFIRMED Minutes of the Planning, Population Health and Partnerships Committee held in Public on 2 July 2026
in the Boardroom, Carlton Court, St Asaph and via Teams

Committee Members Present	
Name	**Title**
Clare Budden	Independent Member (Chair of PPHP Committee)
Billy Nichols	Independent Member
Caroline Turner	Independent Member
Gareth Williams	Independent Member
In Attendance	
Tehmeena Ajmal	Chief Operating Officer (via Teams)
Emma Lea	Interim Assistant Director of Corporate Planning: Transformation and Improvement (part meeting)
Stuart Keen	Director of Environment and Estates
Jane Moore	Executive Director of Public Health
Justine Parry	Acting Director of Digital, Data and Technology (via Teams)
Paolo Tardivel	Interim Executive Director of Transformation & Strategic Planning
Pam Wenger	Director of Corporate Governance (via Teams)
Kamala Williams	Head of Health Strategy and Planning (via Teams - part meeting)
Kathy Williams	Senior Public Health Practitioner (via Teams - part meeting)
Committee Support	
Laura Jones	Corporate Governance Manager
Philippa Peake-Jones	Head of Corporate Governance

OPENING BUSINESS

PP26.67 Welcome and Apologies

The Chair of the Committee welcomed everyone to the meeting and apologies were noted for Helen Stevens-Jones.

PP26.68 Declarations of Interest

No declarations of interest were raised.

PP26.69 Unconfirmed Minutes of Meeting held on 7 May 2026

It was resolved that the Committee:

- **AGREED** that the minutes of the Planning, Population Health and Partnerships Committee meeting held on 7 May 2026 were a true and accurate record.

PP26.70 Matters Arising & Action Log

The Committee reviewed the action log and agreed to close the actions that were proposed for closure.

Unconfirmed

Ablett Mental Health Unit

- Reference was made to the note in the minutes referring to the potential remodelling of the Ablett Mental Health Unit. It was confirmed that Welsh Government will not support replacement facilities. A meeting has taken place with the All Wales Vice Chairs and it has been agreed to develop an overarching Business Case.

Action:

- Interim Executive Director of Transformation and Strategic Planning to collate a position statement to confirm the proposed approach to the Ablett Mental Health Unit.

STRATEGIC PRIORITIES

PP26.71 Director of Planning Report

Members received the report and the Interim Executive Director of Transformation and Strategic Planning highlighted:

- The Ten-Year Strategy remains in the discovery phase, with the diagnostics nearing completion. The findings will inform the case for change and the final version of the discovery report, before progressing to the design phase, with a fully developed options appraisal expected to be presented to the Board in Quarter Three. This work will subsequently inform the Integrated Medium Term Plan which will be refined in line with the strategic intentions, and work is ongoing to recover the programme timelines following some delays.
- The Clinical Services Plan Engagement Output Report has also been shared with the Committee noting that clinical engagement continues to progress, supported by a well-received engagement event and active involvement from Clinical Leads in shaping future service models and priorities. The Executive Medical Director is leading this area of work on behalf of the clinicians. A methodology is being finalised to identify priority areas for the initial phase, alongside development of a framework and service heat map to proactively assess areas of risk and performance indicators which will inform the Clinical Services Plan and integrate into the Quality Management System and the planning cycle. The next steps include developing a Clinical Services Plan Programme Initiation Document alongside establishing a single integrated framework for clinical services planning incorporating wider external partner perspectives.
- The Penley service change proposal was considered by the Board in May 2026, with a draft consultation planned for mid-July 2026, while the Tywyn proposal is scheduled for Board consideration in July 2026 ahead of proposed consultation commencing in September 2026.
- In relation to Special Measures, a monthly executive summary report is in the final stages of development which will highlight the de-escalation criteria, trajectory measures and lines of assurance.
- Work is underway to develop a North Wales Third Sector Partnership Framework in partnership with Continuing Healthcare leads to strengthen the Health Boards approach to partnership working. Whilst a workshop had been planned for Quarter One, the timescales have been extended to ensure the development is appropriately informed by stakeholder engagement.

In discussing the item, the Committee:

Unconfirmed

- Reflected that, whilst the Penley and Tywyn service change process has been thorough, this has also been resource and time intensive and queried whether a less involved approach could be adopted where appropriate. It was recognised that Welsh guidance requires a greater depth of engagement than in England, noting that the scale of the process is broadly the same for small and large change, and that the organisation may need to take a more strategic, less risk-averse method to service change in future to achieve an accelerate approach.
- Noted the need to build organisational capacity for change by developing staff skills in improvement techniques, whilst ensuring transformation resources are primarily focused on progressing the Major Change Programmes, supporting operational planning, and targeting interventions that align with the Health Boards strategic intentions.
- Referred to the revised Annual Delivery Plan reporting arrangements, including the Committee's role in monitoring delivery and providing assurance to the Board. It was noted that quarterly reporting timelines do not align with the Board cycle, and monthly reports can provide an early warning mechanism to identify areas requiring intervention pending full quarterly assurance.
- Noted that estate implications are not reflected in the report recognising that the Health Board estates need to be considered as part of the Clinical Services Plan.
- Emphasised the need to move forward with the Electronic Healthcare Records programme as key enablers to support Health Board developments and expressed concerns regarding the uncertainty of Welsh Government funding and the implications of further delays. Noted that correspondence has been sent to Welsh Government from the Health Board Chair raising concerns in relation to the Electronic Healthcare Records business case. He highlighted that there is currently no confirmation from Welsh Government regarding funding. Agreed that concerns would be shared with the Health Board Chair to suggest a joint Chairs approach is adopted to reiterate concerns with Welsh Government. Stated the need for a contingency plan should external funding not progress, including assessment of potential local funding options, recognising the importance of the system to service delivery, patient safety and wider transformation ambitions.
- Recognised the themes raised by staff during the Clinical Services plan event held in May 2026 which included a lack of trust, organisational fragility and perceived barriers to implementing the transformation required to change clinical services. It was suggested that this is reviewed in further detail by the People and Culture Committee.
- Discussed whether the Foundations for the Future Programme should proceed in the current context recognising concerns regarding the high proportion of senior staff in interim roles and the need to provide greater clarity to colleagues on future arrangements. It was agreed that a strategic Board discussion is required to determine whether to continue the full Organisational Change Programme now, or to accelerate selected changes to improve stability, capacity and performance.

Actions:

- **PP26.71.1** Director of Corporate Governance to share concerns raised in relation to the suspended development of the Electronic Healthcare Records system and suggest a joint Chairs approach is adopted with Welsh Government.

Unconfirmed

- **PP26.71.2** Director of Corporate Governance to reinforce the concerns raised by the Committee in relation to the Electronic Healthcare Records system in the presentation for the Escalation Board meeting.
- **PP26.71.3** People and Culture Committee to review the themes raised by staff during the engagement activity undertaken in relation to the Clinical Services Plan around the perception that staff do not feel enabled to implement the transformation required to change clinical services.
- **PP26.71.4** A strategic Board discussion to take place in relation to the Foundations for the Future Programme to determine opportunities to continue the full Organisational Change Programme or accelerate selected changes to improve stability, capacity and performance.

It was resolved that the Committee:

- **COMMENTED** on the content of the report.

PP26.72 Integrated Medium Term Plan 2026-2029 Reflection and Learning Report

Members received the report and the Interim Executive Director of Transformation and Strategic Planning highlighted:

- The paper is presented in draft format to allow reflections and learning from the Committee to be captured.
- The annual planning cycle is being strengthened to improve transparency and clarity, with learning and reflection informing its ongoing development.
- The Planning Maturity Matrices were introduced in November 2025 and are being used to inform the Integrated Planning Framework, helping identify gaps and areas requiring improvement.
- The themes captured within the report highlight improvements to the planning process, increased access to the planning team and stronger organisational collaboration. The Integrated Medium Term Plan has been described as more accessible and visible, enabling staff to better identify their contributions and priorities within the plan.
- Planning remains focused on Quarter Four as a reactive sprint rather than continuous planning. Greater integration is required across finance, workforce and service planning as well as stronger clinical leadership ownership, clearer alignment to priorities, and enhanced data and digital support.
- Greater emphasis is required on population health and earlier, system-wide planning with stakeholders supported by stronger engagement with frontline staff and clinicians to ensure a clear ‘golden thread’ throughout the organisation.
- The Planning Maturity Matrices will align with the themes identified and the learning will be used to inform a review of the Integrated Planning Framework and future planning arrangements.
- The Committee were invited to consider whether the findings accurately reflected their observations and whether any additional themes should be considered.

In discussing the item, the Committee:

- Noted the need to align strategic direction with finance and workforce resources to support delivery, recognising that progress has previously commenced in this area but was not sustained due to demand and capacity pressures.

Unconfirmed

- Referred to prevention and public health noting that an analysis had been undertaken against each strategic intention to identify opportunities to create a framework where prevention is embedded within existing priorities and can inform future planning discussions.
- Referred to discussions at the Performance, Finance and Information Governance Committee around zero based budgeting and noted the need to review the extent to which current budgetary arrangements are aligned to service need rather than historic allocations. It was confirmed that this direction of travel is being progressed but will be challenging given existing budget misalignment.

Action:

- **PP26.72.1** Performance, Finance and Information Governance Committee to review zero based budgeting to ensure budgets are fit for purpose moving forward and review the position routinely throughout the year.

It was resolved that the Committee:

- **NOTED** the content of the report.
- **REVIEWED** the work being undertaken.

PP26.73 Proposal - Format for Population Health Delivery Reporting 2026-2027

Members received the report and the Executive Director of Public Health highlighted:

- The proposed report will be structured around the four headings included in the Integrated Medium Term Plan that underpin the strategic intention, enabling all elements and prevention indicators to be aligned within the framework including Community by Design and the Clinical Services Plan.
- The report aims to provide assurance on progress at both strategic Health Board level and individual programme level, with the current mock-up intended to test the approach ahead of a more comprehensive scorecard being presented to the next meeting.

In discussing the item, the Committee:

- Recognised that the proposed reporting approach aligns with the work of the Performance, Finance and Information Governance Committee and supports the development of a single performance report, providing a consistent view of performance across areas including Planned Care and Urgent and Emergency Care allowing specific elements to be reported to the respective Committees.

It was resolved that the Committee:

- **REVIEWED** the proposed new format for the Quarterly Performance Scorecard Report delivery report which provides a scorecard approach to the performance metrics plus brief narrative for items ‘off-track’ - included as Appendix A.
- **APPROVED** the new reports – Quarterly Performance Scorecard Report and Executive Director of Public Health Report for use, commencing September PPHP Committee.
- **APPROVED** the schedule for proposed papers - Appendix C.
- **AGREED** that items requiring more detailed narrative/discussion identified through the course of review of the Quarterly Performance Scorecard Report and the

Unconfirmed

Executive Director of Public Health Report, which do not form part of the cycle of business will be requested by the Committee and/or Executive Director of Public Health.

PP26.74 Year End Report: Use of Grant Funding 2025-2026

Members received the report and the Executive Director of Public Health highlighted:

- Historically, the majority of prevention funding received by the Health Board has been provided through Welsh Government grants for specific purposes. While the funding is spent internally, delivery is undertaken by the relevant service teams, such as smoking cessation and weight management, with the Public Health Team providing oversight and monitoring delivery against requirements.
- Assurance was provided to the Committee that services are delivering against the grant requirements, with clear links to the outcomes developed by Public Health Wales. It was noted that, while smoking rates in North Wales have reduced and targets have been exceeded over the last two years, achieving the current 6% population smoking target remains challenging.

In discussing the item, the Committee:

- Reflected that internal controls have been a barrier in the past to maximising Welsh Government grant funding. It was confirmed that advanced planning is being strengthened in this area to improve oversight, repurpose underspends where appropriate and reduce year-end pressures.
- Highlighted similar issues in relation to cluster funding and the requirement to return underspends can create uncertainty and limit the ability to appoint substantive staff. It was confirmed that work is ongoing to secure funding to ensure substantive posts are included within the baseline position.
- Noted that the grant deliverables are largely activity-based suggesting further work is required to strengthen links to outputs, outcomes and impact. It was confirmed that the work in this area has been process focussed to ensure a grip on grant programmes noting the need to balance plans and outcomes going forward.

It was resolved that the Committee:

- **NOTED** the progress made to maximise grants received and the actions in place for continual improvement to both processes and outcomes.
- **NOTED** the risk identified during the recent audit, (specifically to Dietetics, Weight Management, Infant Feeding and Help Me Quit Services) to delivery and staff, should PEY grant not be received for 27/28 and the consequent impact on delivery of prevention services to the population.
-

PP26.75 Estates Strategy Review 2023-2033

This item was deferred to the September 2026 meeting.

PP26.76 Climate Adaptation and Decarbonisation Strategy Review

Members received the report and the Director of Environment and Estates highlighted:

Unconfirmed

- A review has recently been undertaken in this area and identified a fragmented and siloed approach, however the review also highlighted that there are pockets of good practice and strong staff commitment, including initiatives such as the Gloves Off campaign and vehicle sharing.
- Currently, there is limited resource and a lack of consistent organisational direction to address climate adaptation and decarbonisation, noting that the proposed FFF structure includes a Head of Decarbonisation and Head of Sustainability which would support a more coordinated and strategic approach.
- Additional work is required to strengthen governance, provide access to resources and Board-level understanding of the issues, noting that the current position is not sufficient and requires further action.

In discussing the item, the Committee:

- Recognised the links to Emergency Preparedness, Resilience and Response and issues relating to adverse weather and climate change noting the need for a sustainable cross organisational approach and alignment with the wider work taking place with the Regional Partnership Board.
- Reflected on the estate of the organisation not being configured for recent weather issues noting the need to learn from the recent heatwave response, identify site-specific mitigations through a Task and Finish Group and ensure timely action to protect staff and patients in future adverse weather events.
- Highlighted that climate adaptation and decarbonisation is a whole-organisation strategic issue requiring coordinated Executive leadership, improved communications and proactive team engagement to support delivery against the Welsh Government net zero commitment by 2030 and future Board assurance requirements.
- Agreed that this should be discussed further by the Executive Committee to consider the next steps for strengthening organisational coordination and strategic approach as well as developing a clear plan to support Board-level discussion.
- Queried the Health Board's ability to meet the reporting duties against the plan to submit a return to Welsh Government by September 2026. It was confirmed that while minimum reporting requirements had been met, the quality and credibility of the submission needs to be strengthened.

Action:

- **PP26.76.1** Director of Environment and Estates to ensure the Climate Adaptation and Decarbonisation Strategy are discussed further by the Executive Committee to consider the next steps for strengthening organisational coordination and strategic approach as well as developing a clear plan to support Board-level discussion.

It was resolved that the Committee:

- **NOTED** the current programme position and trajectory of development.
- **SUPPORTED** the continued strengthening of programme governance and delivery arrangements.
- **SUPPORTED** the development of programme capacity and coordination.
- **SUPPORTED** the continued alignment of sustainability activity with organisational and system priorities.

Unconfirmed

GOVERNANCE, RISK AND ASSURANCE

PP26.77 Corporate Risk Register Report

Members received the report and the Director of Corporate Governance highlighted:

- Work is taking place to strengthen controls around reducing risk exposure and a number of risks have now been revised in line with this area of focus noting that the risks relating to strategy and the Clinical Services Plan now align with the Integrated Medium Term Plan.

As part of the discussion, the Committee:

- Referred to the recent case of Ebola in Germany noting that this has reinforced the ongoing communicable disease risk, with further work required to ensure staff awareness, site readiness and the capability to safely manage patients noting that all sites are currently working to revise site plans and address any gaps.
- Expressed concern that some risks have remained on the same trajectory for over a year with no reduction in score. It was confirmed that further check and challenge will be undertaken with the relevant Executive Leads to review whether the current level of risk remains appropriate and to strengthen actions to support downward trajectories.

It was resolved that the Committee:

- **REVIEWED** and **SCRUTINISED** the corporate risks set out in the report, including consideration of the current risk position, existing controls, and identified gaps.
- **ENDORSED** the risks for submission to the Board, noting that one risk remains above the Health Board's risk appetite and therefore represent a continued exposure.
- **NOTED** that a programme of risk-specific meetings with Executive Leads is being established to further refine individual risks, ensure actions are sufficiently targeted, and support delivery of measurable reductions in risk scores within the agreed risk appetite.

PP26.78 Corporate Governance Report

Members received the report and the Head of Corporate Governance highlighted:

- The report now includes additional information relating to the summary of business considered in private providing the Committee resolution and a rationale for each item to confirm to confirm the need to be discussed in private.
- The draft cycle of business was also included for consideration prior to reporting to the Board.

It was resolved that the Committee:

- **NOTED** the matters considered in Private at the 7 May 2026 meeting.
- **NOTED** the draft Cycle of Business for comment prior to approval.
- **NOTED** The Committee forward workplan.

CLOSING BUSINESS

PP26.79 Agree Items for Referral to Board / Other Committees

Unconfirmed

It was agreed that the Chair's Assurance Report would refer to the discussions around Foundations for the Future and the issues highlighted in relation to the Electronic Healthcare Records systems.

PP26.80 Review of Meeting Effectiveness

It was confirmed that some challenging issues had been discussed and the conversations aligned with the Health Board values noting the need to continue to support one another and remain mindful of differing perspectives.

PP26.81 Date of Next Meeting

Thursday 3 September 2026, 9.15am

PP26.82 Resolution to Exclude the Press and Public

'Those representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960'

Unconfirmed

Planning, Population Health & Partnerships Committee Action Log (Public)

Updated 27.08.26

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	**PP26.70**	02.07.26	**Matters Arising & Action Log: Ablett Mental Health Unit** Interim Executive Director of Transformation and Strategic Planning to collate a position statement to confirm the proposed approach to the Ablett Mental Health Unit.	Paolo Tardivel	Nov 26	**Remain Open** **27.08.26** This is being discussed in further detail and an update will be provided in due course.
2	**PP26.76.1**	02.07.26	**Climate Adaptation and Decarbonisation Strategy Review** Director of Environment and Estates to ensure the Climate Adaptation and Decarbonisation Strategy are discussed further by the Executive Committee to consider the next steps for strengthening organisational coordination and strategic approach as well as developing a clear plan to support Board-level discussion.	Stuart Keen	Nov 26	**Remain Open** **27.08.26** This will be taken forward and an update will be provided in due course.
ACTIONS PROPOSED FOR CLOSURE						
1	**PP26.71.1**	02.07.26	**Director of Planning Report** Director of Corporate Governance to share concerns raised in relation to the suspended development of the Electronic Healthcare Records system and suggest a joint Chairs approach is adopted with Welsh	Pam Wenger	Sept 26	**Action proposed for closure** **27.08.26** Welsh Government approval has been received with conditions.

			Government.			
2	**PP26.71.2**	02.07.26	**Director of Planning Report** Director of Corporate Governance to reinforce the concerns raised by the Committee in relation to the Electronic Healthcare Records system in the presentation for the Escalation Board meeting.	Pam Wenger	Sept 26	**Action proposed for closure** **27.08.26** Welsh Government approval has been received with conditions.
3	**PP26.71.3**	02.07.26	**Director of Planning Report** People and Culture Committee to review the themes raised by staff during the engagement activity undertaken in relation to the Clinical Services Plan around the perception that staff do not feel enabled to implement the transformation required to change clinical services.	Pam Wenger Laura Jones	Sept 26	**Action proposed for closure** **27.08.26** This action has been transferred to the P&C Committee.
4	**PP26.71.4**	02.07.26	**Director of Planning Report** A strategic Board discussion to take place in relation to the Foundations for the Future Programme to determine opportunities to continue the full Organisational Change Programme or accelerate selected changes to improve stability, capacity and performance.	Pam Wenger	Sept 26	**Action proposed for closure** **27.08.26** This was discussed at the private session of the P&C Committee held on 13 August 2026.
5	**PP26.72.1**	02.07.26	**Integrated Medium Term Plan 2026-2029 Reflection and Learning Report** Performance, Finance and Information Governance Committee to review zero based budgeting to ensure budgets are fit for purpose moving forward and review the position routinely throughout the year.	Philippa Peake-Jones	Nov 26	**Action proposed for closure** **27.08.26** This action has been transferred to the PFIG Committee.

6	**PP26.53.1**	07.05.26	**Population Health Delivery Report** Executive Director of Public Health to recirculate the report outside of the meeting once the final year end figures have been calculated.	Jane Moore	Sept 26	**Action proposed for closure** **27.08.26** A copy of the report has been circulated outside of the meeting which includes figures updated to year end. **24.06.26** Data is still being collated and the information will be circulated outside of the meeting once available.
7	**PP26.48.1**	07.05.26	**Key Programmes Report** Acting Director of Digital, Data and Technology and Director of Corporate Governance to review progress and current status of the Mental Health Electronic Healthcare Records system and circulate an update outside of the meeting.	Justine Parry Pam Wenger	Sept 26	**Action proposed for closure** **27.08.26** An update has been circulated outside of the meeting. **22.06.26** The Chairs of BCU and CTM along with the CEOs have formally written to the Cabinet Minister for Health and Social Care this week in relation to the Mental Health Electronic Healthcare Records system and are awaiting a response. This has been shared with members of the PPHP Committee via email.
8	**PP26.48.2**	07.05.26	**Key Programmes Report** Director of Corporate Governance to share the draft Capital review commissioned by the Chief Executive relating to Llandudno Orthopaedic Hub and future project delivery.	Pam Wenger	Sept 26	**Action proposed for closure** **27.08.26** A copy of the Capital Governance Arrangements Advisory Report has been circulated outside of the meeting. **22.06.26** The Capital Report is

						currently with the CEO for sign off and will be shared with members of the PPHP Committee once approved.
Closed Actions (as agreed at meeting on 02.07.26)						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	**PP26.48.3**	07.05.26	**Key Programmes Report** Acting Director of Digital, Data and Technology to provide a briefing paper for the Committee Chair on the current position relating to the Laboratory Information Management System (LIMS).	Justine Parry	July 26	A Briefing Paper relating to the LIMS 2.0 Programme was shared with the Chair of the PPHP Committee.
2	**PP26.50.1**	07.05.26	**Director of Planning Report** Director of Corporate Governance and Interim Executive Director of Transformation & Strategic Planning to discuss the draft Well-being Statement outside of the meeting for inclusion in the Annual Report.	Pam Wenger Paolo Tardivel	July 26	**19.06.26** This has been discussed in detail and actioned.
3	**PP26.51.1**	07.05.26	**Citizen Experience and Engagement Report** Director of Partnerships, Engagement and Communications to share the report based on the Emergency Department patient experience with the Committee.	Helen Stevens-Jones	July 26	**23.06.26** The People's Experience ED Civica Survey Analysis 2025-26 has been circulated via email outside of the meeting for information.
4	**PP26.52.1**	07.05.26	**Emergency Preparedness, Resilience and Response Annual Report** Include an additional recommendation to state that the report has been endorsed for Board approval.	Pam Wenger	July 26	**18.06.26** A recommendation has been included in the minutes from the May 2026 meeting to state: It was resolved that the Committee ENDORSED the

						report for Board approval.
5	**PP26.52.2**	07.05.26	**Emergency Preparedness, Resilience and Response Annual Report** Executive Director of Public Health to ensure the Internal Audit report, actions and next steps are referenced in the report being shared with the Board in May 2026.	Jane Moore	July 26	**18.06.26** This information was included in the report that was submitted to the Board meeting in May 2026.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Planning, Population Health & Partnerships Committee

CITIZEN EXPERIENCE AND ENGAGEMENT REPORT

Dyddiad y Cyfarfod Date of Meeting	03 September 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications

Pwrpas yr Adroddiad Report Purpose	For Noting

**Crynodeb Gweithredol
Executive Summary**

This Citizen Experience and Engagement Report provides the Health Board with a high-level overview of citizen feedback from April to June 2026, with emerging issues from July where these materially inform the strategic picture. It draws together direct patient engagement, community conversations, political correspondence, digital engagement and the work of Llais.

Across these routes, the dominant themes are:

- Waiting times and access across planned care, diagnostics, primary care and NHS dentistry
- Urgent and emergency care conditions, hospital capacity and patient flow
- Continuity and coordination of care, particularly at discharge and between services
- Communication, involvement and confidence in how decisions are made
- Rural access, transport, digital exclusion and other dimensions of equity

Alongside these concerns, citizens consistently recognise compassionate and professional staff, clean and welcoming environments, Welsh-language care and responsive community services. Local feedback is producing identifiable service-

level changes. The continuing recurrence of the main system themes shows that stronger evidence of organisation-wide impact is still required.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
A draft version of the Report was discussed at Executive Committee	22.08.26	

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
GP	General Practitioner
NHS	National Health Service

CITIZEN EXPERIENCE AND ENGAGEMENT REPORT

1. SITUATION

1.1 PURPOSE

This report provides the Planning, Population Health and Partnerships Committee with a strategic overview and assurance on citizen feedback from April to June 2026. It focuses on the themes emerging from patient interactions, direct engagement, political correspondence, digital discussion and the work of Llais. Emerging issues from July are included where they materially inform the strategic picture.

The report considers not only what citizens are saying, but what this means for the Health Board: where feedback is translating into change, where themes remain persistent and what further assurance is needed that improvement is being experienced consistently.

2. BACKGROUND

2.1 What citizens are telling us: Headline themes

Across the available evidence, the dominant themes during this period were:

- Waiting times and access across planned care, diagnostics, primary care and NHS dentistry
- Urgent and emergency care conditions, hospital capacity and patient flow
- Continuity and coordination of care, particularly at discharge and between services
- Communication, involvement and confidence in how decisions are made
- Rural access, transport, digital exclusion and other dimensions of equity

These themes are highly consistent across different sources. Political correspondence and Llais representations most frequently raised planned-care waits, access to NHS dentistry, diagnostic delays, mental health access and cross-border care. Social media discussion focused on urgent care, bed capacity, discharge and community provision. Direct engagement highlighted the practical and emotional effects of uncertainty, travel and discontinuity.

Alongside these concerns, people repeatedly described staff as kind, professional and compassionate. Direct patient interviews also identified cleanliness, clear explanations, family involvement and Welsh-language care as important strengths. Community hospitals, NHS 111, paramedic-at-home care and community intravenous services were among the locally responsive services praised through Llais engagement.

This report brings together sources with different purposes and levels of representativeness. Political correspondence, complaints advocacy and social media are more likely to capture concern than routine positive experience; direct engagement activity is valuable but relatively small in scale. The findings should therefore be read as triangulated intelligence about recurring experience and risk, rather than as a statistically representative measure of all care.

2.2 All-Wales People's Experience Survey

From 1 April 2026 – 30 June 2026, the Health Board received 16,387 All-Wales People's Experience Survey responses. Of these, 96.03% were completed by patients and 3.96% by carers, family members or others. Overall, 86.61% of respondents rated their experience of accessing Health Board services positively: 18.14% rated it as 'good' and 68.47% as 'very good'.

73.52% of people shared positive experiences around "the time they waited" with 29.94% of respondents reporting the wait was 'about right', 11.01% felt it was 'a bit shorter than expected' and 32.57% felt it was 'much shorter than expected'.

In addition, 86.46% of respondents reported that they were 'always' treated with dignity and respect, while 90.99% said they were 'always' able to communicate in their preferred language.

Other key survey data:

- 75.35% of people were 'always' well cared for
- 79.31% of people were 'always' listened to
- 77.40% of people were 'always' involved in decisions about their care
- 81.69% of people said things were always explained to them in a way they could understand

The NHS Wales People's Experience Survey is now available to the public in nine of the most commonly spoken languages in Wales, together with a British Sign Language video survey.

2.3 Direct patient experience, learning and improvement

During Quarter 1, the People's Experience Service undertook 27 Care 2 Share visits across acute, community and specialist services, hearing directly from more than 103 patients, carers and staff. The strongest positive themes were compassionate and person-centred care, clear communication and involvement, cleanliness, food quality in many areas and the value of receiving care in Welsh.

Recurring areas for improvement included call-bell response times, communication during admission, transfer and discharge, access to suitable food and drink, and the availability of equipment and medicines. Feedback was escalated directly to the

relevant clinical and operational teams, resulting in prompt action. Examples included addressing a patient's dignity and mobility needs, strengthening the management of call-bell and catering concerns, improving the identification of Welsh-language needs and reviewing delays in medicines reaching a chemotherapy unit.

Access to feedback has also been widened through QR-code posters across the three acute hospitals and by ensuring that survey routes are available in nine commonly spoken languages and British Sign Language. Fourteen patient-information documents were reviewed through the Readers Panel, while interpretation-awareness sessions were delivered to targeted services.

Ward and service managers receive patient feedback each month and are expected to review themes and identify appropriate improvements. Learning is considered through Integrated Health Community and Specialist Services Patient and Carer Experience Groups, with broader themes and emerging trends reported through the Patient and Carer Experience Group to the Quality Delivery Group.

Citizen feedback is also increasingly informing strategic planning and service development, including the Ten-Year Strategy, Clinical Services Plan and Integrated Medium-Term Plan, as well as specific engagement and service-change programmes in Tywyn, Penley, Prestatyn and Rhyl.

This activity demonstrates that local feedback can lead to timely and practical change. The continuing assurance challenge is to demonstrate that recurring learning is consistently aggregated, shared and sustained across services, and that citizen experience is influencing organisation-wide priorities as well as local operational improvements.

3. SPECIFIC MATTERS FOR CONSIDERATION

To strengthen assurance that citizen voice leads to tangible change, the Executive Committee is presented with key themes arising from citizen engagement during this period, alongside actions taken and early indications of impact.

3.1 Waiting times and access to care

People said: Long waits remain the most consistent concern across planned care, diagnostics and access to services. Political correspondence and Llais representations particularly identified orthopaedics, dermatology and ophthalmology, as well as delays in diagnostic tests and results. People described increased pain, worsening quality of life, cancellations at short notice and anxiety where there was little communication about their place on a waiting list or what would happen next.

Llais Local engagement in Denbighshire, involving 165 people between January and March 2026, reinforced these themes. It identified long waits for ophthalmology,

orthopaedics and gastroenterology; difficulty accessing some GP practices; and people unable to secure NHS dental care. This sits alongside positive accounts of prompt local clinics and community services, illustrating variation in experience by service and place.

Access to NHS dentistry remains a prominent concern. People reported travelling long distances, paying privately or going without care, while changes associated with the new NHS dental contract have caused confusion. Public feedback for the Pharmaceutical Needs Assessment was generally positive about helpful and knowledgeable pharmacy teams and the wider services they provide. However, people also raised long queues, stock shortages, delays in dispensing, limited opening hours and the absence of delivery services.

Actions taken:

To reduce long waits for people waiting for appointments, the Planned Care Programme is coordinating 16 improvement initiatives, including additional evening and weekend clinics, use of external capacity in high-pressure specialties, waiting-list validation, electronic referrals, Community Health Pathways, modernised booking arrangements and development of a pan-Health Board ‘One Waiting List’ approach. During Quarter 1, more than 31,000 patient pathways were validated, resulting in almost 8,000 closures; electronic referrals were introduced across 10 specialties; 228 Community Health Pathways were delivered; and teledermoscopy achieved a 66% discharge rate.

These actions are contributing to some measurable improvement. Between July 2024 and May 2026, the number of people waiting more than two years for treatment reduced by 76%. The number waiting beyond the eight-week diagnostic target also fell by 52% between January and May 2026, from 21,800 to 10,461. However, the overall waiting list increased during April and May, and the Health Board continues to account for a disproportionate share of the longest waits in Wales. Further work is therefore required to translate increased activity and improved pathway management into consistently shorter waits and a better experience for patients.

Alongside this work to reduce waiting times, the Health Board continues to offer support for people while they wait for assessment or treatment. Information and self-management resources are available through the 'While You Wait' programme, providing advice on symptom management, maintaining wellbeing and accessing appropriate support whilst awaiting care. This aims to help people manage the impact of long waits and improve understanding of what support is available during this period.

While these actions are intended both to reduce waits and improve the experience of waiting, feedback continues to highlight communication and uncertainty as areas requiring further improvement.

3.2 Urgent and Emergency Care

People said: Urgent and emergency care continues to be associated with long waits, overcrowding, corridor care and a lack of comfort and basic amenities. Although political correspondence included fewer Emergency Department cases than in January to March, Healthcare Inspectorate Wales reporting about Ysbyty Glan Clwyd prompted renewed public discussion and personal accounts of prolonged waits, discharge delay and poor experience.

Social media discussion frequently connected Emergency Department pressures with bed availability, delayed discharge and limited step-down or rehabilitation capacity. Across April to June, monitoring recorded 6,651 engagements relating to the Health Board, of which 77% were categorised as negative. This is not a representative opinion survey, but it provides a useful indicator of the intensity and direction of online discussion during the period.

Despite frustration, people consistently distinguished between system performance and frontline staff, expressing support for nurses, doctors, paramedics and other colleagues working under pressure.

Actions taken:

The Urgent and Emergency Care Improvement Plan has been refreshed around three priorities: Discharge to Recover and Assess, frailty and clinical engagement. Site-specific 90-day plans are in place, supported by weekly CEO-led oversight and more detailed monitoring of ambulance handovers, 12-hour waits, time to triage and time to clinical assessment.

Operational actions underway include strengthening adherence to the ambulance handover through enhanced operational oversight; strengthened staffing and safety arrangements for patients cared for in undesignated areas; phased implementation of the Forward Waiting procedure; review of staffing against peak demand; implementation of the Emergency Department business case; and work to create additional clinical assessment space. The Forward Waiting approach at Wrexham Maelor has produced an improvement in ambulance handover performance, and time to senior clinical assessment is showing an improving trend.

A senior leader has recently been appointed as Recovery Director for Urgent and Emergency Care across BCU. They will provide stronger leadership and direction across the region, driving improvement and transformation to improve patient flow and safety. Urgent and Emergency Care extends far beyond Emergency Departments, so the plans will bring together colleagues and partners across the whole pathway to deliver better care for communities.

This remains a complex whole-system challenge and while some progress has been made, further sustained improvement is required. The programme remains focused on whole-hospital flow and discharge as the principal means of improving safety, dignity and experience in Emergency Departments. While these actions will not immediately eliminate concerns about corridor care or the comfort of patients waiting for care, reducing delays and improving patient flow should reduce the pressures that contribute to these issues. Further assurance will be required that improvements in performance are being experienced by patients through more timely, dignified and comfortable care.

3.3 Continuity, coordination and discharge

People said: Transitions between services are a recurring point of vulnerability. Patients described uncertainty when moving between departments, limited information about what would happen next and concerns not always being acknowledged. Llais reported concerns about cancer-care coordination, post-discharge care, end-of-life care and the recognition and involvement of unpaid carers in discharge planning.

The Quarter 1 People's Experience Service Activity Report provides contrasting examples of coordination at the point of discharge. The 'Dying Matters' story describes compassionate, joined-up end-of-life care provided by the Môn Enhanced Care Team, Beaumaris Health Centre and District Nursing. By contrast, the 'Missing Shoe' story highlights the loss of dignity and continuity experienced when an older person was discharged to residential care without one of her shoes.

The People's Experience Service has fed transition and discharge concerns directly to operational leaders, while Llais continues to raise the need for carers to be identified and involved. The expansion of the AiDi app and digital library support for adult carers in Gwynedd are positive developments, but do not replace consistent person-to-person involvement in discharge decisions.

Actions taken:

Executive-led, system-wide discharge reviews are now taking place each week, supported by validation of delayed-patient lists and a new dashboard highlighting Pathway of Care Delays.

The Health Board and local authorities have developed a shared purpose and implementation approach intended to strengthen joint ownership of discharge and address delays across organisational boundaries.

Further action includes accelerating reviews of patients with stays exceeding 21 days, embedding flow audits, strengthening the application of Discharge to Recover and Assess and Home First principles, and developing criteria-led discharge routes into virtual wards, Hospital at Home and hot clinics.

There has been month-on-month improvement since April in delays within the three acute hospitals, but this has not yet been replicated in community hospitals and the number of days lost to delay remains volatile. The current focus is therefore on embedding consistent discharge practice and demonstrating that improved flow is accompanied by better communication and involvement for patients and carers.

3.4 Communication, involvement and confidence

People said: Communication is both a feature of individual care and a determinant of confidence in the organisation. People value clear explanations and involvement in decisions, but describe anxiety where information is delayed, inconsistent or difficult to navigate. Llais also reported dissatisfaction with some complaint responses and difficulty identifying the right point of contact.

Engagement about proposed boundary changes for Healthy Prestatyn illustrated this clearly. Patients were concerned about continuity of relationships, the transfer of records and prescriptions, access to existing specialist services, the capacity of receiving practices and the practical effect of additional travel. Some questioned whether the decision had already been made and whether their views would genuinely influence the outcome.

Actions taken:

As outlined in section 2.3, the Health Board is widening access to feedback and using direct patient experience to support practical improvements at service level. Alongside this, learning from engagement is informing how the Health Board communicates and involves people in developing service proposals.

In relation to Healthy Prestatyn, further engagement sessions were arranged after the initial communication caused confusion and anxiety. Patients were given clearer information about the status of the proposal, the transfer of records and prescriptions, continuity of specialist support and the protection of GP access. Transport and accessibility concerns have also been identified for consideration through the Equality Impact Assessment. This learning will inform future service changes, particularly the need to explain proposals early and clearly, and to avoid creating the impression that decisions have already been made.

3.5 Rural access, transport and equity

People said: Rural geography magnifies access problems. Citizens described long travel distances, limited public transport, hospital parking difficulties, fragile local services and challenges accessing primary care, dentistry, diagnostics and specialist services. Older people also raised concern about the increasing use of digital systems and whether meaningful non-digital alternatives remain available.

A rural health briefing prepared for the Chief Medical Officer for Wales identifies wider structural factors, including hidden deprivation, housing affordability, seasonal

pressures, workforce recruitment and retention, digital connectivity and social isolation. It also highlights the strength of community-led responses, including transport schemes, wellbeing hubs, physical activity programmes and community-based mental health support.

Actions taken:

The Health Board recognises that rurality continues to create significant barriers to accessing care, including long travel distances, limited transport options, difficulties accessing some services and the risk of digital exclusion. These challenges cannot be addressed quickly and many reflect wider geographic, demographic and infrastructure factors. However, there are programmes of work being developed to improve local access and reduce the need for travel wherever possible.

The Community by Design programme is bringing together work intended to provide more care closer to home, strengthen prevention and reduce avoidable reliance on hospital services. National funding has been secured and initial priorities include urgent and same-day community care, management of long-term conditions and prevention. Work has begun to develop Breathlessness Hubs and a frailty model, while Primary Care, Radiology and Point of Care Testing teams are assessing opportunities to expand community diagnostics.

Related urgent care work includes progressing a Single Point of Access model, implementing a Community Based Falls Response Framework and providing falls-prevention support to care homes. These developments are intended to improve local access and reduce unnecessary travel or hospital attendance, particularly for older and more vulnerable people.

Although many of these initiatives remain at an early stage and measurable benefits have not yet been demonstrated, they represent a longer-term approach to addressing some of the factors that contribute to rural inequalities in access to care. Not all of the issues raised can be resolved solely through Health Board services, and continued collaboration with partner organisations will be required to address wider challenges relating to transport, digital connectivity and community infrastructure.

Rurality, transport, digital exclusion, Welsh-language needs and access to viable non-digital routes will therefore need to be explicitly considered through place-based planning and the impact assessment of individual service changes.

3.6 Compassionate care and strengths to build on

People said: Across all evidence sources, people continued to recognise staff kindness, respect and professionalism. Patients described staff taking time to explain care, involve families and see them as individuals. Welsh-speaking care increased

comfort and confidence, while clean and welcoming environments supported a sense of safety.

Community-based and responsive services were also praised, including Ruthin and Denbigh community hospitals, NHS 111, paramedic-at-home care, community intravenous services and the Rapid Diagnosis Clinic at Ysbyty Gwynedd. Thirty-nine Feel Good Friday awards were presented during the quarter, providing an additional route for recognising teams and sharing positive experience.

These strengths provide an important foundation for improvement, with further opportunity to identify what enables positive experience and spread this learning more consistently across services.

4. ENGAGEMENT ON STRATEGY AND SERVICE DEVELOPMENTS

Engagement is informing strategic development at two connected levels. Learning from the work undertaken so far has led the Health Board to bring the Ten-Year Strategy and Clinical Services Plan together as an integrated strategic planning portfolio, with a clearer connection between strategic ambition, the future clinical model and delivery. Stakeholder insight will form part of the strategic evidence base and case for change, with further engagement planned around strategic choices and trade-offs, priorities and outcomes, the draft Ten-Year Strategy and the emerging future Clinical Model. A joint Strategic Planning Programme Board and supporting engagement, advisory and assurance arrangements are being established to oversee this work.

Engagement is also shaping individual strategic service developments. The Penley Community Hospital consultation is now underway and includes drop-in sessions and community meetings, while continuing engagement in Tywyn has been seeking to capture the views of year-round and summer residents. At the Royal Alexandra Hospital, staff engagement and regular updates are supporting operational planning for Phase 1.

The Healthy Prestatyn engagement is a good example of feedback influencing a developing proposal. An eight-week process has included direct communication with affected households, four community events, online, telephone, email and written routes, staff sessions and engagement with Llais, elected representatives, GP practices and community stakeholders. Feedback about GP access, continuity of care, travel and transport is informing the Equality Impact Assessment and consideration of boundary amendments, alternative provision and implementation arrangements before the final proposal is presented for decision.

Taken together, this activity demonstrates a developing approach in which engagement contributes to strategic choices, service design and mitigation.

5. ASSURANCE FOR THE PLANNING, POPULATION HEALTH & PARTNERSHIPS COMMITTEE

Citizen feedback is being gathered through a growing range of sources, and the consistency of themes across surveys, direct engagement, community conversations, political correspondence and Llais reporting provides a credible picture of the main experience issues. There is evidence that feedback is producing practical change at service level and is increasingly informing strategic planning and service development. However, further assurance is required that recurring learning is systematically shared, sustained and translated into consistent improvement across the organisation,

6. RECOMMENDATIONS

6.1 The Planning, Population Health and Partnerships Committee is asked to:

- **NOTE** the key themes from citizen feedback.
- **ASSURE** itself that citizen voice is shaping organisational objectives and decision-making, as well as operational improvements.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	3. Improve Access, Outcomes and Experience If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	People First If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	Many of the themes highlighted in this paper align directly with existing risks on the Health Board's Board Assurance Framework (BAF) and Corporate Risk Register (CRR). These include risks relating to timely access and waiting times, quality and safety of care, workforce resilience, health inequalities, and reputation/public confidence. The citizen feedback presented here reinforces areas already identified as strategic risks and provides further evidence to inform mitigation and assurance.
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	A Healthier Wales If more than one applies, please list below:

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality** *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Do / Yes: ☐	No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	An Equality Impact Assessment (EqIA) is not required for this paper, as it provides a strategic summary of citizen feedback rather than proposing or implementing specific service changes. EqIAs will be undertaken as appropriate to support individual service change proposals.
Asesiad o'r Effaith Economaidd-gymdeithasol	Do / Yes: ☐	No: ☒
	Canlyniad/Outcome:	

A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol? **Socio-Economic Impact Assessment** *Have you undertaken a Socio-Economic Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	A Socio-Economic Impact Assessment is not required for this paper, as it provides a strategic summary of citizen feedback rather than proposing or implementing specific service changes.
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	**Galluogwyr Ansawdd** **Enablers of Quality** Culture and Valuing People	**Meysydd Ansawdd** **Domains of Quality** Person Centred
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	A Healthier Wales	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) **Environmental /Sustainability Impact (5Rs)**	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: **Armed Forces Covenant Due Regard Duty**	Do / Yes: ☐	Naddo / No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm:	

Have you considered the Armed Forces Covenant Due Regard Duty?	If no, please include rationale:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do / Yes: ☐	Naddo / No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Do / Yes: ☐	Naddo / No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	Yes (Include further detail below)	
	There is a risk to public confidence and reputation in relation to waiting times, bed capacity, staff shortages, corridor care and ambulance delays, underscoring the importance of timely reassurance, clear factual communication and addressing misinformation to maintain public confidence and reduce uncertainty	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Planning, Population Health & Partnerships Committee

EXECUTIVE DIRECTOR OF PUBLIC HEALTH REPORT SEPTEMBER 2026

Dyddiad y Cyfarfod Date of Meeting	03 September 2026
Statws Cyhoeddi Publication Status	Open/ Public
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Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Dr Jane Moore, Executive Director of Public Health
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Dr Jane Moore, Executive Director of Public Health

Pwrpas yr Adroddiad Report Purpose	For Approval

Crynodeb Gweithredol Executive Summary
This report provides the Planning, Population Health and Prevention (PPHP) Committee with an update on key prevention, population health and early intervention activities across the Health Board.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	**Dyddiad Date**	**Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data**

Acronymau / Rhestr Termau Acronyms / Glossary of Terms	
PHW	Public Health Wales
OPIP	Obesity Pathway Innovation Programme
EPRR	Emergency Preparedness, Resilience & Response

Executive Director of Public Health Report – September 2026

1. SITUATION

The purpose of this report is to provide Committee(s) with an update on a range of strategy and delivery matters. This is a regular report to PPHP raising key items for attention and information. It may also be used in other Committees when required.

2. BACKGROUND

This report replaces the former Population Health Quarterly Delivery Report (introduced in 2025). The former report provided details across a range of delivery programmes alongside additional detailed papers which provided organisational and regional context. This and subsequent reports are not intending to cover this detail and will therefore be concise, focused on providing assurance or matters of interest to the Committee.

3. SPECIFIC MATTERS

In preparation for the development of Health Board plan 2027/28 our activity is focused across the Health Board, bringing together practical inputs that enable teams and directorates to assess and implement core interventions focused on improving health inequalities, preventative approaches and improve population health outcomes.

3.1 STRATEGIC PRIORITY 1 – FOCUS ON HEALTH AND WELLBEING THROUGH EVERY STAGE OF LIFE

3.1.1 The **four principal areas** of focus for 2026/27 are:

- 1A – Preventative Approaches to Health & Wellbeing.
- 1B – Proactive strategies for disease prevention, falls & frailty
- 1C – Health Inequalities
- 1D – Health Protection

Prevention is an integrated theme across each of the priorities within the Strategic Intent which form the strategic framework for the IMTP.

4. 1A PREVENTATIVE APPROACHES TO HEALTH & WELLBEING

4.1 Gambling levy funding via Public Health Wales Ring-fenced Welsh Government statutory levy funding is to be distributed by Public Health Wales (PHW) to Health Boards for the period of September 2026-March 2027 to drive local action to embed a population health approach to gambling harm prevention across North Wales. BCUHB would receive £162,000 for the period for which the Health Board is accountable for spend of the funding to approved plans.

4.2 Obesity Pathway Innovation Programme (OPIP) - Public Health Wales (PHW) have been awarded £8m grant funding for 'MyPath Cymru', a digitally enabled and community led healthy weight pathway. PHW will lead the National Programme with two Health Boards planned to pilot the approach from August 2026 to January 2027 with remaining Health Boards implementing from January 2027. BCUHB is one of the Health Boards scheduled for implementation post pilot with a two-year funding allocation for local delivery of £270,000 each year.

A cross-directorate programme of work led by the Population Health Service to prepare for implementation including roles, governance and awareness raising. MyPath Cymru will support the implementation of the Weight Management Service Review recommendations.

4.3 BCUHB Health Improvement Framework *(formal paper update to PPHP agenda September 2026)* - A BCUHB Health Improvement Framework and Menu of Interventions has been developed to support a systematic approach to strengthening preventative health improvement interventions across the Health Board. It is an internal framework and the first attempt to set out both an evidence-based set of interventions and a structured and methodical approach to taking recommendations forward and making change happen.

4.4 Prevention and Early Years (PEY) and Whole School Approach to Emotional and Mental Wellbeing (WSAEMWB) grants - All PEY funding has been allocated with Service MoUs agreed and quarterly reports and meetings established. Regular finance meetings in place with re-allocation of Service underspend to agreed priorities. WSAEMWB MoUs agreed with six Local Authorities and an additional allocation of £9,200 offered by Public Health Wales in July to increase local workforce capacity was accepted by the Board, confirmation letter is awaited.

5.0 1B – PROACTIVE STRATEGIES FOR DISEASE PREVENTION, FALLS FRAILTY

5.1 Population Health Management and intelligence - The health board has delivered on key actions and milestones including recruitment to the Population Health Management posts which will contribute to developing and strengthening the Health Board understanding of population needs and how best to address these needs. The Population Health Management posts will help to develop intelligence led population approaches to delivering improvement.

5.2 High Value High Impact / Diabetes - Governance structures to support delivery of the programmes of work have been developed. The structures provide the mechanisms and assurance to quality improvement and transformation work linked to Diabetes, prevention and care in North Wales with the aim of improving outcomes and reducing unwarranted variation in access an outcomes of care. GP and cluster level processes for identifying unwarranted variation have been identified.

6.0 1C – HEALTH INEQUALITIES

6.1 Arts in Health – delivery against year two of the Three-year BCUHB 'Creative Well' Strategic Framework

Funded Projects – Delivery of Creative Approaches to Support Vulnerable Groups - The culmination of a three-year project in the Ty Llywelyn medium secure unit represents a notable success this year, which concluded with two performances in March of a play called ‘Hope’ about Ernest Shackleton’s expedition. 50 people were involved in the production, including 23 patients, who supported set design, script writing, music production, costumes, and acting.

Findings from the independent evaluation identified that the project gave men purposeful activity in an environment where boredom, isolation and lack of stimulation can be significant challenges. Furthermore, the creative sessions supported self-expression, helping men communicate, reflect and be seen beyond their diagnosis, offence history or patient status. Further details are provided in *Appendix A*. Plans have been developed to showcase a documentary film of the project for key stakeholders, supported by the BCUHB Chair.

BCUHB Staff Health and Wellbeing - Regular ‘Creative Well’ Forums for BCUHB staff are held to engage with training and learning around adopting creative approaches to wellbeing within services, benefiting both staff and service users. An integrated plan is being developed with colleagues from BCUHB Public Health, Occupational Health, Staff Psychology and Trauma Informed Wales align and strengthen the creative wellbeing offer to BCUHB staff.

Optimising ‘Creative Well’ opportunities within the Health Board and with Partners - Partnership Steering Group meetings provide an opportunity to strengthen how we measure the impact of our work, share notable practice, and identify funding and collaboration opportunities across the region. An example includes the 'Stepping In' project that is mentoring and upskilling Welsh-medium artists to work in the Arts in Health space. Work is also progressing to further integrate the creative wellbeing offer within our social prescribing services.

Strategic Direction The current ‘Creative Well’ Strategic Framework is due to refresh from the 30th September 2027. To align the next iteration with the Health Board's financial-year business cycle, the existing Framework will be extended to the end of March 2028. This extended period will enable strengthened co-production and ensure stronger alignment with Health Board planning cycles, whilst enabling delivery of existing commitments, including Grant Funded projects.

6.2 Joint Commissioning of Social Prescribing - Work has been progressing well with partners to secure joint-commissioning arrangements for each Local Authority Area. New three-year contracts have been secured for Anglesey, Gwynedd, Denbighshire, Wrexham and Flintshire, and progress is on track to procure a new provider in Conwy by October. These new arrangements optimise our collective efforts to prioritise prevention, early intervention, and holistic community-based support, reduce the risk of duplication, optimise local assets, enable an

increased focus on reducing inequalities, and secure improved stability and sustainability of our third sector providers. Quarterly monitoring meetings will ensure impact is captured, in line with the National Framework for Social Prescribing.

7.0 1D - HEALTH PROTECTION

7.1 Vaccination & Immunisation – most of the service will be relocating from leased accommodation and interim accommodation to Bryn Tirion, Bryn-y-Neuadd during the next few months. This will allow development of the centralised service operating across the Health Board and include storage facilities for vaccines. The move will allow a more streamlined delivery and enable efficient vaccine deployment, cost reduction and targeted delivery of service to meet population needs. It will also allow greater opportunity for collaborative working across the Public Health Directorate due to co-location.

Phase 2 (strategic matron immunisation role and support staff) and Phase 3 (integration of school immunisation teams into the integrated vaccination service) of the organisational change process are due to complete in November 2026 and 2027 respectively. This will provide greater integration and enable optimisation of vaccine uptake within the school delivery programmes.

7.2 Health Protection - A report from the service has been submitted to PPHP Committee as part of the September agenda.

8.0 Emergency Preparedness Resilience & Response (EPRR)

8.1 EPRR have built an established governance and risk framework aligned to national directives and frameworks. This includes representation and collaboration with multi agency partners and Local Resilience Forum requirements. Following consultation on a new national set of EPRR Core standards issued by NHS Performance & Improvement, EPRR governance structures and work programmes will be reviewed and updated to ensure ongoing compliance, alongside the review of the Civil Contingencies Act 2004.

8.2 Since April 2026, EPRR have led or supported 17 incident responses across the health board, examples of these are ensuring business continuity arrangements initiated in response to incidents involving potential service disruption from 3rd party Cyber-attacks, service delivery impacts following loss or interruption to digital clinical systems and the response to patient care, service continuity and staff welfare following a number of periods of extreme weather resulting in Heatwaves, with impact on wildfires initiating multi-agency collaboration and cooperation. A comprehensive heatwave report has been submitted to Welsh Government on our planning, response and lessons captured to improve future severe weather planning arrangements.

8.3 Business Continuity planning continues to improve across the health board with EPRR supporting service-based workshops, planning and exercising. A comprehensive governance programme and compliance dashboard has been introduced to measure performance and identify areas that require further support.

8.4 Internal training for management on call has reached 90% compliance across the health board, this together with attendance at external EPRR training and exercise events will continue to support incident response capability. Focus will now move to clinical major incident training response of front-line staff.

8.5 The EPRR team are proud to announce reaching shortlisting stage for the NHS Wales Team Culture award 2026, "Stronger Together and Embedding Resilience" (Appendix B) and the shortlisting of one of the Deputy Heads of EPRR for European Business Continuity and Resilience Newcomer 2026. Awards winners to be announced.

9.0 PREVENTION & POPULATION HEALTH IMPROVEMENT – ORGANISATIONAL DELIVERY

9.1 Annual Delivery Plan Strategic Priorities 2-4 The current Annual Delivery plan 2026/27 provides opportunities to consider prevention and population health. Appendix C provides an initial assessment carried out at the start of Q1 and demonstrates the breadth of activity where informed integration of population health planning could create environments for change and support evidencing a shift to prevention. Integral areas of work are Community by Design, development of the Clinical Services Plan and Strategy, Health and wellbeing hubs, Value based health, Demand and capacity modelling.

9.2 Removal of non-smoking narrative from patient reminder texts Public Health Directorate have challenged the proposed removal of non-smoking narrative from patient reminder texts as a scheme to reduce costs. Patient texts provide opportunity to strengthen BCUHB No Smoking policy position, evidence commitment to prevention and to promote our HMQ Service. A recent report identifies the cost of smoking to the health board at £299m The cost of smoking in Wales - Public Health Wales.

9.3 Future Generations – Assessment of Prevention Spend BCUHB is currently participating in a project led by the office of the Future Generations Commissioner. This work involves a budgetary assessment of organisational spend attributed to prevention over three years. The aim of the assessment is to provide organisation insight, strengthen the case for change and to provide a baseline to support future decision making and progression. Currently Hywel Dda health board and several local authorities are participating with further health boards due to participate.

10.0 KEY RISKS / MATTERS FOR ESCALATION

10.1 The Public Health Directorate is experiencing capacity issues due to several senior programme / leadership posts on long term leave. The workplan and prioritisation of key deliverables is under review by the Senior Leadership Team.

10.2 The BAF and Corporate Risk have been updated during July to reflect key deliverables in the Annual Delivery Plan.

11.0 RECOMMENDATIONS

The Committee is asked to:

- **CONSIDER** format to receive updates across all aspects of delivery, from across the health board.
- **NOTE** progress across all programmes of work.

Appendix A

Key evaluation findings from the Ty Llywelyn Arts in Health Project

An independent evaluation of the final third year of the project has been completed, focusing on the impact on the unit, as well as the patients and staff. Key findings include:

- The story for the play is about what creativity makes possible: confidence, connection, purpose, hope and a more human experience of care.
- The findings from Year 3 are strongly consistent with Years 1 and 2: the project improves confidence, wellbeing, social connection, motivation and engagement amongst the men in the Unit.
- There has been an observed reduction in incidents on the Unit, reduced medication (in some cases), and faster transitions to lower-secure settings.
- The project gives the men purposeful activity in an environment where boredom, isolation and lack of stimulation can be significant challenges, and acts as a protective structure within the Unit
- The creative sessions support self-expression, helping men communicate, reflect and be seen beyond their diagnosis, offence history or patient status.
- Conclusion – this project is not simply an arts activity; it is a strategic, low-cost, preventative, relational and recovery-focused intervention within a complex mental health setting.

An additional unintended benefit of the project relates to how patients who live in Ty Llywelyn perceive and respond to visitors and new members of staff on the Unit. Because of participating in the creative experience and building more trusted relationships, staff supporting the Unit report that patients are responding more positively to meeting new people.

Quotes from patients involved in the project:

“It takes your mind off being in hospital… gives a sense of normality.”

“The sessions are like a magic pill!”

“It has increased my confidence… getting to know others.”

Quotes from staff involved in the project:

“It didn’t feel so clinical… easier and faster to build rapport.”

“It builds resilience and confidence… patients interact more readily.”

Image 1: *Co-produced poster for the play performance*

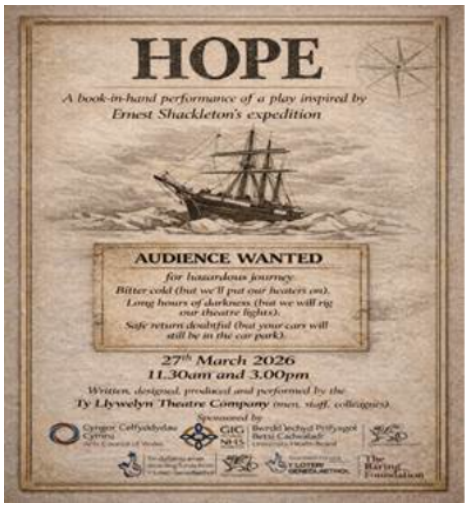


Image 2: Script read-through in the Unit



Image 3: Early taster performance for patients, carers and BCUHB staff (patient faces have been covered)



APPENDIX B – EPRR Poster entry NHS Awards



APPENDIX C – Initial assessment of Annual Delivery Plan links to Prevention / Population Health opportunities

Section	Ref	Deliverable
Community by Design	2A.5	The Health Board will strengthen the model of integrated primary and community care across North Wales by designing and delivering strategic priorities that align with the national Community by Design Transformation Programme. The key areas of focus will include urgent and same day care, management of chronic conditions in the community and prevention and population health management.
Management of Chronic Diseases	2A.6	Develop a costed primary care-led frailty model to enable proactive, coordinated care closer to home, as part of the Community By Design work. Identify the impact that current initiatives are having on maintaining patients at home.
	2A.7	Finalise a proposal to increase the use of the Audit Plus Frailty Tool in the community to ensure that patients receive proactive care in line with their agreed care plans.
Community by Design	2B.1	Develop Community by Design as a Major Change programme, working with partners to ensure it reflects national priorities and local needs.
	2B.3	Map current Enhanced Community Care services across North Wales, identifying where services are located and the differences. Develop a proposal that offers recommendations as to how to further reduce unnecessary hospital conveyance and admissions.
	2B.4	Develop a proposal for creating an investment fund for community groups and third sector organisations to work with the Health Board on community based solutions to some of the largest challenges facing the system.
Frailty Services	2B.9	The Health Board will enhance the coordination of care for people with long term conditions and improve access to a broader range of community-based services, investing in integrated primary and community care.
	2B.10	Implement appropriate best practice within the national Quality Statement for Older people and people living with frailty.
Community Diagnostics	2B.11	Develop a proposal to establish local breathlessness hubs to provide specialised support and care for people experiencing chronic breathlessness.
	2B.12	Diagnostic Provision in the Community will be reviewed including undertaking a needs assessment for diagnostics and working with current providers to review and agree the most efficient delivery mechanism.

Integrated H&WB Hubs	2C.1	Bangor Integrated Health & Well-being Centre – work with partners on a strategic outline case.
	2C.3	Penygroes Integrated Health & Well-being Centre – develop an outline business case, progress the parallel elements of the programme plan.
	2C.4	Porthmadog Integrated Health & Well-being Centre – revise options appraisal for location, progress the parallel elements of the programme plan.
	2C.5	Conwy West Integrated Health & Well-being Centre – finalise site location, progress the parallel elements of the programme plan.
	2C.8	Rhyl (Royal Alexandra Hospital - Phase 1) Integrated Health & Well-being Centre – commence construction, and progress the programme plan for delivery. Develop the case for Phase 2 later in the financial year.
UEC 1: Implement the Community-Based Falls Response Services	3A.1	Reduce avoidable ambulance conveyances and ED admissions from Care Homes through providing falls lifting equipment and level one falls prevention training to be delivered to 30 Care Homes across North Wales.
	3A.3	Reduce avoidable ambulance conveyances and ED admissions from the community by developing a proposal to use Six Goals Programme funding to increase Community Resource Teams (CRT) capacity, focused on mobilising Band 3 therapy support staff as a dedicated pan BCU community falls response resource.
Cancer	3B.10	Finalise the oncology clinical strategic plan for north Wales.
Fragile Services	3C.40	Design and implement a support package for services of concern in order to support their improvement, incorporating learning from the Clinical Services Plan Phase 1 work on Challenged Services.
Mental Health	3D.4	Engage with the National workstream to Improve Physical Health of People with Severe and enduring Mental Illness including review and alignment of the BCU MHLD physical health policy in line with national developments.
Learning Disabilities	3D.6	Reduce Health Inequalities for people with learning disabilities by increasing the uptake of the annual health checks and public health screening initiatives across services.
	3D.7	Define and formally adopt a tiered crisis response framework for LD services with clear pathways for prevention, early intervention, urgent response, intermediate care provision in partnership with the Local authorities and post-crisis stabilisation.
Digital Solutions	3D.8	Establish a digitally delivered specialist All-Wales gambling harm and treatment service.

CAMHS	3E.1	Early Help - Strengthen Early Intervention and Prevention. Develop and embed CAMHS Early Help systems and processes within the new model with partners across IHCs and regionally, to align with Flexible Open Access Mental Health Support and NYTH/NEST. Including: integration of schools in-reach, establishing reliable data reporting and measurement of impact, and establishing plans for secondary prevention that targets those at greatest risk of developing mental health problems.
C&YP Vaccination Uptake	3F.1	Delivery of school age immunisation programme by immunisation team with targeted work in low uptake areas.
Healthy Child Wales 2 Prog	3F.2	Working with partners, undertake a gap analysis of the requirements to fully implement the Healthy Child Wales 2 Programme and submit proposals to the Health Board for implementation.
Access to speciality Community Nursing - Children with complex needs	3F.5	Ensure that children with diabetes have timely provision of insulin pumps and CGM
	3F.6	Assess compliance with Diabetes NICE Guidance in readiness for the launch of the Type 1 diabetes screening programme for children
Access to Service for Children with LD	3F.8	Work with the Partnership Transformation Programme to commence the development of a strategic plan for children with a learning disability, and reduce inequalities for consultation.
	3F.9	Finalise and implement the Transition Pathways for children into adult services across all long-term conditions (respiratory, endocrine, cardiac and neurological conditions, cancer, CAMHS and Learning Disabilities).
Womens Health Plan	3G.3	As part of the Clinical Services Plan, undertake a comprehensive review of the configuration of Pan–North Wales Perinatal Services to ensure the delivery of safe, high-quality and sustainable care.
	3G.8	Deliver improvements to Women's Health prevention and early intervention, including preconception health and earlier identification of women's health conditions.
Raising Awareness of Prevention	3I.8	Design and implement a staff campaign to raise awareness of prevention - as it affects dementia.
Processes	4A.6	Review and improve the process for creating, reviewing, and approving business cases.
Structures	4A.7	Implement the Foundations for the Future design and thereby establish a clear organisational structure led by an effective and complete executive team with the leadership capacity and capability to deliver high quality, sustainable care.

Strategy	4B.1	Complete the Discovery Phase of the new 10-year Health Board Strategy by finalising evidence gathering, synthesising insights from key stakeholders, and undertaking structured engagement across the organisation and wider partners. This will culminate in an agreed Discovery Report, to inform the subsequent Design Phase of the Strategy.
	4B.2	Complete the full strategy design phase by translating the insights from the discovery phase into a validated strategic framework, including defined goals, strategic priorities, delivery roadmaps, and governance model, culminating in a final Strategy ready for Board approval. This will include structured engagement with key stakeholders throughout the design process to test assumptions, refine options, and build organisational alignment, ensuring aspects such as the Marmot principles (relating to early childhood, education, employment, preventing ill-health, housing and community well-being) are covered within the scope.
	4B.3	Implementation of the strategy will be via key underpinning quality impact assessed strategic plans (e.g. Clinical Services Plan) and their key deliverables falling within the 2027 30 IMTP.
Partner working	4B.4	Co-create a Third Sector Partnership Working Framework with Third Sector Partners to move to more proactive and strategic collaborative approach.
Improved Modelling	4B.5	Draw on support from NHS Performance and Improvement (NHS P&I) colleagues to develop proposals on an improved approach to a unified modelling across demand, capacity, skills mix, activity, performance, finance and workforce, incorporating benchmarking against other Health Boards – to be utilised in the 2027-30 IMTP planning cycle.
CSP	4C.1	Agree the CSP methodology and first tranche of areas to be prioritised and establish the CSP Programme by developing the programme structure, governance, and delivery approach, supported by targeted internal engagement and awareness raising activities to build understanding and organisational buy in.
	4C.2	Operationalise the CSP Programme by finalising detailed delivery plans for the process (pertaining to the first tranche of areas), establishing programme reporting and risk management processes, and initiating structured engagement with leads to prepare for CSP assessments.
	4C.3	Deliver the full CSP assessment process for the first tranche of priority services, including evidence gathering (including use of key population level intelligence, assessment workshops, option development and prioritisation.
	4C.4	Finalise and submit the first tranche of CSP service change proposals for formal approval by the CSP Programme Board. This will include refining proposals based on feedback, completing required documentation, and ensuring alignment with strategic, operational and financial considerations
Demand & Capacity	4D.1	Identify and commence implementation of best practice and tools available to support improved organisation wide demand and capacity planning.

Population Health Management	4D.11	Further enhance existing information products to introduce elements of Population Health Management (PHM) e.g. deprivation analysis, further identification of patient cohorts for targeted interventions. (Shared objectives with Public Health Team on PHM).
	4D.12	Create a suite of population health measures based on existing approaches that will facilitate sustainable healthcare transformation by targeting interventions that prevent ill health, improve care & support for people with ongoing health conditions, and reduce inequalities in health outcomes.
Innovation	4E.1	RD&I strategic plan and delivery plan approved, aligned to health board strategic intentions and national performance metric.
Research & Development	4E.5	Work with local academic partners to identify and implement to increase joint appointments and/or honorary contracts, closely working with the Academic Careers Community of Interest, ensuring that posts add value to research and innovation activity
Clinical Variation	4G.2	Review current progress with the implementation of the Value & Sustainability Board Diabetes' High Value High Impact (HVHI) pathway and produce a proposal to support further implementation. This is to be managed as part of the Primary Care IMTP plans.
Value Based Healthcare	4G.9	Develop a robust benefits framework for the programme, which allows for the effective measurement of activity and resources linked to VBHC (clinical staff, administrative staff, budgets, buildings, energy etc) to improve patient outcomes, patient experience and resource efficiency to ensure value and patient-centred care.
	4G.10	Use Value Based Health Care (VBHC) guidance for designing services, responding to key population level intelligence including OECD PaRIS report 2025 - Value in Health and through service level Patient Reported Outcome Measurements (PROMs), Patient Reported Experience Measurements (PREMs) and social value measures for procurement. This is to be managed as part of the Clinical Services Plan.
	4G.11	As part of our refined planning process, we will utilise the value-based approach that provides the discipline to stop low-value activity, shifting finite resources to prevention and earlier access, community-based care, better-value interventions, and supporting people to manage more of their own health. All of our major investment and dis-investment decisions should therefore be assessed according to their impact on outcomes, experiences, and the value generated from resources used. This is to be overseen by the Planning Team.
Effectiveness of Care	4H.14	Provide direction and oversight through the organisation's Quality governance for the application of appropriate best practice within the national Quality Statements - the ones not covered elsewhere in the plan are: Care of the critically ill, Respiratory Disease, Heart conditions, Kidney Disease, Liver Disease, Musculoskeletal health, Neurological conditions, Stroke, Infection prevention and control, Osteoporosis and bone health.

Estates Strategy	4I.5	Agree the approach to developing a revised Estates Strategic Plan, in line with the Health Board's 10-year Strategy and Clinical Services Plan.
Climate Adaptation, Decarbonisation	4I.10	Develop a BCUHB Climate Adaptation plan aligned with the NHS Wales Decarbonisation Plan and in parallel implement estate decarbonisation programmes.
	4I.11	Maximising the access to grant funding through the Refit Framework to deliver a programme of works to support carbon reduction.
Future Ways of working	4J.7	Implement in partnership strategic workforce planning across the organisation, improving alignment with Clinical Service Plans, use of technology, Financial Plans linked to IMTP objectives. Progress will be measured through the Foundations for the Future programme board. Plans will proactively identify any workforce capacity, skills and talent gaps and set out initiatives to address these in order to meet organisational objectives.
Financial control Environment	4K.1	Maintain financial control measures from start of financial year, with a view to step them down as assurance and confidence is being gained in delivery of the financial plan. Particularly important due to FFTF structure changes mid-year that could otherwise cause some disruption in delivery of financial plan.
Shift to Primary & Community	4K.4	Repeat the exercise to quantify current spend on primary and community services to compare against the baseline produced in 2025/26, in order to ascertain whether the required strategic move to proportionately increasing investment into primary and community care when compared to secondary care is happening.
Commisioning Strategic approach	4K.5	Develop and commence implementation of a Commissioning Strategic Approach for all externally commissioned healthcare activities, that provides direction to the organisation on the role of commissioned services as part of longer-term strategic planning. Forming strategic partnerships will be an important part of the Clinical Services Plan work.
Annual Commissioning review	4K.7	Individual services to undertake an annual review of all their commissioned and contracted services as part of the IMTP process to ensure that the right strategic decisions are made on what the organisation should provide or commission. This should trigger de-commissioning, recommissioning, as well as commissioning of new services where that best meets the needs of the population.
	4K.8	In advance of the annual review of all services, undertake a risk-based review of contracts to ensure they are delivering value against current population need.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	4.Create a Modern, People Centred Healthcare System Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: Strategic Objective 1 – Building and effective organisation, Strategic Objective 2 - Developing Strategy and long lasting change Strategic Objective 4 - Improving quality, outcomes and experience. Health Board Wellbeing Objectives: • to improve physical, emotional and mental health and well-being for all. • to target our resources to those with the greatest needs and reduce inequalities. • to support children to have the best start in life. • to work in partnership to support people – individuals, families, carers, communities – to achieve their own well-being. • to listen to people and learn from their experiences. Strategic Priority 1 – Focus on Health & Wellbeing through every stage of life. Prevention and Population Health are Ministerial priorities for 26/27 with specific deliverables.
Yr Egwyddorion Dylunio **Design Principles**	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: Consistency with organisational values Inclusive Design Equity & Accessibility Wise Spending Simplify, standardise and adopt good practice
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	CRR25-03 – Population Health *There is a risk that the organisation will fail to meet the health needs of the population and will not enable good health and wellbeing of the population.* BAF 26_01 *Failure to deliver improved population health and reduced inequalities* BAF24-05 - Not Engaging with Citizens, Partners and Communities ▪ BAF24-06 - Not Delivering the Required Improvements to Transform Care and Enhance Outcomes BAF24-08 - Not Implementing Evidenced Based Improvement and Innovation

Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality** *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o'r Effaith Economaidd-gymdeithasol *A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?* **Socio-Economic Impact Assessment** *Have you undertaken a Socio-Economic Impact Assessment*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	**Galluogwyr Ansawdd** **Enablers of Quality** Whole-systems Perspective Data to Knowledge	**Meysydd Ansawdd** **Domains of Quality** Person Centred All apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
	Data to knowledge	Efficient Safe
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant	A Healthier Wales	

Wellbeing of Future Generations Act – Wellbeing Goals		
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: **Armed Forces Covenant Due Regard Duty** Have you considered the Armed Forces Covenant Due Regard Duty?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Planning, Population Health & Partnerships Committee

QUARTERLY POPULATION HEALTH DELIVERY REPORTING 26/27 - QUARTER 1

Dyddiad y Cyfarfod Date of Meeting	03 September 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Business Sensitive
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Gwyneth Page, Head of Public Health Assurance and Development
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Dr Jane Moore, Executive Director of Public Health

Pwrpas yr Adroddiad Report Purpose	For Approval

Crynodeb Gweithredol Executive Summary
1. Quarter 1 performance target scorecard 2. Bi-annual Public Health Outcomes Framework update

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	**Dyddiad Date**	**Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data**

Acronyms / Glossary of Terms	
PHOF	Public Health Outcomes Framework
MMR	Measles, Mumps, Rubella
MenACWY	quadrivalent meningococcal vaccine
RSV	Respiratory Syncytial Virus
CO validation	readings of carbon monoxide (CO) in exhaled breath

QUARTERLY POPULATION HEALTH DELIVERY REPORTING 26/27 - QUARTER 1

1. Y SEFYLLFA
SITUATION

During the 2026/27 there are a range of key Prevention and early intervention focused performance indicators and targets which are being worked towards both nationally and locally as part of the National Performance Framework, Ministerial Priorities, national and local improvements as part of key programmes of work.

2. PERFORMANCE SCORECARD

Quarterly Measures	Target	Plan Trajectory	Q1 24/25	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27	Welsh Benchmark	Portfolio	Variance / Assurance	Reference
Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, Hib/MenC booster and second MMR dose)	95%	91%	*90.0%*	89.5%	88.8%	90.5%	89.7%	**87.6%**	*RIA*	4th of 7 (at Mar 26)	Public Health		1DP01 / NPF04
Percentage of children who are up to date with second MMR by age 5	N/A	91.0%	*91.1%*	90.5%	90.1%	90.3%	90.9%	**89.3%**	*RIA*		Public Health		-
Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the end of year 8	N/A	63%	-	-	61.4%	63.1%	0.1%	**23.9%**	*RIA*		Public Health		-
Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the end of year 9	N/A	76%	-	-	68.6%	70.4%	63.3%	**64.5%**	*RIA*		Public Health		-
Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	76%	*77.9%*	70.8%	71.7%	72.3%	70.3%	**70.8%**	*RIA*	6th of 7 (at Mar 26)	Public Health		1DP02 / NPF05
Percentage of teenagers receiving the MenACWY vaccination by the end of year 9	N/A	TBC	-	-	62.7%	66.4%	21.1%	**55.9%**	*RIA*		Public Health		-
Percentage of teenagers receiving the MenACWY vaccination by the end of year 10	N/A	71%	-	-	71.9%	72.5%	67.4%	**70.0%**	*RIA*		Public Health		-
Percentage of teenagers receiving the MenACWY vaccination by the end of year 11	N/A	77%	-	-	73.8%	**74.8%**	73.1%	**74.5%**	*RIA*		Public Health		-
Percentage of adult smokers who make a quit attempt via smoking cessation services	Q1: 1.5%	1.5%	*1.9%*	7.0%	2.3%	4.2%	6.0%	**8.1%**	*RIA*	3rd of 7 (at Mar 26)	Public Health		1AP01 / NPF01
Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks	40%	40%	*17.9%*	19.9%	24.9%	25.2%	22.0%	**22.5%**	*RIA*	4th of 7 (at Mar 26)	Public Health		1AP02 / NPF01
Tiny Tums – increase number of settings who achieve Tiny Tums award	10%↑	118	-	-	98	104	116	121	**125**		Public Health		
Come and Cook - increase family programmes via schools	12	3	-	-	4	0	3	1	**4**		Public Health		
Level 2 adult weight service - increase digital activity	10%↑	102	-	-	-	-	-	370	**138**		Public Health		1AP05

Seasonal Measures	Target	Plan Trajectory	Jun 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Welsh Benchmark	Portfolio		Reference
Percentage uptake of the influenza vaccination amongst children aged 2-3	N/A	TBC	-	42.8%	43.5%	44.0%	-	-	-		Public Health		-
Percentage uptake of the influenza vaccination amongst those aged 6 months to 64 years with clinical risk	N/A	TBC	-	39.4%	41.5%	42.8%	-	-	-		Public Health		-
Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	75%	TBC	-	73.8%	74.5%	75.3%	-	-	-	1st of 7 (at Mar 26)	Public Health		1DP03 / NPF06
Percentage uptake of the influenza vaccination amongst BCU staff	N/A	TBC	-	45.5%	45.9%	46.1%	-	-	-		Public Health		-

Monthly Measures	Target	Plan Trajectory	Jun 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Welsh Benchmark	Portfolio	Variance / Assurance	Reference
Percentage of patients (*adults) with diabetes who received all eight NICE recommended care processes	Equival-ent month increase	44%	*40.2%*	41.6%	43.1%	44.1%	43.7%	43.2%	**43.0%**	7th of 7 (at Mar 26)	Primary Care		1BP01 / 2AP05
Percentage of patients (*adults) with diabetes who have had foot surveillance recorded	80%	TBC	*65.6%*	65.6%	66.9%	67.8%	**67.1%**	66.1%	**65.3%**	5th of 7 (at Jun 26)	Public Health		2AP07 / NPF09
Percentage of patients (*adults) with diabetes who have had their urine albumin recorded	80%	2705	*59.2%*	62.1%	63.7%	64.9%	65.0%	**64.6%**	**64.4%**	6th of 7 (at Jun 26)	Public Health		2AP08 / NPF10
Inequalities: Number of clusters achieving 40% of 8 care processes completed	14	80%	*8*	10	10	11	11	11	**10**		Public Health		1CP02
Babies exclusively breast fed at birth	N/A	45%	*57.0%*	61.0%	61.5%	60.9%	59.9%	**57.9%**	**55.7%**		Women's		-
Percentage of babies who are exclusively breastfed at 10 days old	N/A	48%	*34.4%*	39.8%	38.5%	38.2%	39.7%	**36.7%**	**32.4%**		Public Health		1AP03
Babies exclusively breast fed at 6 weeks following birth	N/A	TBC	*31.6%*	33.4%	35.1%	33.7%	31.0%	**23.8%**	-		Public Health		-
Percentage uptake of the Respiratory Syncytial Virus (RSV) for those turning 75 years old	70%	45%						52.6%	**55.0%**	6th of 7 (at May 26)	Public Health		1DP04 / NPF07
Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%	TBC	*7.6%*	16.4%	21.8%	13.3%	8.6%	**11.9%**	-	4th of 7 (at Apr 26)	Public Health		1BP01 / NPF08
Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)	80%	TBC	*95.2%*	95.0%	97.5%	96.2%	97.6%	97.5%	**96.4%**	1st of 7 (at Mar 26)	MH&LD		3DP05 / NPF03

RIA = Reported in arrears

3.0 Reporting by exception – where items are off track or flagged

Performance Indicator	**Childhood and school immunisations.**
Risks and constraints to delivery	• Vaccine uptake / hesitancy • Data • Declining uptake in secondary vs primary school and primary vs pre-school • Inequity between high/low areas
Current Forecast year end position (impact under current conditions)	• Reporting in arrears – data for Q1 not yet available
Corrective actions required and by when	• Vaccine Equity plan is a key deliverable in 26/27 that will inform planning and provision • Workshop and framework developed to support reduction in inequity of access • Review of uptake data in community based sessions to inform planning and optimisation of uptake
Delivery confidence – to meet actual target in year	Low to meet actual national target however performance on 25/26 is anticipated to improve.
Performance Indicator	**% Uptake RSV - 75 year**
Risks and constraints to delivery	• Public awareness • Primary care capacity
Current Forecast year end position (impact under current conditions)	• Improvement achieved month on month reporting – increased uptake
Corrective actions required and by when	• Currently, there is monthly improvement on the position. • Plans are succeeding in driving uptake; however it is unlikely that the national target will be achieved.
Delivery confidence – to meet actual target in year	Low to meet actual national target, high in terms of meeting local ambition to see growth in uptake on 25/26
Performance Indicator	**% patients offered index colonoscopy within 4 weeks booking screening specialist practitioner assessment appointment**
Risks and constraints to delivery	• Capacity and demand across screening services. Nationally led screening activity.

Current Forecast year end position (impact under current conditions)	• Note: these figures are the wait time for index colonoscopy within 4 weeks of booking (target to achieve is 90%)
Corrective actions required and by when	• Public Health Wales are working with BCU Endoscopy Network Manager • Updated performance figures are being presented to BCU Cancer Partnership Board • Part of wider BCU planned work in relation to reducing variation in uptake across screening programmes to include bowel screening
Delivery confidence – to meet actual target in year	Low to meet national target.
Performance Indicator	**Adult Weight Service (L2) - increase digital activity**
Risks and constraints to delivery	• Change request has been submitted as performance targets are not reflected correctly.
Current Forecast year end position (impact under current conditions)	• Baseline position should start from zero. Total for 26.27 target is 380 demonstrating a 10% increase on 25.26
Corrective actions required and by when	• Approval for change request by Q2 report to PPHP
Delivery confidence – to meet actual target in year	On track
Performance Indicator	**Diabetes 8 Care Processes Percentage of patients with all eight care processes recording in primary care patient record and percentage of patients with foot surveillance / urine albumin tests recorded in primary care patient records**
Risks and constraints to delivery	• Work is underway with clusters and GPs who deliver Diabetes Care processes as part of annual clinical review to understand key issues and constraints. • Key issues identified to date are around data accuracy and completion of care within secondary care not recorded into GP patient records and limited access and offer within General Practice.
Current Forecast year end position (impact under current conditions)	• Unchanged
Corrective actions required and by when	• A newsletter will be issued to clusters and individual GPs with lower uptake of care processes followed by contact and support to complete a local action plan to target increased uptake in Q2 & Q3.
Delivery confidence – to meet actual target in year	Remains on track within current trajectory - for the eight care processes, 80% target for foot care and urine albumin remains a nationally set stretch target, with a further position update once targeted improvement work has commenced.
Performance Indicator	**Diabetes – inequalities – clusters achieving 40% 8 Care Processes**
Risks and constraints to delivery	• Work is underway with clusters and GPs who deliver Diabetes Care processes as part of annual clinical review to understand key issues and constraints. • Key issues identified to date are around data accuracy and completion of care within secondary care not recorded into GP patient records and limited access and offer within General Practice. •
Current Forecast year end position (impact under current conditions)	• Unchanged
Corrective actions required and by when	• *A newsletter will be issued to clusters and individual GPs with lower uptake of care processes will be contacted and supported to complete a local action plan to support increased uptake in Q2 & Q3.*
Delivery confidence – to meet actual target in year	Confidence in delivery in moderate - whilst year on year position is improving fluctuations in completion and data recording are evident. A position update will be possible once targeted cluster engagement and practice improvement work has been undertaken.
Performance Indicator	**Smoking Cessation – Quit attempt via Smoking Cessation Services**
Risks and constraints to delivery	• Data reporting periods – report in arrears

Current Forecast year end position (impact under current conditions)	• Reporting in arrears – data for Q1 not yet available
Corrective actions required and by when	• Data will be updated for next reporting period, once available
Delivery confidence – to meet actual target in year	
Performance Indicator	**Smoking Cessation – CO Validated at 4 weeks**
Risks and constraints to delivery	• There have been delays in the implementation of the national Pharmacy Level 2 local enhanced service with pharmacies offering CO validation to all HMQ Service users upon collection of their stop smoking medications • Telephone support remains a popular choice with service users
Current Forecast year end position (impact under current conditions)	• Reporting in arrears – data for Q1 not yet available
Corrective actions required and by when	• Currently there are early indications of an improvement on 25/26 figures however with slower than expected rollout of new pharmacy specification it is unlikely the 40% will be reached by the end of Q4.
Delivery confidence – to meet actual target in year	Low to meet actual national target, high in terms of meeting local ambition to see growth in uptake on 25/26
Performance Indicator	**% of babies who are exclusively breast fed at 10 days old**
Risks and constraints to delivery	There is a data discrepancy in reporting which is currently being investigated.
Current Forecast year end position (impact under current conditions)	There is a discrepancy in the wording and measure associated with breastfeeding nationally and locally. We are seeking to confirm whether the measure is: 'exclusively' breastfed of 'All' breastfed. The local trajectory is based on the latter ('All babies breastfed at 10 days') which incorporates both exclusive and breast + bottle fed..
Corrective actions required and by when	Confirm the correct measures for national and local reporting. We will continue to use the measure as described in the Health Board Annual Delivery Plan.
Delivery confidence – to meet actual target in year	The position is under trajectory however we note the data recording issue.

2. PHOF Update (Full report included as Appendix A)

4.1 PHOF indicator update

A range of PHOF indicators have been updated in July 2026, including the indicators which had been previously removed by Public Health Wales Observatory due to an error.

The indicators based on data from the latest National Survey for Wales (2024/25) have only been produced at health board and all Wales level; this is due to fieldwork issues resulting in lower response rates than previous years and smaller sample sizes[1]; local authority data is only available for 2021/22-2022/23.

4.2 BCUHB comparisons with Wales

BCUHB is statistically significantly better compared with Wales for working age adults satisfied with life; avoidable mortality; and preventable mortality.

BCUHB is statistically significantly worse compared with Wales for 11 to 16 year olds using alcohol; smoking; and drinking sugary drinks daily.

[1] Welsh Government, 2025. *National Survey for Wales headline results: April 2024 to March 2025*

3. EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE (EPRR)

Training compliance of management on call colleagues has reached 90% across the health board and the EPRR team now start to move training focus to clinical teams, including CBRN and Pandemic response arrangements.

4. MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

As we continue through quarter 2 2026/27, we have made progress on all major programmes of work and will see increasing efforts through the Autumn campaign to improve delivery and take up of staff vaccinations. We are also looking at continuing improvement against the 8 Care Processes for Diabetes and progression of the wider Diabetes programme.

5. RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO
KEY RISKS / MATTERS FOR ESCALATION

6.1 Delivery against ADP and associated metrics forms a significant element in reducing the risk score for Corporate Risk (CRR25-03) – Population Health, currently above tolerance (16) and also the Board Assurance Framework 26-01 -
Failure to deliver improved population health and reduced inequalities. The Corporate Risk has been refreshed and links directly to programmes of work which are reflected in the Health Board plan. Progress against the plan will contribute to delivering controls which support reduction of risk score over time.

6. ARGYMHELLION
RECOMMENDATIONS

7.1 Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:
The Committee is asked to:

- **Note** the content of the report and progress to date plus corrective actions.
- **Note** the PHOF update.

APPENDIX A – Public Health Outcomes Framework Update

The Public Health Outcomes Framework for Wales Update

Author: Claire Jones, Senior Public Health Intelligence Specialist, Public Health Intelligence, Research & Evaluation (PHIRE), BCU Public Health Directorate; Cllr Dr Rob Atenstaedt, Consultant in Public Health Medicine, Public Health Intelligence, Research & Evaluation (PHIRE), BCU Public Health Directorate; Dr Denise Alexander, Senior Public Health Practitioner, Public Health Intelligence, Research & Evaluation (PHIRE), BCU Public Health Directorate; Anna Varela-Raynes, Principal Public Health Practitioner Public Health Intelligence, Research & Evaluation (PHIRE), BCU Public Health Directorate.

Date: 28th July, 2026	**Version:** 0e (Working Draft)

Publication/ Distribution: (Delete as applicable)

- PPHP Committee

Review Date: n/a

Purpose and Summary of Document: To provide a summary of data from the Public Health Outcomes Framework tool as of July 2026.

Work Plan reference: N/A

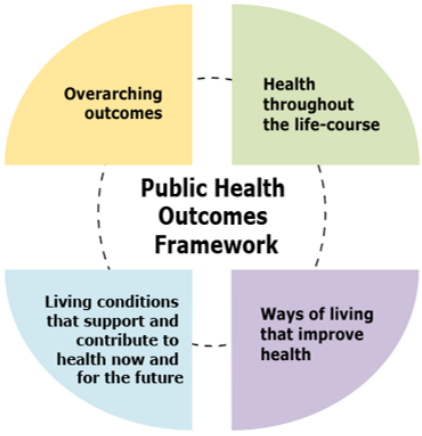
1. Introduction

The Public Health Outcomes Framework (PHOF) sets out a shared understanding of the health outcomes that are important to the people of Wales. It was published in March 2016 following 15 months of development, engagement and consultation. It can be used by Government, local communities, public services, private and voluntary sector organisations as well as individuals and their families to inspire and inform action to improve and protect health and well-being. It is linked to the Well-being of Future Generation Act's national indicators and milestones, which have been set by Welsh Government Ministers.

Within the framework, each outcome has individual indicators. It is through these indicators progress can be measured to see where BCUHB is now, and in the future.

The PHOF links closely to other outcomes frameworks. There is a direct overlap with some indicators that are shared across these frameworks, whilst there are some indicators which are complementary to others. All of the frameworks are overarched by the Well-being of Future Generations (WBFG) Act.

The Public Health Wales Observatory's PHOF reporting tool is available in English and Welsh : Public Health Outcomes Framework (2026)/ Fframwaith Canlyniadau Iechyd y Cyhoedd (2026).



The Public Health Wales Observatory have produced a Data Sources and Indicator Guide which describes the data sources, interpretation and limitations of the data used in the PHOF tool.

2. Public Health Outcomes Framework Indicator Update: July 2026

The PHOF reporting tool has recently been updated by the Public Health Wales Observatory and Cancer Analysis Team to support the PHOF for Wales, with the support of Health Board Public Health Directorates, including BCUHB. The tool is being developed iteratively as the latest data becomes available.

In January 2026, we were informed by the Public Health Wales Observatory of an error in the indicators that they have produced for the national PHOF reporting tool, that use data from the National Survey for Wales (NSW). These indicators were removed from the PHOF reporting tool and from any of our local health intelligence reports.

The indicators have since been amended and included in the PHOF reporting tool. However, local authority data is only available for 2021/22-2022/23. The indicators using the latest National Survey for Wales data for 2024/25 have only been produced at health board and all Wales level; this is due to fieldwork issues resulting in lower response rates than previous years and smaller sample sizes (Welsh Government, 2025).

The recently updated and corrected PHOF indicators are shown in Table 1, along with the latest available year and geographical level.

Table 1: Latest PHOF indictors published, by latest available year and geographical level

	Indicator	Latest available year	
		BCUHB level only	Local authority level
Overarching outcomes	Life Expectancy at Birth: Males (Years)		2022-2024
	Life Expectancy at Birth: Females (Years)		2022-2024
	Healthy Life Expectancy at Birth: Males (Years)		2022-2024
	Healthy Life Expectancy at Birth: Females (Years)		2022-2024
	Mental well-being among adults	2024/2025	
	Mental well-being among adults		2022/2023
	Gap in healthy life expectancy at birth between most and least deprived: Males (Years)	2022-2024	
	Gap in healthy life expectancy at birth between most and least deprived: Females (Years)	2022-2024	
Living conditions that support and contribute to heath now for the future	Percentage of children (aged 0-15) living in poverty*	2024/25	2024/25
	Percentage of people able to afford everyday goods and activities*	2024/2025	
	Percentage of people able to afford everyday goods and activities*		2021/22-2022/23
	Percentage of people in education, employment or training. Persons aged 16-18 years	2024 (wales only)	
	Percentage of people in education, employment or training. Persons aged 19-24 years	2024 (wales only)	
Ways of living that improve health	Percentage reporting a sense of community	2024/2025	
	Percentage reporting a sense of community		2021/2022
	Percentage adults reporting to volunteer	2024/2025	
	Percentage adults reporting to volunteer		2022/2023
	Percentage adults reporting to feel lonely	2021/22-2022/23	2021/22-2022/23
	Quality of the air we breathe, average NO_2 concentration (ug/m^3), residential dwellings*		2023
	Percentage of adults (aged 16 years and over) who smoke	2024/2025	2021/22-2022/23
	Percentage of adults (aged 16 years and over) meeting physical activity guidelines	2024/2025	2021/22-2022/23
	Percentage of adults (aged 16 years and over) drinking alcohol above recommended guidelines	2024/2025	2021/22-2022/23
	Percentage of adults (aged 16 years and over) eating 5 fruit or vegetable portions a day	2024/2025	2021/22-2022/23
	Percentage females smoking in pregnancy	2024	
Health through the lifecourse	Percentage of working age adults in good health	2024/2025	2021/22-2022/23
	Percentage of working age adults free from limiting long term illness	2024/2025	2021/22-2022/23
	Percentage of working age adults satisfied with life	2024/2025	2021/22-2022/23
	Percentage of working age adults of healthy weight	2024/2025	2021/22-2022/23
	Percentage of older people in good health	2024/2025	2021/22-2022/23
	Percentage of older people free from limiting long term illness	2024/2025	2021/22-2022/23
	Percentage of older people satisfied with life	2024/2025	2021/22-2022/23
	Percentage of older people of healthy weight	2024/2025	2021/22-2022/23

Source: Public Health Wales; Public Health Outcomes Framework Tool

3. BCUHB and Wales comparisons

The following tables and charts have been taken from the PHOF tool and show Betsi Cadwaladr UHB's position compared to Wales across all the PHOF indicators.

Tables 2 and 3 show the indicators which BCUHB is statistically significantly better or worse compared to Wales. Statistical significance determines whether a difference is caused by something other than chance.

Table 2: PHOF indicators for BCUHB, which are statistically significantly better compared to Wales

	BCUHB statistically significantly better than Wales
Overarching Outcomes	NIL
Living conditions that support and contribute to heath now for the future	NIL
Ways of living that improve health	NIL
Health throughout the life-course	Percentage of working age adults satisfied with life Avoidable mortality, rate per 100,000 persons Preventable mortalilty, rate per 100,000 persons

Table 3: PHOF indicators for BCUHB, which are statistically significantly worse compared to Wales

	BCUHB statistically significantly worse than Wales
Overarching Outcomes	NIL
Living conditions that support and contribute to health now for the future	NIL
Ways of living that improve health	Percentage of 11-16 year olds using alcohol Percentage of 11-16 year olds who smoke Percentage of 11-16 year olds drinking sugary drinks once a day or more
Health throughout the life-course	NIL

4. Summary of Unitary Authority data

The following section summarises any available trends and comparisons of statistical significance with Wales if available in the latest PHOF tool, followed by full data tables for each PHOF domain.

4.1 Overarching outcomes and indicators

Years of life and years of health

Life expectancy at birth for males and females in BCUHB (2022-24) has remained fairly stable. For males, life expectancy in Wrexham is statistically significantly lower compared to Wales; for females, it is statistically significantly lower in Denbighshire but higher in Gwynedd compared to Wales.

Healthy life expectancy for males and females across BCUHB as a whole has declined in 2022-24. Years of healthy life expectancy for BCUHB as a whole and each of the unitary authorities are similar to Wales.

Mental well-being
The 2024-25 mental well-being scores for BCUHB are similar to Wales. The latest available scores at unitary authority level are for 2022/23 and are also similar to the Wales score in the same period.

A fair chance of health
The latest available data (2020-22) on the gap in life expectancy between the most and the least deprived males in BCUHB (7.2) is similar to Wales (7.8), with little change since 2018-20.

Data on the gap in healthy life expectancy for 2022-24 is only available at an all Wales level. The latest available data for BCUHB and unitary authorities is still 2018-2020.

Overarching outcomes and indicators

BCUHB comparison with Wales	BCUHB comparison with previous data
Significantly higher then Wales	↑ Increased
Similar to Wales	↔ Similar
Significantly lower than Wales	↓ Decreased

Years of life and years of health	Year	Wales	BCUHB Trend	BCUHB	Isle of Anglesey	Gwynedd	Conwy	Denbighshire	Flintshire	Wrexham
Life Expectancy at Birth: Males (Years)	2022-24	78.3	↔	78.4	78.7	78.8	78.9	77.7	78.8	77.5
Life Expectancy at Birth: Females (Years)	2022-24	82.2	↔	82.4	82.7	83.2	82.6	81.2	82.4	82.1
Healthy Life Expectancy at Birth: Males (Years)	2022-24	59.2	↓	60.6	61.2	62.3	61.1	59.9	59.1	60.3
Healthy Life Expectancy at Birth: Females (Years)	2022-24	58.5	↓	60.1	61.1	62.5	60.7	59.2	58.2	60.1

Source: Public Health Wales Observatory, PHOF Reporting Tool

Statistical comparisons with Wales not included in the PHOF tool for these indicators: confidence intervals cannot be calculated due to data availability.

Mental well-being	Year	Wales	BCUHB Trend	BCUHB	Isle of Anglesey	Gwynedd	Conwy	Denbighshire	Flintshire	Wrexham
Mental well-being among adults: age-standardised average, Warwick-Edinburgh Mental Well-being Scale. Score from 14 to 70 with a higher score representing better mental well-being*	2024/2025	48.3	N/A	49.4	LA data not available for 2024/2025					
	2022/23	48.1	N/A	48.5	46.5	48.7	48.3	49.5	47.4	48.9

Source: Public Health Wales Observatory, PHOF Reporting Tool
*National Indicator for Wales

Statistical comparisons with Wales not included in the PHOF tool for these indicators: confidence intervals cannot be calculated due to data availability.

A fair chance of health	Year	Wales	BCUHB Trend	BCUHB	Isle of Anglesey	Gwynedd	Conwy	Denbighshire	Flintshire	Wrexham
Gap in healthy life expectancy at birth between most and least deprived: Males (Years)	2022-24	18.1		2022-24 data available for Wales only*						
Gap in healthy life expectancy at birth between most and least deprived: Females (Years)	2022-24	19.0		2022-24 data available for Wales only*						
Gap in life expectancy at birth between most and least deprived: Males (Years)	2020-22	7.8	↔	7.2	6.0	3.0	7.5	9.2	8.0	7.3
Gap in life expectancy at birth between most and least deprived: Females (Years)	2020-22	6.5	↔	5.7	2.8	2.8	5.3	8.9	5.5	7.5
Gap in healthy life expectancy at birth between most and least deprived: Males (Years)	2018-20	13.3	↔	12.2	7.8	4.9	18.8	10.8	9.9	18.8
Gap in healthy life expectancy at birth between most and least deprived: Females (Years)	2018-20	16.9	↓	10.9	7.4	1.7	13.8	5.0	14.4	10.6

Source: Public Health Wales Observatory, PHOF Reporting Tool

4.2 Living conditions that support and contribute to health now and for the future

Children have the best opportunity for a healthy start
In 2024/25, the percentage of children aged 0 to 15 years living in poverty in BCUHB (21.7%) is similar to Wales (21.2%). This ranges from 19.1% in Flintshire to 24.1% on the Isle of Anglesey. Statistical significance comparisons with Wales were not provided in the PHOF tool for this indicator.

Families and individuals have the resources to live fulfilled, healthy lives
The availability of data for indicators in this topic vary in terms of time period, geographical level and statistical comparisons with Wales.

Resilient, empowered communities
The availability of data for indicators in this topic vary in terms of time period, geographical level and statistical comparisons with Wales.

Living conditions that support and contribute to health now and for the future

BCUHB comparison with Wales	BCUHB comparison with previous data
Significantly higher then Wales	↑ Increased
Similar to Wales	↔ Similar
Significantly lower than Wales	↓ Decreased

Statistical comparisons with Wales not included in the PHOF tool for these indicators: confidence intervals cannot be calculated due to data availability.

Children have the best opportunity for a healthy start	Year	Wales	BCUHB Trend	BCUHB	Isle of Anglesey	Gwynedd	Conwy	Denbighshire	Flintshire	Wrexham
Percentage of children (aged 0-15) living in poverty*	2024/2025	21.2	↓	21.7	24.1	22.9	22.6	23.5	19.1	20.4

Source: Public Health Wales Observatory, PHOF Reporting Tool
*National Indicator for Wales

Note:
Children living in poverty: households with an income below 60% of the UK median income before costs are paid, by financial year.

Families and individuals have the resources to live fulfilled, healthy lives	Year	Wales	BCUHB Trend	BCUHB	Isle of Anglesey	Gwynedd	Conwy	Denbighshire	Flintshire	Wrexham
Percentage of people able to afford everyday goods and activities*	2024/2025	88.6	N/A	89.2	LA data not available for 2024/2025					
Percentage of people able to afford everyday goods and activities*	2021/22-2022/23	86.7	N/A	87.8	88.9	86.1	90.8	89.1	87.6	85.8
Percentage of people in education, employment or training. Persons aged 16-18 years*	2024	88.3	N/A	Wales only						
Percentage of people in education, employment or training. Persons aged 19-24 years*	2024	85.3	N/A	Wales only						
Percentage gap in employment rate for those with long term health conditions	2024	12.0	↔	11.9	16.2	12.0	13.2	13.4	9.2	10.8

Source: Public Health Wales Observatory, PHOF Reporting Tool
*National Indicator for Wales

Statistical comparisons with Wales not included in the PHOF tool for these indicators: confidence intervals cannot be calculated due to data availability.

Resilient, empowered communities	Year	Wales	BCUHB Trend	BCUHB	Isle of Anglesey	Gwynedd	Conwy	Denbighshire	Flintshire	Wrexham
Percentage reporting a sense of community*	2024/2025	56.8	N/A	61.9	LA data not available for 2024/2025					
Percentage reporting a sense of community*	2021/2022	64.2	N/A	65.9	66.9	72.4	70.7	65.5	62.7	58.4
Percentage adults reporting to volunteer*	2024/2025	32.1	N/A	35.2	LA data not available for 2024/2025					
Percentage adults reporting to volunteer*	2022/2023	29.7	N/A	28.6	25.8	33.0	23.3	25.3	29.8	29.9
Percentage adults reporting to feel lonely*	2021/22-2022/23	12.8	N/A	11.5	11.1	10.5	9.3	9.1	11.2	15.9

Source: Public Health Wales Observatory, PHOF Reporting Tool
*National Indicator for Wales

Statistical comparisons with Wales not included in the PHOF tool for these indicators: confidence intervals cannot be calculated due to data availability.

Natural and built environment that supports health and well-being	Year	Wales	BCUHB Trend	BCUHB	Isle of Anglesey	Gwynedd	Conwy	Denbighshire	Flintshire	Wrexham
Quality of housing: % assessements free from category 1 hazards*	2021/22-2023/24	68.7	↓	78.7	43.6	73.5	92.4	84.3	62.6	59.7
Quality of the air we breathe, average NO_2 concentration (ug/m^3), residential dwellings*	2023	6.8	↓	4.8	3.1	3.1	4.0	4.1	6.3	6.5

Source: Public Health Wales Observatory, PHOF Reporting Tool
*National Indicator for Wales

Note:

Category 1 hazards: The Housing Health and Safety Rating System (HHSRS) is used to determine whether residential premises are safe to live in. Local authorities use the System to determine whether a hazard exists that may cause harm to the health and safety of a potential occupant. Hazards are divided into two categories. Those which score high on the scale (and therefore the greatest risk) are called Category 1 hazards. Those that

fall lower down the scale and pose a lesser risk are called Category 2 hazards. Where a condition is classified as a Category 1 hazard the local authority has a duty to take the appropriate enforcement action. If it poses a Category 2 hazard the local authority may take enforcement action (Public Health Wales, 2025).

4.3 Ways of living that improve health

Healthy actions
Data from the Schools Health Research Network Survey (SHRN) 2023, show that students aged 11 to 16 in BCUHB report statistically significantly higher percentages of using alcohol, smoking and drinking sugary drinks compared to Wales as a whole.

At unitary authority level, alcohol use is statistically significantly higher compared to Wales in Gwynedd and Flintshire. Smoking is statistically significantly higher on the Isle of Anglesey, Gwynedd, Flintshire and Wrexham.

Physical activity levels are statistically significantly higher compared to Wales as a whole in Conwy and Denbighshire, but lower in Wrexham.

Daily surgary drinks consumption is statistically significantly higher for Isle of Anglesey, Flintshire and Wrexham, compared to Wales as a whole.

The latest adult (16 years and over) health behaviours data from the National Survey for Wales (2024/25) is only available at Wales and health board level. The percentages of adults in BCUHB who report smoking, drinking alcohol above guidelines, meeting physical activity guidelines and eating five portions of fruit or vegetables daily are similar to Wales.

UA level data are available for 2021/22-2022/23; statistical significance comparisons with Wales were not provided in the PHOF tool for this indicator.

Healthy start
Teenage conceptions rates across BCUHB and the six UAs are similar to the Wales average.

The percentage breastfeeding at 10 days in BCUHB as a whole is similar to Wales. At UA level, breastfeeding is statistically significantly lower in Wrexham and higher in Gwynedd compared to Wales as a whole.

Ways of living that improve health

BCUHB comparison with Wales		BCUHB comparison with previous data	
	Significantly higher then Wales	↑	Increased
	Similar to Wales	↔	Similar
	Significantly lower than Wales	↓	Decreased

Healthy Actions	Year	Wales	BCUHB Trend	BCUHB	Isle of Anglesey	Gwynedd	Conwy	Denbighshire	Flintshire	Wrexham
Percentage of 11-16 year olds using alcohol	2023	35.6	N/A	36.8	36.6	38.2	36.2	33.7	39.3	34.7
Percentage of 11-16 year olds who smoke	2023	2.6	N/A	3.3	4.5	3.4	2.9	2.5	3.6	3.2
Percentage of 11-16 year olds physically active every day (at least 60 mins) in past week	2023	18.3	N/A	18.2	18.3	18.3	20.2	19.7	17.6	16.1
Percentage of 11-16 year olds drinking sugary drinks once a day or more	2023	17.5	N/A	18.1	21.5	14.3	17.1	16.8	19.4	20.6

Source: Public Health Wales Observatory, PHOF Reporting Tool

Statistical comparisons with Wales not included in the PHOF tool for these indicators: confidence intervals cannot be calculated due to data availability.

Healthy Actions	Year	Wales	BCUHB Trend	BCUHB	Isle of Anglesey	Gwynedd	Conwy	Denbighshire	Flintshire	Wrexham
Percentage of adults (aged 16 years and over) who smoke	2024/2025	10.2	N/A	8.7	LA data not available for 2024/2025					
Percentage of adults (aged 16 years and over) meeting physical activity guidelines	2024/2025	60.0	N/A	61.8	LA data not available for 2024/2025					
Percentage of adults (aged 16 years and over) drinking alcohol above recommended guidelines	2024/2025	14.9	N/A	15.1	LA data not available for 2024/2025					
Percentage of adults (aged 16 years and over) eating 5 fruit or vegetable portions a day	2024/2025	32.9	N/A	34.1	LA data not available for 2024/2025					
Percentage of adults (aged 16 years and over) who smoke	2021/22-2022/23	13.0	N/A	12.6	10.4	17.1	6.3	13.8	11.3	14.5
Percentage of adults (aged 16 years and over) meeting physical activity guidelines	2021/22-2022/23	56.0	N/A	49.3	42.0	46.9	37.4	56.1	52.8	56.3
Percentage of adults (aged 16 years and over) drinking alcohol above recommended guidelines	2021/22-2022/23	16.4	N/A	16.4	12.5	19.8	14.1	14.9	18.4	15.3
Percentage of adults (aged 16 years and over) eating 5 fruit or vegetable portions a day	2021/22-2022/23	29.1	N/A	25.4	16.1	27.2	23.2	23.3	29.3	28.0

Source: Public Health Wales Observatory, PHOF Reporting Tool

BCUHB comparison with Wales	BCUHB comparison with previous data
Significantly higher then Wales	↑ Increased
Similar to Wales	↔ Similar
Significantly lower than Wales	↓ Decreased

Healthy Starts	Year	Wales	BCUHB Trend	BCUHB	Isle of Anglesey	Gwynedd	Conwy	Denbighshire	Flintshire	Wrexham
Teenage conception rates per 1,000 females aged under 18	2022	15.7	↔	17.6	16.8	14.5	15.1	20.9	19.8	17.7
Percentage females smoking in pregnancy	2024	N/A	↔	15.8	Health Board level only					
Percentage breastfeeding at 10 days	2024	38.8	↔	37.9	38.4	42.4	36.9	37.6	37.2	35.3
Percentage vaccination rate at age 4 years	2024/25	85.3	↔	86.8	91.4	88.0	83.0	86.1	87.3	86.4

Source: Public Health Wales Observatory, PHOF Reporting Tool

4.4 Health throughout the life-course

Health in the early years and childhood

The percentages of low-birth-weight births across BCUHB as a whole and at UA level are similar the Wales.

The mean number of decayed, missing and filled teeth in 5-year-olds across BCUHB and the unitary authorities are similar to the Wales average with the exception of Conwy and Flintshire where they are statistically significantly lower compared to Wales.

Good health in working age
The latest health data from the National Survey for Wales (2024/25) is only available at Wales and health board level. BCUHB reports similar levels to Wales for self-reported good health, being free from limiting long term illness and being a healthy weight. The percentage of working aged adults in BCUHB reporting to be satisfied with life is statistically significantly higher compared to Wales as a whole.

UA level data are available for 2021/22-2022/23; statistical significance comparisons with Wales were not provided in the PHOF tool for this indicator.

Healthy aging
The latest health data from the National Survey for Wales (2024/25) is only available at Wales and health board level. BCUHB reports similar levels to Wales for self-reported good health, being free from limiting long term illness, being a healthy weight and life satisfaction.

UA level data are available for 2021/22-2022/23; statistical significance comparisons with Wales were not provided in the PHOF tool for this indicator.

The latest data on hip fractures in persons aged 65 years and over is for 2023/24 and is only available for Wrexham. This is due to all Wales issues with coding completeness and data suppression.

Minimising avoidable ill health
The rate of premature deaths from non-communicable diseases in BCUHB has declined and is similar to Wales. At UA level, rates are statistically significantly higher compared to Wales in Denbighshire and Wrexham.

The death rate from injuries in BCUHB has increased and is similar to the Wales average. At UA level, rates are statistically significantly lower in Flintshire compared with Wales; all other UAs are similar to Wales.

Deaths from road traffic injuries in BCUHB have remained stable and are similar to Wales. Road traffic injury death rates are statistcally significantly higher in Conwy and Wrexham compared to Wales.

The BCUHB suicide rate has increased recently and is similar to the all Wales rate. The rates are also similar at UA level with the exception of Flintshire which is statistically significantly lower compared to Wales.

The avoidable mortality rate for BCUHB has increased but the rate is statistically significantly below Wales. Rates are also statistically significantly lower for Isle of Anglesey and Flintshire.

Preventable mortality has declined in BCUHB and, along with Flintshire, is statistically significantly below Wales.

Treatable mortality has recently increased in BCUHB and is similar to the Wales rate. Treatable mortality rates are statistically significantly higher compared to Wales in Denbighshire and Wrexham.

Health throughout the life-course

BCUHB comparison with Wales	BCUHB comparison with previous data
Significantly higher then Wales	↑ Increased
Similar to Wales	↔ Similar
Significantly lower than Wales	↓ Decreased

Health in the early years and childhood	Year	Wales	BCUHB Trend	BCUHB	Isle of Anglesey	Gwynedd	Conwy	Denbighshire	Flintshire	Wrexham
Percentage low birth weight*	2024	6.3	↔	6.4	7.3	6.7	5.2	7.7	5.9	6.4
Percentage 11-16 year olds of healthy weight	2021	65.0	N/A	Wales only						
Mean number of decayed, missing and filled teeth in 5 year olds	2022-23	1.1	N/A	1.1	1.3	1.2	0.9	1.0	0.8	1.3

Source: Public Health Wales Observatory, PHOF Reporting Tool
*National Indicator for Wales

Statistical comparisons with Wales not included in the PHOF tool for these indicators: confidence intervals cannot be calculated due to data availability.

Good health in working age	Year	Wales	BCUHB Trend	BCUHB	Isle of Anglesey	Gwynedd	Conwy	Denbighshire	Flintshire	Wrexham
Percentage of working age adults in good health	2024/2025	71.6	N/A	73.1	LA data not available for 2024/2025					
Percentage of working age adults free from limiting long term illness	2024/2025	68.8	N/A	70.4	LA data not available for 2024/2025					
Percentage of working age adults satisfied with life	2024/2025	79.3	N/A	83.2	LA data not available for 2024/2025					
Percentage of working age adults of healthy weight	2024/2025	35.9	N/A	36.4	LA data not available for 2024/2025					
Percentage of working age adults in good health	2021/22-2022/23	74.3	N/A	75.8	73.4	79.8	76.3	73.3	74.7	75.9
Percentage of working age adults free from limiting long term illness	2021/22-2022/23	70.1	N/A	72.8	71.0	74.6	76.3	65.5	74.4	71.9
Percentage of working age adults satisfied with life	2021/22-2022/23	79.9	N/A	82.2	82.0	86.2	84.5	82.8	80.3	78.8
Percentage of working age adults of healthy weight	2021/22-2022/23	35.7	N/A	38.6	44.3	35.1	37.9	42.9	33.5	42.6

Source: Public Health Wales Observatory, PHOF Reporting Tool

BCUHB comparison with Wales	BCUHB comparison with previous data
Significantly higher then Wales	↑ Increased
Similar to Wales	↔ Similar
Significantly lower than Wales	↓ Decreased

Statistical comparisons with Wales not included in the PHOF tool for these indicators: confidence intervals cannot be calculated due to data availability.

Healthy aging	Year	Wales	BCUHB Trend	BCUHB	Isle of Anglesey	Gwynedd	Conwy	Denbighshire	Flintshire	Wrexham
Percentage of older people in good health	2024/2025	56.9	N/A	59.8	LA data not available for 2024/2025					
Percentage of older people free from limiting long term illness	2024/2025	52.2	N/A	54.6	LA data not available for 2024/2025					
Percentage of older people satisfied with life	2024/2025	84.4	N/A	86.3	LA data not available for 2024/2025					
Percentage of older people of healthy weight	2024/2025	36.8	N/A	36.2	LA data not available for 2024/2025					
Percentage of older people in good health	2021/22-2022/23	60.5	N/A	63.3	61.9	67.0	64.1	60.0	63.7	62.6
Percentage of older people free from limiting long term illness	2021/22-2022/23	50.9	N/A	57.4	60.2	58.9	56.8	56.0	54.5	59.3
Percentage of older people satisfied with life	2021/22-2022/23	83.3	N/A	84.7	85.1	86.8	85.3	85.1	84.7	81.1
Percentage of older people of healthy weight	2021/22-2022/23	38.4	N/A	39.3	37.9	41.5	36.7	36.1	48.5	34.5
Hip fractures, rate per 100,000 persons aged 65 years and over	2023/24	Only Wrexham available due to coding completeness & data suppression								619.2

Source: Public Health Wales Observatory, PHOF Reporting Tool

Minimising avoidable ill health	Year	Wales	BCUHB Trend	BCUHB	Isle of Anglesey	Gwynedd	Conwy	Denbighshire	Flintshire	Wrexham
Premature deaths from key non communicable diseases, rate per 100,000 aged 30-70 years	2022-2024	307.6	↓	307.3	305.2	284.9	284.4	341.9	296.3	339.8
Deaths from injuries, rate per 100,000 persons	2022-2024	54.6	↑	53.3	50.2	60.7	58.6	51.0	47.8	51.7
Deaths from road traffic injuries, rates per 100,000 persons	2015-2024	3.0	↔	3.5	3.3	3.1	4.3	3.5	2.7	4.1
Suicides, rate per 100,000 persons	2020-2024	13.1	↑	13.0	15.2	15.8	13.7	12.7	9.4	13.3
Avoidable mortality, rate per 100,000 persons	2022-2024	274.2	↑	265.8	250.6	258.4	258.3	287.2	253.2	288.9
Preventable mortalilty, rate per 100,000 persons	2022-2024	178.4	↓	169.1	162.3	168.8	169.5	177.1	156.5	182.5
Treatable mortality, rate per 100,000 persons	2022-2024	95.8	↑	96.7	88.3	89.5	88.7	110.0	96.7	106.4

Source: Public Health Wales Observatory, PHOF Reporting Tool

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	2. Developing strategy and long-lasting change Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: Strategic Objective 1 – Building and effective organisation, Strategic Objective 2 - Developing Strategy and long lasting change Strategic Objective 4 - Improving quality, outcomes and experience. Health Board Wellbeing Objectives: • to improve physical, emotional and mental health and well-being for all. • to target our resources to those with the greatest needs and reduce inequalities. • to support children to have the best start in life. • to work in partnership to support people – individuals, families, carers, communities – to achieve their own well-being. • to listen to people and learn from their experiences. Strategic Priority 1 – Focus on Health & Wellbeing through every stage of life.

	Prevention and Population Health are Ministerial priorities for 26/27 with specific deliverables.
Yr Egwyddorion Dylunio Design Principles	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: Consistency with organisational values Inclusive Design Equity & Accessibility Wise Spending Simplify, standardise and adopt good practice
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	CRR25-03 – Population Health *There is a risk that the organisation will fail to meet the health needs of the population and will not enable good health and wellbeing of the population.* BAF26-01 - *Failure to deliver improved population health and reduced inequalities.*
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality** *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This paper is a Performance update against agreed National and Local Delivery targets
Asesiad o'r Effaith Economaidd-gymdeithasol	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol? **Socio-Economic Impact Assessment** *Have you undertaken a Socio-Economic Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This paper is a Performance update against agreed National and Local Delivery targets
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	**Galluogwyr Ansawdd** **Enablers of Quality** Whole-systems Perspective	**Meysydd Ansawdd** **Domains of Quality** Person Centred
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
	Data to knowledge	Efficient Safe
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	A Healthier Wales	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) **Environmental /Sustainability Impact (5Rs)**	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: **Armed Forces Covenant Due Regard Duty**	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	This paper is a Performance update against agreed National and Local Delivery targets
	Os naddo, dylech gynnwys y rheswm:	N/A

Have you considered the Armed Forces Covenant Due Regard Duty?	If no, please include rationale:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	This paper is a Performance update against agreed National and Local Delivery targets
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	This paper is a Performance update against agreed National and Local Delivery targets
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Planning, Population Health & Partnerships Committee

ANNUAL UPDATE FROM THE HEALTH PROTECTION SERVICE 2025 - 2026

Dyddiad y Cyfarfod **Date of Meeting**	03 September 2026
Statws Cyhoeddi **Publication Status**	Open/ Public Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Sam Lauder Assistant Director of Health Protection
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Dr Jane Moore Executive Director of Public Health

Pwrpas yr Adroddiad **Report Purpose**	For Assurance

Crynodeb Gweithredol
Executive Summary

The Betsi Cadwaladr University Health Board (BCUHB) Health Protection Service (HPS) completed its third operational year in 2025/26, continuing to provide leadership, expertise and operational support across the North Wales Health Protection System. The service supports the prevention, preparedness and response to infectious disease threats, whilst delivering proactive programmes designed to improve resilience and reduce future health risks.

During 2025/26, the HPS aligned its activities to the Welsh Government's Health Protection Framework for Wales and consolidated its work into 12 defined workstreams operating across three strategic pillars: Protect, Prevent and Respond. Robust governance arrangements were strengthened through dedicated workstream leadership, enhanced performance management and clear measures of success linked to strategic outcomes.

The 2025/26 year demonstrated the continuing maturity, effectiveness and value of the BCUHB Health Protection Service. Through its Protect, Prevent and Respond model, the service has delivered measurable improvements in infection prevention, vaccination uptake, disease elimination activity and incident response across North Wales. While challenges remain around communicable disease preparedness and partnership implementation, the HPS is well positioned to

support the Welsh Government vision for a resilient, preventative and responsive Health Protection System.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
N/A		

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
HPS	Health Protection Service
IPC	Infection Prevention Control

ANNUAL UPDATE FROM THE HEALTH PROTECTION SERVICE 2025 - 2026

1. Y SEFYLLFA / SITUATION

1.1 As a core discipline of public health delivery, health protection is defined as:

"The protection of individuals, groups and populations through expert advice and effective collaboration to prevent and mitigate the impact of infectious disease, environmental, chemical and radiological threats (Ghebrehewet, Stewart and Rufus, 2016)".

1.2 Established on the 1st April 2023, the Betsi Cadwaladr University Health Board (BCUHB) Health Protection Service (HPS) has completed its third operational year and continues to support the wider North Wales Health Protection System and partner organisations in their response to health protection threats and hazards.

1.3 In addition to responding to acute health protection issues, providing strategic leadership for health protection matters within the Health Board, enhancing resilience and reducing pressures within the wider Health Protection System, the HPS supports the delivery of proactive, preventative work streams to strengthen and prepare settings and sectors for current, new and emerging threats.

1.4 This report summarises the HPS structure, key activities, outputs, outcomes, impact from the 1st April 2025 to the 31st March 2026, future developments, risks and challenges.

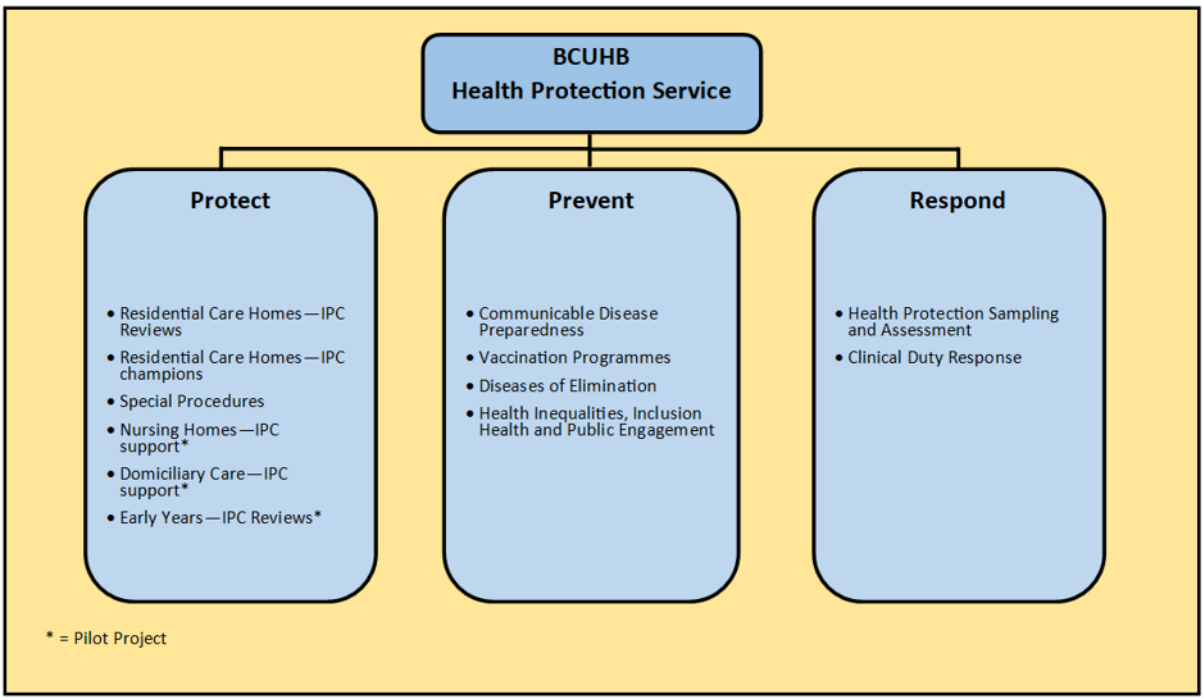
2 Y CEFNDIR / BACKGROUND

2.1 Published on the 5th June 2025, the Health Protection Framework for Wales establishes Welsh Governments vision for a Health Protection System that will prepare, prevent, and respond to existing, emerging and future health protection hazards, in order to protect the people of Wales, minimise risk and harm, promote health and save lives. It will also support communities to recover. The frameworks strategic outcomes have helped guide planning and delivery activities within the HPS to support achievement of the Welsh Government vision.

2.2 The HPS continues to operate a 3-pillar model (Figure 1). Each of the three pillars 'Protect', 'Prevent' and 'Respond' help align service activities and ensure appropriate resource allocation. During 2025/26 all workstreams undertaken across the HPS were subject to review, with several activities consolidated to create 12 discrete workstreams that align to the strategic vision and outcomes within the Health Protection Framework for Wales.

Although not indicated in Figure 1, certain workstreams span all three pillars and can incorporate both a reactive and proactive/preventative element, for example the 'protect' residential care home infection prevention review can be deployed reactively to 'respond' to an incident or outbreak in a care home setting.

Figure 1 – Health Protection Service Delivery Model



2.3 Each workstream has a dedicated workstream lead (at Band 7) and a deputy who have completed workstream Planning and Delivery documentation describing:

- Workstream aims and objectives
- Links to strategic documents
- Measures of success
- Outputs, outcomes and key performance indicators
- Stakeholders
- An overview consideration of behavioural science using the COM-B model
- Delivery obstacles
- Communication plan
- Resource requirements
- Business continuity considerations
- Review, evaluation and reporting requirements

2.4 Workstreams are subject to monthly performance monitoring through the Health Board Portal, quarterly performance reviews, and end of year

reporting. The following table (Table 1) describes the 12 workstreams that exist within the HPS.

Table 1 – Clinical Workstream Summary Descriptor – 2026

Clinical Workstream	Clinical Workstream Summary
Health Protection Sampling & Assessment	To deliver community-based infectious disease sampling and health assessments, 7-days a week as part of a rapid response to infectious disease cases, incidents and outbreaks.
Communicable Disease Preparedness	To support the Health Board in building capability and capacity for responding to communicable diseases threats.
Vaccination Programmes	To increase vaccination and immunisation capacity in the Health Board by delivering a range of vaccines that provide essential protection for individuals and communities against infectious diseases.
Diseases of Elimination	To support and directly contribute to targeted Health Protection interventions aimed at reducing transmission, morbidity and health inequalities associated with HIV, hepatitis B, hepatitis C and tuberculosis. In addition, the HPS provides equitable and accessible sexual health testing to underserved high-risk populations, including within Substance Misuse Services, Probation, and other community settings.
Health Inequalities and Inclusion Health and Public Engagement	Targeted approaches designed to address health inequalities affecting socially excluded populations living in North Wales. Vulnerable groups include people experiencing homelessness, migrants, asylum seekers and refugees, people with drug and alcohol dependence and sex workers.
Residential Care Homes – IPC Reviews	The provision of annual Infection Prevention Control (IPC) reviews to all Residential Care Homes in North Wales on annual cycle. Reviews are comprehensive but non-regulatory and include a supportive discussion-based staff interview and an observational assessment. A written report with recommendations is provided to key stakeholders, with a progress report review completed six weeks later.
Residential Care Homes – IPC Champions	The provision of IPC champions training to all North Wales Residential Care Home's. The focus is on supporting front-line staff to develop core IPC knowledge and skills through monthly educational webinar sessions. Practical support is also provided to promote the delivery of evidenced based IPC interventions in the Care Home setting.

Special Procedures	To deliver Royal Society Public Health level 2 IPC training for Special Procedures Practitioners. Special Procedures are defined as: Acupuncture (including dry needling), Body Piercing, Electrolysis and Tattooing (including semi-permanent make-up/microblading).
Nursing Homes – IPC Support (Pilot)	To offer targeted IPC expertise, guidance and support to Practice Development Nurses, who provide IPC reviews to North Wales Nursing homes, as part of a wide-ranging annual audit programme.
Early Years - IPC Reviews (Pilot)	As part of a pilot project the HPS are currently exploring the benefits of delivering IPC reviews to primary school and nursery settings across North Wales in collaboration with the Local Authority partners. These reviews are both supportive and non-regulatory in nature, consisting of a structured discussion with staff combined with an observational assessment. The pilot project will be evaluated to determine effectiveness and feasibility for expansion across North Wales.
Domiciliary Care – IPC Support (Pilot)	A pilot project is currently exploring the benefits of delivering IPC training, guidance and support across a range of diverse Domiciliary Care settings in North Wales in collaboration with the Local Authority partners. The pilot work will seek to successfully adapt the offer to reflect the unique needs of such settings.
Clinical Duty Response	Communicable Disease reporting is routed through the Public Health Wales AWARe system. As a complimentary supplement to this system the HPS operates a dedicated/acute health protection response service. The Clinical Duty Response ensures there is always a senior clinician on-duty and two supporting registered nurses who are available to coordinate a response to urgent health protection needs across North Wales. This service is available 7-days a week including bank holidays.

3 MATERION PENODOL I'W HYSTYRIED / SPECIFIC MATTERS FOR CONSIDERATION

3.1 **Partnerships**. Partnership working remains fundamental to the delivery and development of the HPS, with many workstreams delivered by the HPS existing as primary functions for partner organisations who often lack the resources or capacity to be able to achieve specific outputs or outcomes. Collaborative working is recognised a key strategic objective in the Health Protection Framework for Wales, with the ability to minimise duplication of effort and maximise the benefits to the population of North Wales.

3.2 Whilst the HPS aims to achieve the strategic objective for partnership working, a significant weakness for the service and the North Wales Health Protection System is the absence of a funded partnership between BCUHB and the six Local Authority Environmental Health services. To date, BCUHB remains the only Health Board in Wales that has not transferred a proportion of their Health Protection funding to a Local Authority partner. This disparity not only weakens the North Wales Health Protection System but also limits progress towards the Framework objectives. The funding for such a partnership has existed since April 2025 and Welsh Government have approved a partnership model put forward by the HPS. A Service Level Agreement outlining six key deliverables has been agreed with all six Directors of Public Protection. To note, the implementation of a funded partnership is identified as a deliverable in the Health Boards Integrated Medium Term Plan (Figure 2).

Figure 2 – Extract from the BCUHB Integrated Medium Term Plan

Health Protection	1D.4 - Deliver the funded Health Protection plan including establishing a Health Protection partnership with a Service Level Agreement in place with the 6 North Wales Local Authorities. (Links to Section 5 – Working with Regional Partners)	Executive Director of Public Health - PPHP	Q3	N/A	P01-P04

3.3 **Funding.** At month 12, the Health Protection Service reported an out-turn spend of £2.309m with a reported £255k underspend. The underspend was primarily because of new vacancies in the structure at the start of the year and subsequent delays in recruiting to posts due to enhanced establishment control restrictions. As the funded partnership described in 3.2 is progressed into 2026/27 similar levels of underspend will not recur.

3.4 **Outputs, outcomes and impact.** In the third operational year, the HPS has continued to deliver significant amounts of work across the pillars of Protect, Prevent and Response. Notable outputs and outcomes are summarised below and further information is provided in a table in Appendix 1.

3.5 **Protect**

Residential care homes. The residential care home infection prevention control (IPC) review workstream continued into 2025/26. IPC reviews in residential care homes are either undertaken in person or remotely over Microsoft teams depending on the risk category associated with the setting. IPC reviews are structured around the Clinical Quality Support Tool audit form developed by the Quality Development Team. Reviews are supported with a Padlet containing resources linked to the areas of focus within the audit form (Figure 3).

Figure 3 – QR code link to the IPC resource Padlet

During the year, 215 of the 220 residential care homes in North Wales received an IPC review, generating 2,527 IPC actions and recommendations. The service achieved an access rate of over 98% with a confirmed action implementation rate of 90.6%

Infection prevention control champions. Following a successful pilot in 2024/25, the HPS deliver an IPC Champions programme to assist residential care homes in developing IPC knowledge and skills in front-line staff. The programme consists of monthly webinars on key topics and an annual half-day conference. At the end of the 2025/26, the number of IPC champions had increased to 141, all of whom represent residential care homes across North Wales.

Nursing homes. A collaborative pilot project was undertaken in year to support Practice Development Nurses in completing IPC reviews within the Nursing Home sector. Alongside these reviews, the HPS offered a coaching and training package to address identified gaps in IPC knowledge and experience.

Domiciliary care. A pilot initiative with providers identified a mechanism for supporting domiciliary care staff to obtain key IPC knowledge and skills. Through a series of on-line training sessions for staff, train-the-trainer sessions for domiciliary care trainers and a small number of on-site IPC reviews, the initiative saw a reported 26% increase in staff IPC knowledge and a 28% increase in confidence in IPC matters.

Special procedures. The HPS continue to provide Level 2 IPC training for special procedures practitioners. As a training centre the service has achieved a pass rate over 95% and feedback from delegates taking the course remains positive.

Early years. A further pilot project was completed aimed at improving IPC standards in early years settings and primary schools. Working in partnership with the six Local Authority Directors of Education, a diverse range of 33 primary schools were visited and provided with an IPC intervention comprising a detailed review of IPC measures, followed by an informal inspection of the setting. In addition, schools were offered a handwashing session for learner in Key Stage 1. The primary school visits resulted in the identification of 586 action points and recommendations. The IPC interventions were supported with an information Padlet (Figure 4) containing links to all relevant guidance

and support materials. The project will be evaluated with the intention for wider roll out across North Wales.

Figure 4 – QR code link to the IPC resource Padlet for primary schools

3.6 Prevent

Diseases of elimination. The HPS continues to work closely with colleagues across BCUHB to support and deliver activities and interventions which contribute to the elimination of Hepatitis B and C, TB and HIV infections. In year activities have included the provision of Hepatitis B and C testing across a variety of venues and settings across North Wales including within Substance Misuse Clinics, at a variety of bite size health events including in major employers like Airbus and poultry processing plants, in women's centres, in probation services and in special procedures practitioners premises. In year, 407 Hepatitis B and C tests were obtained by the HPS. Other activities have included contributing to wider system training events on blood borne viruses, provision of Hepatitis B vaccinations in Substance Misuse Services, supporting respiratory services with community TB sampling for new entrants/asylum seekers, and coordinating the provision and expansion of sexually transmitted infection home testing kit distributor sites across North Wales.

Vaccination programmes. By working in partnership with other BCUHB services, the HPS continues to support the delivery of national vaccination programmes, helping to identify areas of low uptake and providing opportunities to improve accessibility. Vaccination activities supported in year include provision of childhood immunisations in partnership with school nursing services (4305 vaccinations administered), provision of Hepatitis B vaccinations in substance misuse services (45 vaccinations administered) and supporting the BCUHB occupational health service with peer-to-peer influenza vaccinations. During the 'staff flu' campaign, the HPS provided regular hospital canteen vaccination clinics, and visits to wards, departments and community settings both in and out of hours to improve accessibility to vaccination opportunities. At the end of the 'staff flu' campaign, 42% of all influenza vaccinations given to BCUHB staff were provided by the HPS.

Communicable disease preparedness. The HPS has continued to lead a strategic communicable disease preparedness group which has aimed to develop capacity within the Health Board to prepare for, prevent and respond to communicable disease threats. During the year, this group raised awareness of specific disease risks including measles, Mpox and High

Consequence Infectious Diseases (HCIDs), whilst also escalating specific preparedness concerns to the Executive and the Quality, Safety and Experience committees. In the Autumn, the HPS supported the BCUHB contribution to the 4-nation preparedness exercise 'Exercise Pegasus'. In addition, the HPS ran a simulation exercise to test the HPSs ability to provide a community sampling response to a major communicable disease outbreak.

Health inequalities, inclusion health and public engagement. Work undertaken by the HPS to improve access and opportunity to healthcare for individuals and communities in North Wales include establishing a matrix working group with the Health Inequalities team in the Population Health Service, partnering with other services to provide a population health approach to healthcare in Probation Services, ensuring Asylum seekers receive the offer of accessible TB screening, providing accessible blood sampling for those impacted by the infected blood inquiry, and ensuring equitable and consistent application of IPC standards and timely access to diagnostic sampling in care home.

3.7 **Respond**

Health protection sampling and assessment. During 2025/26, 77 care homes were assessed by the HPS and found to meet patient testing criteria resulting in 143 samples submitted from care homes residents for PCR testing. Where COVID-19 incidents were detected, these were managed by the HPS. Also, due to the increase in measles cases in the Cheshire and Merseyside regions, the HPS provided 7-day access to sampling for suspected cases and developed a text-message based 'Warn and Inform' system which was deployed to many contacts generated from a single case attending a BCUHB hospital. This system was used again in the year to provide warn and inform information to the identified contacts of a confirmed Mpox case that attended a BCUHB hospital. The HPS also supported an STEC (E.coli O157) incident in a primary school with microbiological clearance sampling. And, although not a communicable disease incident, the HPS responded to issues arising in care homes in the Flintshire area following a major water supply outage.

Clinical duty response. The HPS continues to provide a clinical duty system to ensure there is always a clinician on-duty supported by at least one registered nurse who are available to coordinate a response to urgent health protection issues in North Wales, 7-days a week. In year, 151 enquiries for health protection advice/action were received, all of which were responded to within 24 hours.

3.8 **Key Learning.** The provision of a Health Protection Framework for Wales has facilitated improved strategic planning within the HPS. Workstreams have been aligned to the strategic vision and objectives in the framework, and accountability and performance monitoring has improved with clear aims, objectives, outputs and outcomes described in each workstream

planning and delivery document. A suite of performance measures now exist which are monitored through the BCUHB portal and directorate assurance mechanisms.

3.9 The proposed partnership with the six Local Authority Environmental Health teams in North Wales will improve resilience and capacity within the North Wales Health Protection System and address existing areas of weakness around collaborative work and planning. Through investment and a partnership service level agreement, the North Wales Health Protection System will be better positioned to expand the impact and effectiveness of proactive preventative workstreams that improve health and wellbeing and contribute to relieving pressures on primary and secondary care services. In addition, the partnership will facilitate a collaborative surge response to major communicable disease threats.

3.10 The workstreams, activities and achievements of the HPS during 2025/26 continue to highlight the value in providing a dedicated health protection resource within BCUHB. Furthermore, the flexibility built into the HPS enables dynamic repositioning of resources to respond to acute needs. Each workstream has been prioritised to enable a safe yet rapid change in focus, which was highlighted and tested during the communicable disease outbreak simulation exercise that was deployed without prior warning.

3.11 Value is also shown in the ability of the HPS to reduce pressures in other BCUHB services through prevention, for example, primary prevention is demonstrated when the HPS supports vaccination programmes, and improves IPC knowledge within care homes, primary schools and special procedures premises. Secondary prevention is delivered through support provided to care homes in incident to prevent onward transmission of disease, and through community testing to identify blood borne viruses and TB. And tertiary prevention is provided by coordinating the response to individuals exposed to Rabies and ensuring swift and timely access to post exposure prophylaxis.

3.12 Innovation has been identified as a success factor and contributed to the delivery of a HPS that will prepare, prevent and respond to health protection hazards. Being willing and able to provide services at different times, including staff flu vaccinations at evenings and weekends, using digital solutions to reach contacts of communicable diseases, and establishing services using existing providers in novel ways, for example establishing a network of Rabies vaccine providers through BCUHB manage practices, has helped enhance the effectiveness and efficiency of the service. Also, where possible, each workstream continues to consider behavioural science methodologies to innovate and enhance service delivery.

3.13 A final key lesson from 2025/26 highlighted in BCUHBs involvement in the four-nation pandemic preparedness exercise ‘Exercise Pegasus’ is the difficulty in engaging key stakeholders within BCUHB to accept

responsibilities for communicable disease preparedness. These challenges continue to highlight a lack of proactive preparedness and a tendency to address key issues in a reactive manner, which may increase the risk of disease transmission to patients, staff, and the wider community during infectious diseases incidents, outbreaks and pandemics.

3.14 **Priorities 2026 – 2029.** Three deliverables to drive workstream objectives and activities during the period 2026-2029 have been identified and incorporated into the BCUHB Integrated Medium Term Plan (2026 – 2029):

1D.4 – Deliver the funded Health Protection plan including establishing a Health Protection partnership with a Service Level Agreement in place with the 6 North Wales Local Authorities

The development of the Local Authority partnership continues to make progress. In July 2026 the BCUHB Executive Committee approved the contents of the Service Level Agreement and funding levels. Commissioning/contracting discussions continue to take place between BCUHB and the six Local Authorities.

1D.5 – Enhance the delivery of health board service to protect people in North Wales against existing, new and emerging health protection threats and hazards by supporting screening and vaccination programmes, and disease elimination activities (Hepatitis B and C, HIV and TB)

1D.6 – Deliver evidence-based approaches to protecting and preventing ill health within specific sectors and settings e.g. delivery of infection prevention control interventions in residential care homes.

4 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO
KEY RISKS / MATTERS FOR ESCALATION

4.1 A tier 1 risk identified by the HPS is currently incorporated into Corporate Risk CRR25-03

"There is a risk that the Health Board does not prepare adequately for outbreaks and incidents of communicable disease such as (but not solely) Measles, M.Pox, COVID-19, Pertussis etc.

This may be caused by the unpredictability of when the disease may first occur, the variety of new and emerging threats, the variations in the nature of the required response to specific diseases, the availability and cost of associated resources (e.g. pharmaceutical products, workforce, estate, contact tracing, sampling, vaccination, communications), the scale of potential outbreaks, the difficulties in protecting specific vulnerable groups and members of staff in a timely way.

Which could lead to greater exposure of the public and staff members to communicable diseases causing an increase in cases, further transmission, interruption of health board services and in some cases death."

4.2 Communicable disease preparedness continues to remain an area of significant concern. There remains no clear forum for maintaining strategic oversight of communicable disease preparedness within BCUHB. The Strategic Communicable Disease Preparedness group was recently stood down owing to poor attendance and engagement from key services. There is an urgent need to identify the appropriate governance mechanisms to ensure the organisation delivers its statutory responsibilities, and can demonstrate the capability to coordinate delivery of consistent preparedness measures across all disciplines in both Secondary and Primary care.

4.3 **Challenges.** Key challenges facing the HPS as it continues to develop include:

Continuing to support communicable disease preparedness measures within BCUHB, with a focus on community sampling, High Consequence Infectious Disease personal protective equipment training, and the preparation and delivery of simulation exercises.

Commencing and ensuring the success of the funded partnership with the six Local Authority Environmental Health Teams whilst establishing appropriate governance mechanisms to oversee the delivery of collaborative activities, including the development of partnership delivery plans.

With many health protection medicines (vaccinations, antibiotics, immunoglobulins etc) absent from primary care contracts, challenges exist in ensuring appropriate routes for obtaining, prescribing and administering these medicines in a timely manner. The absence of such medicines in GP contacts is leading to the development of inconsistent and unequal 'workarounds' across Health Boards in Wales, or inappropriate use of secondary care services. Whilst Welsh Government have been lobbied to address this matter centrally, there is a challenge for the HPS to support the operational delivery of these medicines wherever possible.
Ensuring that the impact and value of the HPS can be evidenced through evaluation, to secure continued funding from Welsh Government and support from within BCUHB.

SESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol **Link to Strategic Intentions**	1. Focus on Health and Wellbeing If more than one applies, please list below: Improve access, outcomes and experience.
Yr Egwyddorion Dylunio Design Principles	People First
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	Corporate Risk ID: CRR25-03

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 **Public Sector Equality Duty:** **Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty):** https://www.gov.wales/public-sector-equality-duty-htmlPublic Sector Equality Duty [HTML] | GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Equality Act 2010 - Socio-economic Duty *Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?*	Do/Yes: ☒	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Have you completed an Integrated Equality Impact Assessment WP8a? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	Naddo/No: No
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	

	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant *Have the principles of the Armed Forces Covenant been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant	A Healthier Wales	

Wellbeing of Future Generations Act – Wellbeing Goals		
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	Choose an item.	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Appendix 1 – Health Protection Service Performance Indicator Summary

No.	Health Protection Service Programme Objective	Project/ Priority Area	Indicator (Annual Target)	Outputs for Quarter 1 (April – May only)	Outputs for Quarter 2 (July – Sept)	Outputs for Quarter 3 (Oct – Dec)	Outputs for Quarter 4 (Jan – March)	Final %
1.	Developing collaborative, evidence-based approaches to protecting and preventing ill-health within specific sectors and settings in North Wales	Delivery of infection prevention control (IPC) support to residential care homes in North Wales	95% of residential care homes accepting an IPC review to have received a review by 31st March 2026	41 out of 225 care homes received IPC review. 18% complete.	148 out of 222 care homes received IPC review. 64.2% complete	203 out of 219 care homes have received an IPC review. 93% complete	215 out of 220 care homes have received an IPC review. 98% complete	**98%**
			75% of residential care homes identified for follow-up to have received a follow-up intervention by 31st March 2026	0% complete	95/222 care homes received IPC follow up interventions 42.79 % complete	178/219 care homes received IPC follow up interventions 88% complete	215/220 care homes received IPC follow up interventions 98% complete	**98%**
			40% of residential care homes represented at IPC Champions training sessions by 31st March 2026 **	45 out of 225 residential care homes represented at IPC champions training sessions 20%	50 out of 222 residential care homes represented at IPC champions training sessions 22.52%	110 out of 219 residential care home represented at IPC champions training sessions 50%	141 out of 220 residential care homes represented at IPC champions training session 64%	**64%**
			** Difficulties with reporting against this indicator have resulted in the final figures not demonstrating representation from all residential care homes. Instead figures show total attendees at training sessions.					

No.	Health Protection Service Programme Objective	Project/ Priority Area	Indicator (Annual Target)	Outputs for Quarter 1 (April – May only)	Outputs for Quarter 2 (July – Sept)	Outputs for Quarter 3 (Oct – Dec)	Outputs for Quarter 4 (Jan – March)	Final %
2.	Enhancing the delivery of Health Board services to protect people in North Wales against existing, new and emerging health protection threats and hazards.	Supporting disease elimination agendas (Hepatitis B and C, HIV and TB)	200 Hepatitis B and C samples obtained in probation services and approved premises in North Wales by 31st March 2026	63/200 31.5%	134/200 67%	147/200 73.5%	257/200 128.5%	**128.5%**
			60 Hepatitis B and C samples obtained during targeted community sampling projects by 31st March 2026	28/60 46.6%	52/60 86.7%	130/60 206.7%	150/60 250%	**250%**
			30 Hepatitis B vaccinations provided through substance misuse services and related venues/projects by 31st March 2026	13/30 43.3%	18/30 60%	38/30 126.6%	45/30 150%	**150%**
		Supporting the delivery of the National Immunisation Framework to ensure a high up-take of vaccinations and equity of access and opportunity	Provision of 5000 influenza vaccinations to BCUHB by 31st March 2026 (to commence in Q3)	Flu not due to start until Q3	Flu not due to start until Q3	4129/5000 82.6%	4412/5000 88.24%	**88.24%**
			Provision of 1,000 additional childhood immunisations in support of school nursing services by 31st March 2026	540/1000 54%	689/1000 68.9%	2988/1000 298.8%	4305/1000 430.5%	430.5%

No.	Health Protection Service Programme Objective	Project/ Priority Area	Indicator (Annual Target)	Outputs for Quarter 1 (April – May only)	Outputs for Quarter 2 (July – Sept)	Outputs for Quarter 3 (Oct – Dec)	Outputs for Quarter 4 (Jan – March)	Final %
3.	Developing capacity within the Health Board to prepare for and respond to health protection threats	Management of health protection enquiries/ incidents received by the Health Protection Service	100% of health protection enquiries received by the Health Protection Services responded to within 24 hours	100%	100%	100%	100%	100%

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Planning, Population Health & Partnerships Committee

DRAFT BCUHB HEALTH IMPROVEMENT MENU OF INTERVENTIONS

Dyddiad y Cyfarfod **Date of Meeting**	03 September 2026
Statws Cyhoeddi **Publication Status**	Open/ Public Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Claire Waddicor-Evans, Strategic Development Manager, Health Improvement, Public Health.
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Dr Jane Moore, Executive Director of Public Health

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol
Executive Summary

The purpose of this paper for the Planning, Population Health and Partnerships Committee is to:

- **INFORM** members on the work so far to develop this initial Draft BCUHB Health Improvement Menu of Interventions and why it matters.
- **INFORM** members on the work so far to develop this first iteration recognising further planned work and engagement during Quarter 3 2026/27 to shape how the health board can practically take this forward.
- **INFORM** members on the work scheduled to take place in Quarter 3 2026/27 to develop the approach in how the interventions identified can be incorporated in the work of the Health Board from Quarter 4 2026/27.

Appendix 1: 1st Draft Health Improvement Menu of Interventions

Developing a Health Improvement Menu of Interventions matters because the Health Board is facing increasing demand for its services with 70% of NHS activity contributable to six major diseases, much of which is preventable.

This is an internal document providing the Health Board with a consolidated evidence-based set of public health recommendations for health improvement interventions (does not include screening and vaccinations) across a range of topic areas. The ambition is that it will enable functions and directorates to incorporate prevention activity in their work and through a collective approach to the design and planning of strategic and operational delivery plans.

This work is a Public Health Directorate Annual Delivery Plan deliverable due by the end of Quarter 2 2026/27 with the final draft of the first phase of the document planned to be presented to PPHP on the 3rd of September.

Work is now underway in Quarter 3 2026/27 to look at how we enable the Health Board to use this Menu of Interventions and maximise its impact, taking an iterative approach involving testing and learning. Developing a Health Improvement Making Change Happen Toolkit during Quarter 3 is key as an additional resource to provide a range of levels of evidence and approaches that can be used proportionately within services to strengthen preventative health improvement.

Initial key stakeholder engagement during the development phase is providing positive feedback on the ambition and that engagement will be continued as we seek to include the six major diseases.

This main risk this work responds to is the risk of further decline in Population Health and wellbeing as articulated in CRR25-03 and the impact that has across the health system.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome, Evidence and Data**
Initial key operational and strategic engagement during the development phase of the document. Strategic Planning and Service Change Group	May to July 2026 26 August 2026	• Collaborative shaping of the interventions. • Feedback on how the document could be received. • Development of the document content for best impact. • Feedback on the opportunities to deliver the document. • Feedback and approval to proceed to PPHP.

Acronyms / Glossary of Terms	
SPSCG	Strategic Planning and Service Change Group
PPHP	Planning, Population Health and Partnerships Committee

BCUHB HEALTH IMPROVEMENT DOCUMENT UPDATE

1. Y SEFYLLFA / SITUATION

Much of the burden on the Health Board could be preventable if we strengthen public health interventions that support positive changes in our population's health-related behaviours. If action is not taken there will be increasing risks accumulating for our population, our health systems, public services and our overall economy in the future.

Responding to this and the IMTP strategic priority, the Public Health Directorate Health Improvement Programme is developing a BCUHB Health Improvement menu of interventions to provide an evidence-led approach in how health improvement preventative approaches can be utilised. These can be applied in part or in whole by services dependent on function and readiness.

Implementing interventions will require stakeholder commitment at every level, strategic alignment with major change and a clear governance approach, all of which will enable leverage to propel the shift that is required.

2. Y CEFNDIR / BACKGROUND

Context of the project:
A Healthier Wales and our strategic intent set out the vision for improving the health and well-being for everyone living in North Wales. This is reflected in our strategic priorities where prevention, early intervention, and reducing avoidable ill-health are a core principle.

The development of a BCUHB Health Improvement Menu of Interventions was established as an Annual Delivery Plan Deliverable aligned to the IMTP objectives for 2025/26 to 2027/28. It also responds to the corporate risk CRR25-03 Population Health Risk. The deliverable was initiated as a project within the Public Health, Population Health Service, Health Improvement Programme.

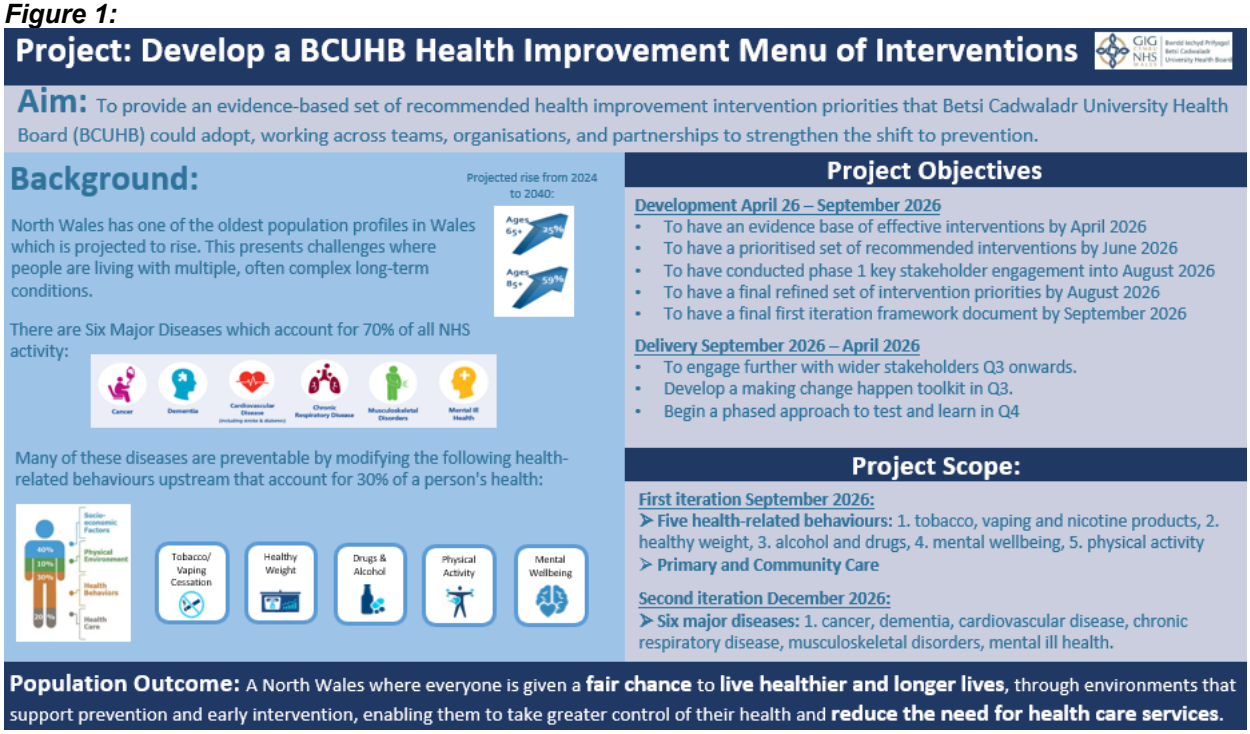
This paper provides a first stage update on the development of the BCUHB Health Improvement Menu of Interventions that focuses internally on what the Health Board can do across its services to strengthen health improvement preventative approaches. It seeks to:

- Sets out the purpose of the Menu of Interventions and why it matters.
- Provide assurance that work is currently on track.
- Confirm that key stakeholders have been engaged during the development phase.
- Assure that a practical delivery approach is being planned including making change happen operationally and strategically through strong governance and strategic alignment.

It also sets out matters for consideration/escalation to create the conditions for embedding a complex long-term Health Board transformation programme for sustainable change in population health.

Purpose of the project:

Figure 1:



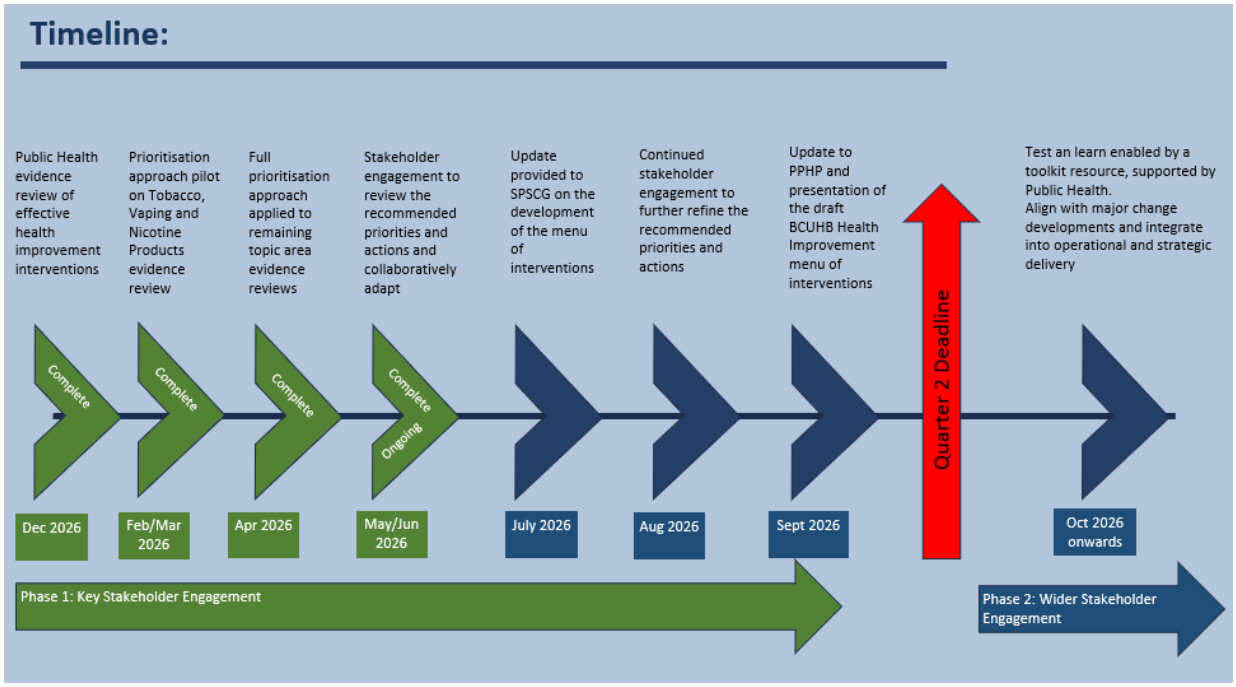
Summary of progress:

The work undertaken to achieve the two key milestones below in 2025/26 has resulted in learning and has further shaped the project:

1. An evidence review of effective and cost-effective health improvement interventions in a healthcare setting against identified topic areas.
2. A prioritisation approach for streamlining the evidence review based on a pilot of one initial topic area.

New milestones have been set for 2026/27 within a set of Annual Delivery Plan Deliverables. The finalisation of phase one of a BCUHB Health Improvement Menu of Interventions is planned for the end of Quarter 2 2026/27 with a second iteration planned for phase 2 that brings in the six major diseases against the main prevention elements. *Figure 2* sets out the timeline to achieve this deadline:

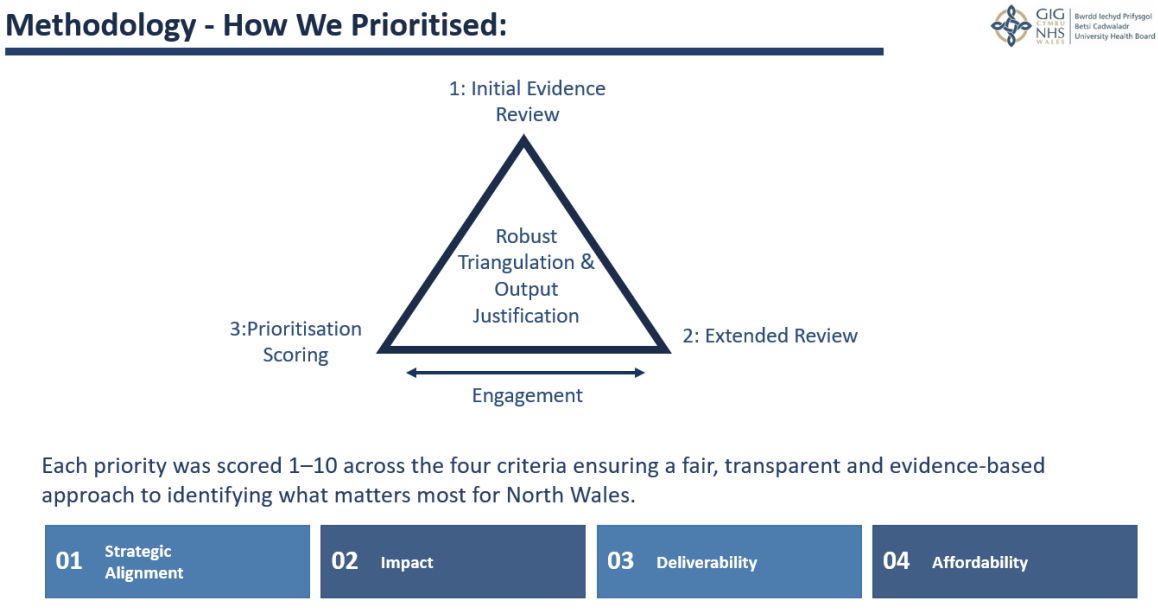
Figure 2:



The prioritisation work *(Figure 3)* carried out by the project team has involved the triangulation of the evidence review against other local and emerging plans and strategies to enable a simplified prioritisation approach against four key criteria:

- Strategic alignment.
- Impact.
- Deliverability.
- Affordability.

Figure 3:



The output:
The approach has resulted in a set of key recommended health improvement interventions (*Figure 4)* for each of the topic areas within the scope of the document underpinned by a set of recommended actions. These are presented at a high level within the BCUHB Health Improvement Menu of Interventions however the technical work conducted has a range of detail that will be available in the delivery phase as required. The recommended health improvement interventions are as follows, please refer to the document for further detail.

Figure 4:

Making Every Contact Count (MECC) – Healthy Behaviour Conversations

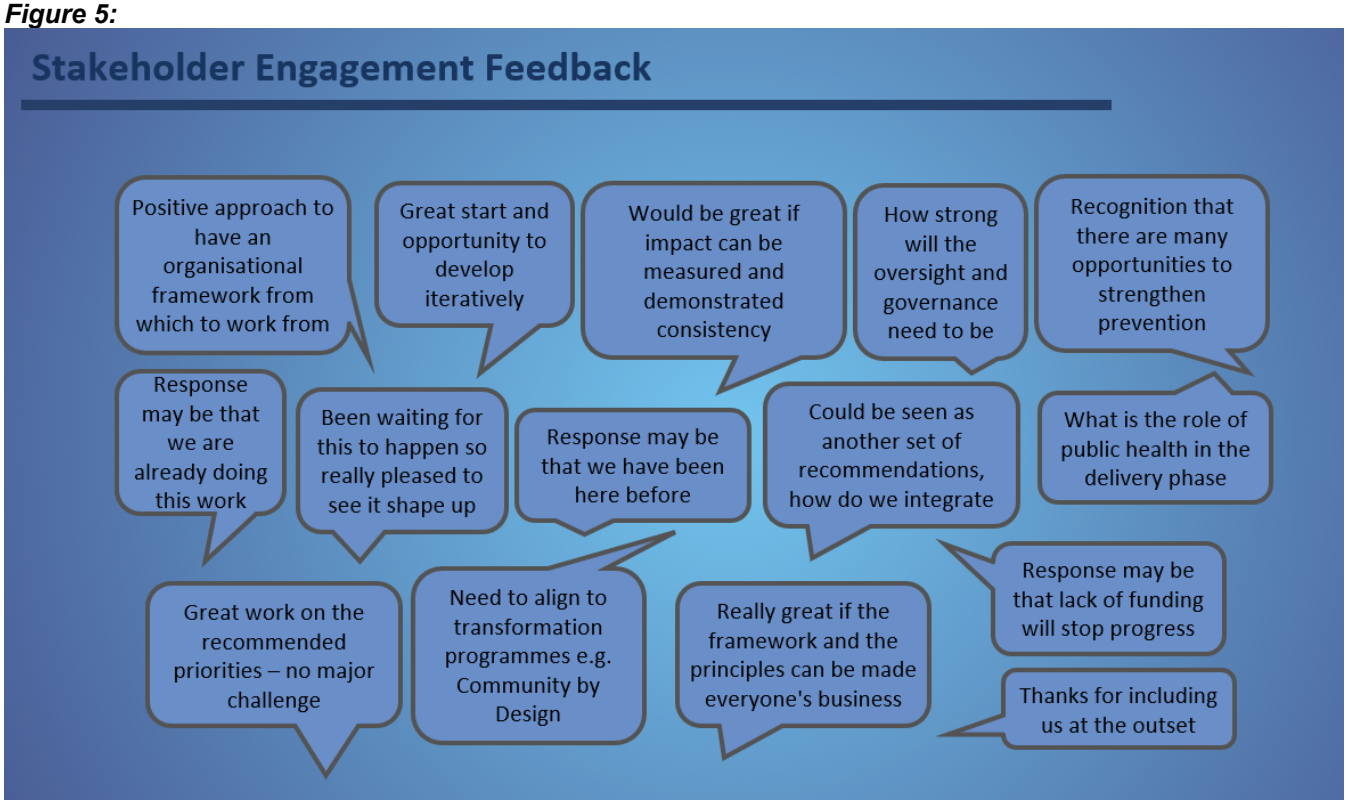
Summary Menu of Interventions
Tobacco, Vaping and Nicotine Products
Deliver targeted smoking cessation support for women during pregnancy Promote and increase public uptake of Help Me Quit services Strengthen nicotine dependence treatment in secondary care Improve prevention and management of vaping and nicotine addiction Create Nicotine-free communities and prevent uptake among children and young people
Alcohol and Drugs
Alcohol and drugs in preconception and pregnancy Identification, screening and brief interventions for substance use Reduce harm to children from parental substance use Strengthen resilience and mental wellbeing in children and young people
Children's Healthy Weight and Early Years Prevention
Deliver a universal healthy weight offer for children and families Develop a Tier 2 community pathway for children and young people Promote healthy weight during pregnancy Strengthen infant feeding, weaning and early years nutrition support Embed healthy eating and healthy weight approaches in schools
Adult's Healthy Weight
Strengthen workforce skills in healthy weight support Improve access through modern referral and monitoring systems Deliver equitable, person-centred weight management support
Babies, Children and Young People's Mental Health and Wellbeing
Protect and promote infant mental health Continue supporting the 'Emotional Health & Wellbeing Resilience Framework' Develop social prescribing approaches for families, children and young people Signpost children, young people and families to Information and resources to protect and promote good mental wellbeing and have the best start in life Prevention and early intervention for groups at higher risk of poor mental health Support young people transitioning from CAMHS to adult services
Adult's and Older People's Mental Health and Wellbeing
Promote mental wellbeing through early identification and timely interventions Strengthen community wellbeing and social prescribing Support perinatal and paternal mental wellbeing Deliver person-centred support and wellbeing for complex mental health needs Embed trauma informed and recovery-focussed approaches Improve mental wellbeing for people with learning disabilities
Physical Activity
Increase physical activity among children and young people Embed physical activity conversations and signposting

Health Inequalities – Health Equity Maturity Matrix

Strengthen physical activity referral and pathway navigation Integrate physical activity into health programmes Optimise physical activity before and after surgery. Promote physical activity during and after pregnancy
Primary and Community Care
Embed prevention in everyday primary and community care Implement preventive conversations through MECC Strengthen place-based prevention Deliver equity-led health improvement Strengthen partnership & community-based outcomes Improve inclusive and equitable access Expand social prescribing and community assets

Stakeholder engagement:
Engagement has included operational, clinical and strategic engagement across all topic areas within scope of the first phase of the work. Some key high-level feedback presented in *Figure 5* has been provided by operational leads, clinical leads, primary care colleagues, senior corporate managers in relation to the content, delivery and how the document may be interpreted by wider stakeholders.

Figure 5:

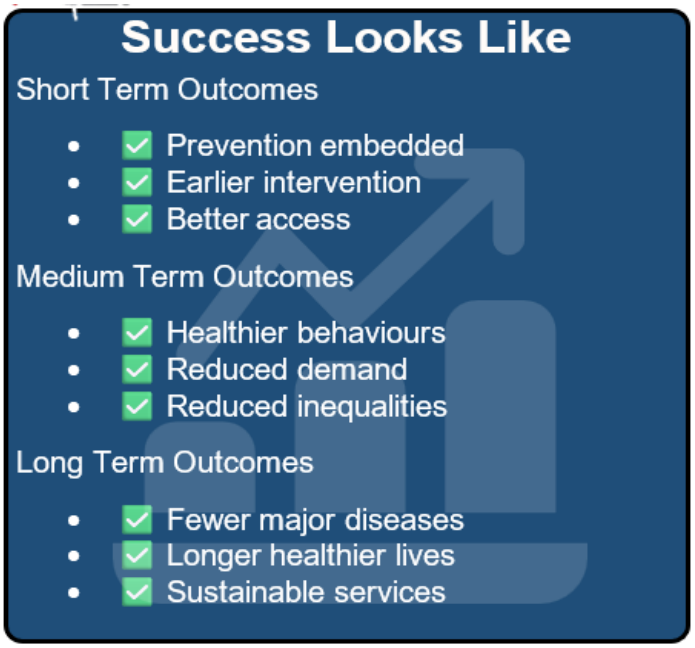


The feedback received to date has informed and shaped the narrative within the BCUHB Health Improvement Menu of Interventions.

Delivery:
Work is currently underway to develop a further practical resource that will support the Health Board to use the Menu of Interventions and that is a Health Improvement Making Change Happen Toolkit. The toolkit will set out recommended approaches to drive and enable the strengthening of preventative health improvement both strategically and operationally noting that it is critical that this is enabled by an environment where senior commitment and leadership prioritise prevention within strategic planning, designing and re-designing care pathways and within their transformation programmes. This will need to be iterative and dynamic as we test and learn recognising the feedback to integrate into current operational delivery plans.

Measuring Success:
At a high level, preventative change is expected to result in short, medium and long-term outcomes but each set of recommendations will deliver its own set of measurable indicators. Figure 6 sets out the overarching outcomes at a population level.

Figure 6:



Recommendations on how success can be measured and evaluated will be a key part of the Making Change Happen Toolkit where outcome indicators and baselines are recognised as critical in justifying the rationale for change and demonstrating that the outcome has been achieved.

Aligning the document:
Further work for Quarter 3 is to consider mechanisms to ensure this work is aligned with emerging strategic developments and major change programmes. Taking the opportunity to integrate the priorities as they develop within the health boards annual planning cycle and

Integrated Medium-term Plan and delivery plans is key. Likewise, how the document aligns with other public health initiatives such as the Regional Wellbeing, Prevention and Anchor Document which crucially compliments this Health Improvement Document from a whole system perspective.

Governance and accountability:
At a strategic level the governance needs to provide the leverage to propel this work forward through senior commitment, effective oversight, informed decision-making, risk management and assurance in what is a broad, far reaching and complex area. The strategic governance is in place through the SPSCG and PPHP. However, the operational governance structure to deliver the change needs to be developed whilst balancing day to day operational business and integrating within current work programmes and strategic delivery plans is essential. Alongside this is the integration into major change programmes both existing such as planned care and emerging such as the clinical services plan and community by design.

3. MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

This document is the first step in establishing direction by consolidating an evidence base of what the Health Board could do to strengthen health improvement preventative approaches. Recognising the complexity of health improvement, the document will continually evolve, adopting an iterative approach through ongoing evaluation, collaboration and learning. This will include the health improvement interventions specific to addressing the six major diseases in terms of prevention as a second iteration by December 2026. Work is underway in Quarter 3 to really set out how the Health Board can use this menu of interventions integrating it into operational delivery recognising much work is already happening.

Prevention has long been recognised as a priority however the ability to prioritise strengthening prevention against the competing day to day demands across primary, community and secondary care in respect of planned and unplanned care is immensely challenging. Ensuring that the health board also has the capacity and capability will be key in enabling the shift to happen. Strategic and operational stakeholder commitment is a critical success factor along with a strong operational governance approach for delivery, assurance and oversight to ensure it receives the traction needed to fully embed within Health Board services, transformation initiatives and planning and delivery processes.

It is recognised that there are emerging strategic developments and programmes such as the Clinical Services Plan, Community by Design and Value and Sustainability and consideration as to how these can integrate to maximise the delivery of the document is needed. Driving forwards what is a complex long-term transformation programme to create the conditions for sustainable change in population health outcomes is crucial through strong strategic governance. It is important to note that there are existing governance routes that the delivery of this document will need to contribute to including Annual Delivery Plan and Corporate Risk Management monitoring.

4. RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO
KEY RISKS / MATTERS FOR ESCALATION

Without strategic alignment and strong operational governance there will be a risk that the Health Improvement Menu of Interventions which seeks to support the ambition to improve health in the population will be impacted. It requires the traction to fully embed across the Health Board's services and within wider transformation, planning and delivery. The impact would be reflected in population health, widening health inequalities and increasing demand across health systems. This links to the corporate risk CRR25-03 Population Health Risk.

Currently, the timeline for the development of a set of priorities aligned to the six major diseases must consider the importance of stakeholder engagement, which cannot be rushed. This will result in a second iteration of the document in December 2026. Overall, this should not impact the delivery timeline.

5. ARGYMHELLION
RECOMMENDATIONS

Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:
The Committee is asked to

- **NOTE** why developing this document matters.
- **NOTE** the dynamic and developmental approach taken to develop this document with a second iteration in December 2026 to include the six major diseases.
- **NOTE** that further work will be underway in quarter 3 to develop an operational governance approach to deliver the document and alongside how it can be integrated into existing and the emerging major change programmes.
- **APPROVE** the work and approach taken to develop this first iteration of a BCUHB Health Improvement Menu of Interventions for further dynamic development.

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol **Link to Strategic Priorities**	3. Improve Access, Outcomes and Experience
	Developing strategy and long-lasting change Building and effective organisation Health Board Wellbeing Objectives: • to improve physical, emotional and mental health and well-being for all. • to target our resources to those with the greatest needs and reduce inequalities. • to support children to have the best start in life. • to work in partnership to support people – individuals, families, carers, communities – to achieve their own well-being. • to listen to people and learn from their experiences. Strategic Priority 1 – Focus on Health & Wellbeing through every stage of life. Prevention and Population Health are Ministerial priorities for 26/27 with specific deliverables.
Yr Egwyddorion Dylunio **Design Principles**	Equity and Accessibility Inclusive Design Simplify, Standardise and Adopt Best Practice
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Document**	CRR25-03 Population Health Risk *There is a risk that the organisation will fail to meet the health needs of the population and will not enable good health and wellbeing of the population.* BAF24-06 - *There is a risk of not delivering the required improvements to transform care and enhance outcomes*

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 **Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector**	Do/Yes: ☐	Naddo/No: ☐x
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm:	*This report is an update on the development of a document document.*

Equality Duty (General Duty): https://www.gov.wales/public-sector-equality-duty-htmlPublic Sector Equality Duty [HTML] | GOV.WALES	If no, please include rationale:	*Due Regard is not required at this point however any projects arising from the document towards the end of 26/27 into 27/28 will require this.*
Equality Act 2010 - Socio-economic Duty *Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?*	Do/Yes: ☒	Naddo/No: ☐x
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	*This report is an update on the development of a document document. An EQIA/SEIA is not required at this point however any projects arising from the document towards the end of 26/27 into 27/28 will require an EQI/SEIA.*
Have you completed an Integrated Equality Impact Assessment WP8a? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	Naddo/No:
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☐x
	Canlyniad/Outcome:	
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: x☐
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	

	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant *Have the principles of the Armed Forces Covenant been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☐ x
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☐
	Canlyniad/Outcome:	
	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Person Centred
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	*A Healthier Wales* *A Resilient Wales* *A More Equal Wales* *A Prosperous Wales*	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: Not applicable at this stage	
	Choose an item.	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?*	Do/Yes: ☐	Naddo/No: x☐
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm:	*This report is an update on the development of a document document. A*

Data Protection Impact Assessment *Have you undertaken a Data Protection Impact Assessment Screening?*	If no, please include rationale:	*DPIA is not required at this point however any projects arising from the document towards the end of 26/27 into 27/28 may require a DPIA.*
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☐ x
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	*This report is an update on the development of a document document. A CFIA is not applicable for this work at this phase.*
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	
	Not during this phase of the project however once the delivery phase is initiated and delivery plans developed there may be a requirement for resource and/or funding.	

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Planning, Population Health & Partnerships Committee

DIRECTOR OF PLANNING REPORT

Date of Meeting	03 September 2026
Publication Status	Open/ Public
	Not Applicable
Report Author name and title	Paolo Tardivel, Executive Director of Transformation & Strategic Planning (Interim)
Lead Executive Team Member name and title	Paolo Tardivel, Executive Director of Transformation & Strategic Planning (Interim)

Report Purpose	For Assurance

Executive Summary
This report provides the Planning, Population Health and Partnerships Committee (PPHP) with an update on key strategic, planning, and transformation activities across the Health Board.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome, Evidence and Data**
N/A		

Acronyms / Glossary of Terms	
PPHP	Planning, Population Health & Partnerships Committee
QSE	Quality, Safety & Experience Committee
PFIG	Performance, Finance & Information Governance Committee
IMTP	Integrated Medium-Term Plan
ADP	Annual Delivery Plan
CSP	Clinical Services Plan
UEC	Urgent and Emergency Care
SRO	Senior Responsible Officer
SPSCG	Strategic Planning and Service Change Group

DIRECTOR OF PLANNING REPORT

1) SITUATION

The purpose of this report is to provide stakeholders with an update on a range of strategy and planning matters. This is a regular report to the Executive SPSCG and PPHP with any key updates provided directly to the Board, it may also be used in other key governance when required.

2) BACKGROUND

This report does not seek to rehearse the background to each of the specific matters for consideration as it acts as a vehicle to provide high level assurance on key progress being made in each area. The full background and detail of each area is subject to separate more detailed reports and can be provided should they be required.

3) SPECIFIC MATTERS FOR CONSIDERATION

3.1: 10-YEAR STRATEGY

The Integrated 10-Year Strategy Programme will establish a long-term framework to improve population health outcomes, reduce inequalities and support sustainable, high-quality services across North Wales. Building on the Strategic Intent Statements developed through co-design during 2025/26, the programme will provide the overarching strategic framework for the Health Board, supporting alignment between future service models, organisational planning, transformation programmes and enabling strategic plans.

During this reporting period, activity has focused on development of the Strategy Programme Initiation Document (PID), establishment of programme governance arrangements and refinement of the programme roadmap. The PID sets out the programme's objectives, scope, governance, delivery approach, milestones, risks and interdependencies and provides a framework for delivery of the Health Board's Strategy Development Programme.

The programme is currently focused on completing the Discovery Phase, including development of the Diagnosis and Insights Reports, Discovery Report and Organisational Case for Change. In parallel, work is underway to establish the Strategic Planning Programme Board (SPPB) and Strategic Partnership Forum

(SPF), refine the emerging Vision, Outcomes and Strategic Principles, and strengthen alignment with the Future Clinical Services Model, IMTP and underpinning enabling strategic plans.

Over the next three months, priorities will include completion of Discovery Phase outputs, preparation for transition into the Design Phase, commencement of Board and Executive development activity, and establishment of the governance and planning arrangements required to support successful programme delivery

3.2: CLINICAL SERVICES PLAN

The Clinical Services Planning (CSP) Programme seeks to provide a structured, evidence-informed approach to shaping sustainable, high-quality clinical services across North Wales, aligned to the Health Board's strategic ambitions and wider system priorities. The programme combines clinical leadership, stakeholder insight and co-production to inform future service models and improve quality, outcomes, experience and sustainability.

The programme is focused on establishing three key products which will be delivered in two stages:

Stage 1:

- A Future Clinical Services Model, setting out the overarching direction for clinical services across North Wales;
- A Clinical Services Planning (CSP) Framework, providing a consistent framework for service assessment, option appraisal and decision-making; and

Stage 2:

- Application of the Framework to develop a suite of Individual Service Area Plans, translating the agreed approach into service-specific recommendations and implementation priorities aligned to the Future Clinical Services Model.

During Q1 and early Q2, activity has focused on programme mobilisation, early stakeholder engagement and development of the Programme Initiation Document (PID). While progress has been made in refining the programme scope and approach, mobilisation has been slower than anticipated due to competing organisational priorities and inconsistent engagement across parts of the organisation, resulting in key activities extending beyond their original timescales.

Over the next three months, priority will be given to programme mobilisation, establishment of governance arrangements, development of the Future Clinical

Services Model and CSP Framework, and strengthening the evidence base required to support future planning activity. Alignment with the emerging Ten-Year Strategy, wider strategic planning portfolio and IMTP will remain critical to ensuring a coherent approach to future service planning and transformation.

3.3: INTERNAL SERVICE CHANGE

Penley
For Penley, the public consultation launched on Thursday 16 July for a period of six weeks, plus six weeks to account for the summer holiday period. A comprehensive engagement activity planner is in development with several drop-in sessions and community meetings in diaries. Full information will be available here: Shaping the Future of Penley Hospital - Betsi Cadwaladr University Health Board with the consultation open until October.

Tywyn
In Tywyn, the Health Board approved to move to public consultation on two options at their meeting on Thursday 30 July. The consultation is likely to launch in September 2026 for a period of 12 weeks. Engagement work will continue in Tywyn to capture the views of summer residents. The two options being consulted on are:

Option A: A return to the inpatient model.
This option proposes the re-opening of the inpatient ward, Dyfi Ward, under the caveat of being able to sustainably achieve safe staffing levels at all times. This would mean the closure of the additional community services that were introduced following the temporary closure of the ward.

OR

Option B: An expansion of the current community services put in place following the temporary closure providing enhanced care at home and hospital based clinics, treatments and therapies. This option proposes the permanent closure of inpatient beds at Tywyn Community Hospital, whilst maintaining and expanding the current community service model that has been developed since the temporary closure.

The shortlisted options are intended to support public consultation, testing the assumptions, evidence, impact and conclusions reached to date and are not presented as a final outcome. The Health Board remains open to alternative suggestions and modifications arising through the consultation process.

3.4: IMTP DEVELOPMENT – 2026-29

The Integrated Medium-Term Plan (IMTP) planning cycle remains a core component of the Health Board's strategic planning framework, providing the mechanism through which strategic, service, workforce, financial, quality, performance, digital and partnership priorities are aligned within a single integrated planning process. The Health Board continues to implement its continuous planning approach, established through the Integrated Planning Framework (IPF), to support improved planning maturity, organisational alignment and a more proactive, evidence-led approach to planning.

Significant progress has been made in finalising the Reflection and Learning exercise and Planning Maturity Matrix refresh, both of which will now inform the refresh of the Integrated Planning Framework, planning guidance, organisational capability development and supporting planning tools.

Whilst overall delivery of the planning cycle remains on track, there are delays in relation to Unified Modelling proposal due to competing priorities from teams needing to contribute; however, progress has been made in defining organisational requirements, identifying baseline datasets and aligning work with NHS Performance & Improvement colleagues.

3.5: ANNUAL DELIVERY PLAN REPORTING 2026/27

This Month 4 report provides an overview of progress against the 2026/27 Annual Delivery Plan (ADP) and highlights a mixed delivery position across the Health Board. Whilst progress has been made, delivery confidence remains fragile, with only 60% of Quarter 1 deliverables completed and a significant number of actions carried forward into Quarter 2. Of the deliverables due during Quarter 2, only half are currently forecast to be achieved within timescale, with a substantial proportion assessed as at risk or having low delivery confidence. At a full-year level, just over half of all ADP deliverables remain on track for delivery, indicating that performance and improvement trajectories continue to be challenged by operational pressures, workforce constraints, financial pressures and dependencies on external partners and national programmes.

Several areas require focused executive attention to prevent further slippage and to improve confidence in achieving year-end objectives. Key risks include delays in major capital and transformation programmes, capacity limitations impacting service redesign and strategic planning, and variable quality and timeliness of reporting, which affects assurance. Whilst mitigating actions and recovery plans are in place

across most areas, a more proactive approach to intervention, prioritisation and accountability will be required to stabilise delivery trajectories. Executive Leads are therefore asked to review those deliverables assessed as at risk or low confidence, implement corrective actions where possible, strengthen ownership and oversight arrangements, and ensure that programme dependencies are actively managed to support delivery of the ADP and the Health Board's strategic priorities.

3.6: SPECIAL MEASURES

Special Measures de-escalation reporting is now in its second month of production, taking refinements into account from the first report. The report will now be clear on which de-escalation criteria the organisation believes it has met.

Next step is to agree the mechanism by which meeting of de-escalation criteria can be tested with Welsh Government. This ties into the target set by the Cabinet Minister of meeting the de-escalation criteria relating to priority areas (such as Planned Care, Diagnostics, Cancer and UEC) by the end of September, not by the end of the financial year as committed to in the ADP.

3.7: PORTFOLIO MANAGEMENT

This area of work has been established to strengthen the organisation's approach to portfolio, programme and project management. The work is to improve oversight, consistency and delivery confidence across Major Change Programmes, Key Programmes and Challenged Services.

Progress has been made in establishing portfolio reporting arrangements, strengthening executive oversight, developing programme governance processes and introducing a more consistent approach to programme documentation and delivery. This work is intended to provide greater organisational visibility of delivery, improve decision-making, support benefits realisation and reduce variation in how programmes are governed and managed.

Stakeholder engagement with programme leads, executives and delivery teams has identified a need for greater consistency in governance arrangements, clearer accountability, improved reporting and more robust assurance processes. These findings are informing the development of the Programme Delivery Framework and supporting documentation.

Over the next three months the focus will be on the Programme Delivery Framework, mobilising Community by Design and the Clinical Services Plan as two new Major

Change Programmes, implementing gateway reviews and strengthening portfolio oversight through improved governance and benefits reporting.

Whilst plans are in place to bring this back on track, successful delivery also remains dependent upon organisational capacity, programme leadership arrangements and the continued engagement of key stakeholders.

3.8: ORGANISATIONAL CAPABILITY

The Organisational Capability area of work is currently on track for delivery, with progress aligning to the planned milestones and timescales. The area of work has been established to strengthen the organisation's ability to lead, support and sustain change by developing accessible learning pathways focused on areas aligned to change, focusing on programme / project management, planning, and improvement. This investment in organisational capability will support delivery of strategic priorities by building a workforce that is confident, skilled and equipped to drive transformation effectively.

The discovery phase has been successfully completed, including stakeholder engagement and analysis. Feedback from stakeholders and service leads identified a need for a more flexible and accessible learning offer, particularly for operational staff who face barriers to participation in existing training opportunities. These insights are now informing the design of learning pathways that are aligned to organisational needs and support wider engagement across the workforce.

Good progress has been made to date, including the development of a draft prospectus outlining the proposed learning pathways and delivery approach, completion of scoping sessions with key stakeholders, identification of organisational capability challenges, and development of content to be hosted via the Change Hub. The Change Hub will host all of the collateral for the training, providing a single point of access for change resources, tools, templates and learning materials, supporting greater consistency and reducing duplication across the organisation.

Over the next three months, activity will focus on finalising learning pathway content, launching the bitesize learning resources, developing a communication and engagement plan, establishing an evaluation framework, and implementing a Power App to streamline training administration and reporting. These activities will support the successful implementation and ongoing improvement of the learning offer.

The initial focus will be on a target audience who will act as the test bed for the new training package. Their participation and feedback will be used to evaluate the

content, format and delivery approach, informing the final version of the programme. Following refinement, subsequent cohorts will focus on Sponsors, Senior Responsible Owners (SROs) and programme leadership roles, recognising the disproportionate influence these groups have on the successful delivery of organisational change. Further cohorts will include targeting staff involved in priority transformation programmes and service improvement initiatives.

3.9: ORGANISATIONAL APPROACH TO CHANGE

BCUHB has completed the discovery phase of developing a consistent organisational approach to change. Evidence from internal learning, leadership insight, and staff feedback shows variation in how change is experienced, leading to inconsistent delivery and outcomes.

A standardised, principle-based approach, supported by practical tools and a central Change Hub, is now proposed. The Change Hub will provide a single, accessible location for staff to access the organisational change principles, practical guidance, templates, tools, case studies and support resources. Its purpose is to make good change practice easier to apply consistently across BCUHB, reducing duplication and providing a common approach that can be scaled across programmes, projects and local service change.

The programme has now moved into the Design Phase (July – September 2026) to co-develop and test this approach with staff and stakeholders.

There are a small number of key risks to delivery, including the potential for limited engagement due to competing organisational priorities, the perception that this represents ‘another framework’, and the risk that benefits are not clearly demonstrated. In addition, undertaking the design phase over the summer period may impact participation. These risks will be mitigated through flexible engagement approaches, clear articulation of value, visible senior sponsorship and the development of an evaluation framework.

The Committee is asked to note progress to date and to support the transition into the design phase, including actively championing engagement across the organisation to ensure the approach is co-produced and adopted at scale.

3.10: THIRD SECTOR PARTNERSHIP UPDATE

Initial work has commenced to strengthen the Health Board’s approach to partnership working with the third sector through the development of a North Wales

Third Sector Partnership Framework. Early engagement with the six County Voluntary Councils (CVCs) has provided valuable insight into how the framework should be shaped, with partners emphasising the importance of genuine co-production, broader involvement of organisations and communities, and sufficient time to develop a shared understanding of purpose and outcomes. As a result, the original workshop approach planned during May was stood down and reset to ensure that the framework is developed in a way that reflects the expertise and priorities of the third sector and supports a more collaborative and strategic relationship.

The next phase will focus on working closely with CVC Chief Officers and Health and Wellbeing Facilitators to agree the purpose, ambition and key questions for the framework, alongside defining a shared approach to engagement across North Wales. This will enable wider conversations with third sector organisations and communities, with feedback used to develop a draft framework for further discussion and refinement.

The framework is expected to support stronger strategic partnership working, earlier involvement of the third sector in service planning and transformation, and a more preventative and community-focused model of care.

Alongside the framework, and building on the strengthened joint working approach, the sector will be engaged on the development of a proposal for creating an investment fund for community groups and third sector organisations to work with the Health Board on community-based solutions to some of the largest challenges facing the system (IMTP reference 2B.4).

4) KEY RISKS / MATTERS FOR ESCALATION

As this report demonstrates, there is a large number of important pieces of work being orchestrated through this portfolio, all requiring concurrent focused development and delivery work. This does generate capacity challenges across the team, which are difficult to mitigate leading up to organisational structural changes and in the current and future financial climate.

A number of challenges exist within the Service Change, Key Programmes and Major Change Programmes, which are being managed and mitigated through their own individual governance and reporting.

Meeting the full set of Ministerial expectations within the IMTP given the challenging financial landscape.

5) RECOMMENDATIONS

The Committee is asked to:

- **NOTE** and **COMMENT** on the content of the report

ASSESSMENT	
Link to Strategic Priorities	4.Create a Modern, People Centred Healthcare System If more than one applies, please list below:
Design Principles	Simplify, Standardise, and Adopt Best Practices If more than one applies, please list below:
Corporate Risks and Board Assurance Framework	♣ BAF24-01 - Not Fully Building an Effective and Accountable Organisation ♣ BAF24-02 - Not Delivering Strategic Development and Digital Transformation ♣ BAF24-03 - Not Achieving Long Term Financial Sustainability ♣ BAF24-04 - Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability ♣ BAF24-05 - Not Engaging with Citizens, Partners and Communities ♣ BAF24-06 - Not Delivering the Required Improvements to Transform Care and Enhance Outcomes ♣ BAF24-07 - Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk ♣ BAF24-08 - Not Implementing Evidenced Based Improvement and Innovation
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales If more than one applies, please list below:

IMPACT ASSESSMENTS		
Equality *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	
Socio-Economic Impact Assessment	Yes: ☐	No: ☒
	Outcome:	

Have you undertaken a Socio-Economic Impact Assessment	If no, please include rationale:	
Quality *Have you undertaken a Quality Impact Assessment Screening?*	**Enablers of Quality** All Apply	**Domains of Quality** All Apply
	If more than one applies, please list below:	If more than one applies, please list below:
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	

Environmental /Sustainability Impact (5Rs)	If more than one applies, please list below:	
	No - Not Applicable	
	If more than one applies, please list:	
Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	
Data Protection Impact Assessment *Have you undertaken a Data Protection Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	
Counter Fraud Impact Assessment *Have you considered the counter fraud impacts*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	
Legal	There are no specific legal implications related to the activity outlined in this report.	

Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

Planning, Population Health & Partnerships Committee

WELSH GENERAL OPHTHALMIC SERVICES (WGOS) ANNUAL REPORT 2025/26

Dyddiad y Cyfarfod **Date of Meeting**	03 September 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Draft Status - Final Version will be Published
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Sarah Lloyd-Hughes Primary Care Programme Manager – East IHC
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Carol Shillabeer, Chief Executive

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol
Executive Summary

The Ministerial Directions require Health Boards to produce and publish an annual eye care report, for the purpose of monitoring the provision of Welsh General Ophthalmic Optometric Services (WGOS) 1-5 across its area.

Wales General Ophthalmic Services were introduced on 20 October 2023, with unification of the service architecture, governance and evaluation across Wales to provide care closer to home and ensure that people only attend hospital eye services when required. WGOS is a Primary Care Optometry service delivered from both fixed location premises in the community and closer to/in homes via mobile/domiciliary providers.

WGOS is a tiered service comprising of the following:

- **WGOS 1**: eye examinations and patient management plan
- **WGOS 2**: made up of three bands:
  - Band 1 – Acute eye care and referrals for examination from another healthcare professional
  - Band 2 - Further examinations following WGOS 1 to inform or prevent a referral

  - Band 3 - Follow up examinations to WGOS 2 Band 1 and Cataract Post-operative Assessments
- **WGOS 3**:
  - Assessments for those with low vision and providing low vision aids where appropriate, as well as holistically supporting the patient and providing rehabilitative support
  - Certification of Vision Impairment for patients whose leading cause of vision loss is Dry Age-Related Macular Degeneration

- **WGOS 4**: examinations for patients who would previously have been referred to/or managed in the Hospital Eye Service (HES) instead remain in primary care for further enhanced assessment as part of an agreed referral refinement or monitoring pathway for patients:
  - with or with suspected medical retina conditions
  - with or with suspected glaucoma or ocular hypertension; and
  - who are at risk of retinopathy due to taking hydroxychloroquine or chloroquine

- **WGOS 5**: examinations in primary care for acute eye conditions that require management by an independent prescriber optometrist to reduce the need for onward referrals to Hospital Eye Services

- **NHS Optical Vouchers**: financial support for the provision of spectacles or contact lenses to patients in eligible categories determined by Welsh Government

This is the Health Board's second WGOS annual report. It includes a breakdown of WGOS 1-5 provided in the previous financial year and contains the following information:

a) A summary of the provision of WGOS 1–5
b) A summary of the workforce providing those services
c) An assessment of the effectiveness of the provision of WGOS 1–5,
d) Any identified gaps in service provision and the steps taken to try to address and then close those gaps
e) Any identified need and, if applicable, proposals, for service improvement pathways
f) Financial forecasts for service delivery
g) A summary of the Local Health Board's communications activity relating to WGOS 1–5 to raise awareness of those services among the public and healthcare professionals and its proposals for future communications activity

WGOS governance is provided through the Optometry Implementation Group, which reports to the Eye Care Collaborative and the Primary Care Board.

The Committee is asked to **NOTE** the WGOS Annual Report prior to publishing.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
Optometry Implementation Group	16/04/2026	Approved
East Senior Leadership Team	07/05/2026	Approved
Operational Leadership Team	10/08/2026	TBC

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
WGOS	Welsh General Ophthalmic Services

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol **Link to Strategic Intentions**	3. Improve Access, Outcomes and Experience If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Equity and Accessibility
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	n/a

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 **Public Sector Equality Duty:** **Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty):** https://www.gov.wales/public-sector-equality-duty-htmlPublic Sector Equality Duty [HTML] | GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
Equality Act 2010 - Socio-economic Duty	Do/Yes: ☒	Naddo/No: ☒
	Canlyniad/Outcome:	

Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
Have you completed an Integrated Equality Impact Assessment WP8a? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not applicable
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant *Have the principles of the Armed Forces Covenant been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not applicable
	Galluogwyr Ansawdd Enablers of Quality Culture and Valuing People	

	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	A Resilient Wales	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not applicable
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
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Welsh General Ophthalmic Optometric Services (WGOS)

Annual Report

2025-26

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1. Introduction

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- Financial forecasts for service delivery

- A summary of the Local Health Board's communications activity relating to WGOS 1–5 to raise awareness of those services among the public and healthcare professionals and its proposals for future communications activity

2. Wales General Ophthalmic Services in North Wales

Betsi Cadwaladr University Health Board is the largest health organisation in Wales, responsible for the delivery of health care services across the six unitary authorities of North Wales (Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire and Wrexham). North Wales has a population of approximately 700,000.

The six unitary authorities serving Betsi Cadwaladr University Health Board Wales are divided into fourteen Primary Care Clusters, as shown in the map below:



The WGOS 1 to 5 pathways are now fully established across BCUHB. As of March 2026, services are being delivered by 71 Optometry practices throughout North Wales, supported by a further 7 domiciliary providers and the Teach and Treat Centre, located in Holywell Community Hospital, North West Flintshire.

Between April 2025 and March 2026, a total of **191,468** WGOS 1 eye examinations were completed across North Wales. During the same period, **57,004** examinations were undertaken under WGOS 2, while WGOS 3 activity resulted in **1,643** low-vision assessments.

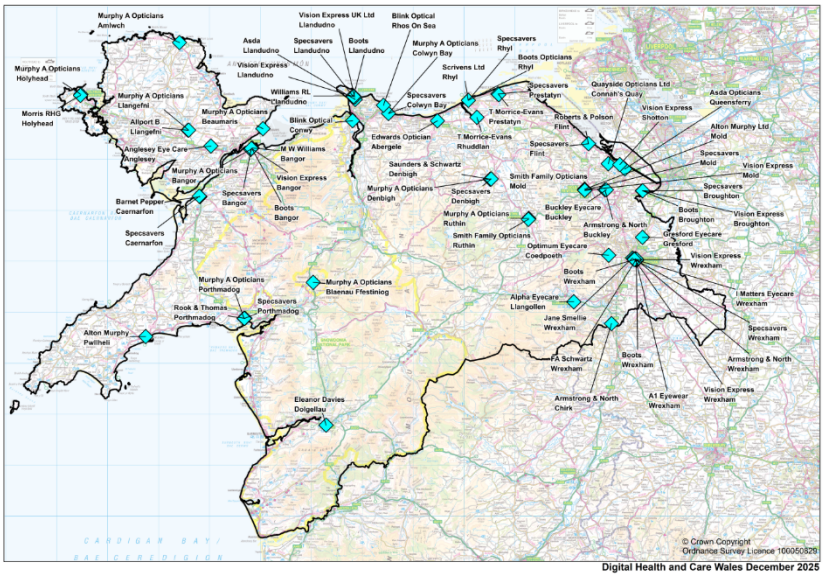
The WGOS 4 Hydroxychloroquine screening pathway became operational in December 2024 and is currently delivered by seven practices across North Wales, with further expansion anticipated during 2026. Between April 2025 and March 2026, a total of **149** patients received HCQ screening in primary care.

The WGOS 4 Medical Retina and Glaucoma pathways have been active since July 2025. At present, there are 21 glaucoma contractors, including nine filtering higher-certificate Optometrists, alongside 37 medical retina contractors across BCUHB. These numbers are expected to grow as additional providers come forward. Between July 2025 and March 2026, **1,780** Medical Retina and Glaucoma assessments have been carried out.

WGOS 5 was established earlier, in January 2024, and is now provided by 24 contractors. Between April 2025 and March 2026, a total of **3,983** WGOS 5 examinations were undertaken.

3. Summary of the provision of WGOS 1–5

A map showing the location of the 71 Optometry Practices serving the population of North Wales is provided below:



All practices offer the mandatory WGOS 1 and WGOS 2 services.

An overview of the current WGOS 3-5 service provision at practice and cluster level is provided in the table below:

Cluster	Practice	WGOS 3 Low Vision	WGOS 4 Glau Filt	WGOS 4 Glau Mon	WGOS 4 MR Filt	WGOS 4 MR Mon	WGOS 4 HCQ	WGOS 5 IPOS
Anglesey	Allport Opticians, **Llangefni**				×	×	×	
	Alton Murphy, **Amlwch**	×		×				
	Alton Murphy, **Beaumaris**	×						
	Alton Murphy, **Holyhead**	×			×	×		
	Alton Murphy, **Llangefni**	×		×				
	Roberts Gray Morris, **Holyhead**							
	Anglesey Eye Care, **Gaerwen**		×	×	×	×	×	
Arfon	Alton Murphy, **Bangor**	×						x
	Barnet Pepper, **Caernarfon**	×		×	×	×		
	Boots, **Bangor**				×	×		
	Specsavers, **Bangor**	×			×	×		
	Specsavers, **Caernarfon**	×	×	×	×	×		×
	Vision Express, **Bangor**							
	M W Williams, **Bangor**		×	×	×	×		×
Dwyfor & North Meirionydd	Alton Murphy, **Porthmadog**	×			×	×		
	Alton Murphy, **Pwllheli**	×						
	Alton Murphy, **Blaenau Ffestiniog**	×						
	Rook & Thomas, **Porthmadog**	×	×	×				
	Specsavers, **Porthmadog**	×	×	×	×	×		×
South Meirionydd	Eleanor Davies, **Dolgellau**	×	×	×	×	×		×
Conwy East	Alton Murphy, **Colwyn Bay**	×						
	Edwards Opticians, **Abergele**				×	×		
	Specsavers, **Colwyn Bay**	×		×	×	×		×
	Blink Optical, **Rhos on Sea**			×				
Conwy West	Asda, **Llandudno**							
	Blink Optical, **Conwy**	×			×	×		
	Boots, **Llandudno**				×	×		
	MRC Searle, **Llandudno**	×						
	Gareth Roberts, **Llandudno**	×			×	×	×	
	Specsavers, **Llandudno**	×		×	×	×		×
	Vision Express, **Llandudno**							

Cluster	Practice	WGOS 3 Low Vision	WGOS 4 Glau Filt	WGOS 4 Glau Mon	WGOS 4 MR Filt	WGOS 4 MR Mon	WGOS 4 HCQ	WGOS 5 IPOS
Central & South Denbighshire	Alton Murphy, **Denbigh**	×						
	Alton Murphy, **Ruthin**	×						
	Smith Family Opticians, **Ruthin**			×	×	×		×
	Saunders & Schwartz, **Denbigh**			×	×	×		×
	Specsavers, Denbigh							
	Studio Optical, **St Asaph**							
North Denbighshire	Boots, **Rhyl**			×				
	Scrivens Ltd, **Rhyl**							
	Specsavers, **Rhyl**				×	×		×
	Specsavers, **Prestatyn**				×	×		
	T Morrice-Evans, **Prestatyn**	×			×	×		×
	T Morrice-Evans, **Rhuddlan**	×			×	×		×
North West Wrexham	Eye Care 4U, **Coedpoeth**							
	Gresford Eyecare, **Wrexham**							
Central Wrexham	A1 Eyewear, **Wrexham**							
	Armstrong & North, **Wrexham**				×	×		×
	Boots, Eagles Meadow, **Wrexham**	×			×	×		
	Boots, Hope St, **Wrexham**							
	FA Schwartz, **Wrexham**		×	×	×	×		×
	I Matters Eyecare, **Wrexham**	×	×	×	×	×		×
	Jane Smellie, **Wrexham**	×	×	×	×	×	×	×
	Specsavers, **Wrexham**							
	Vision Express, Tesco, **Wrexham**							
	Vision Express, Hope St, **Wrexham**							
South Wrexham	Alpha Eyecare, **Llangollen**	×						
	Armstrong & North, **Chirk**				×	×		×
South Flintshire	A1 Vision, **Buckley**							
	Alton Murphy, **Mold**	×						
	Armstrong & North, **Buckley**							×
	Buckley Eyecare, **Buckley**				×	×		×
	Smith Family Opticians, **Mold**			×	×	×		×
	Specsavers, **Mold**				×	×		
	Vision Express, **Mold**							
North East Flintshire	Asda, **Queensferry**							
	Boots, **Broughton**							
	Quayside, **Connahs Quay**	×						
	Specsavers, **Broughton**		×	×	×	×	×	×
	Vision Express, **Broughton**							
	Vision Express, **Shotton**							x
North West Flintshire	Roberts & Polson, **Flint**				×	×		
	Specsavers, **Flint**	×	×	×	×	×	×	×
	Teach and Treat, **Holywell**				x	x	×	
Domiciliary Providers	Home Vision Care Ltd	×						
	Avako Ltd							×
	Eyecare Oncall Ltd							
	Vison Care at Home North West Ltd							
	Iris Domiciliary Services	×						
	Clwyd & Snowdonia Domiciliary Specsa	×						
	Outside Clinic Services Ltd							

4. Summary of the workforce providing WGOS 1-5

(a) BCUHB Optometry Performance List Workforce Data (at March 2026)

Number of Primary Care Optometrists listed on the BCUHB Performers List	289
Number of Primary Care Dispensing Optometrists listed on the Administrative List	63
Number of Primary Care Contact Lens Optometrists listed on the BCUHB Performers List	6
Number of Student Optometrists listed on the BCUHB Performers List	17

Note: Data not split by cluster as some Performers work across a number of practices and/or clusters

(b) BCUHB Higher Certificate Opticians by Cluster

In the absence of a dedicated workforce reporting tool, the Health Board undertakes periodic reviews as part of WGOS 4 scoping to identify where Optometrists with Higher Qualifications are located. The findings are summarised in the table below:

Cluster	Prof Cert Med Retina	Higher Cert Med Retina	Prof Cert Glaucoma	Higher Cert Glaucoma	Diploma Glaucoma	Ind Pxing	Prof Cert Low Vision	HCQ
Anglesey	4	0	2	1	0	0	1	3
Arfon	11	0	7	2	0	3	6	1
Dwyfor & North Meirionydd	4	0	2	1	1	2	3	0
South Meirionydd	1	0	2	1	0	1	1	0
Conwy East	6	0	1	0	0	2	3	0
Conwy West	3	0	1	0	0	1	3	1
Central & South Denbighshire	2	0	2	0	0	3	2	0
North Denbighshire	7	0	4	0	0	2	1	0
North West Wrexham	0	0	0	0	0	1	0	0
Central Wrexham	9	0	4	3	0	4	4	3
South Wrexham	1	0	0	0	0	0	1	0
South Flintshire	5	0	1	0	0	3	2	0
North East Flintshire	3	0	3	1	0	2	1	3
North West Flintshire	3	0	1	0	0	1	1	2
Domiciliary	0	0	0	0	0	1	4	0
Totals	**61**	**0**	**30**	**9**	**1**	**26**	**33**	**13**

(c) Optometrist in Training (as at March 2026)

The table below summarises Optometrists currently undertaking Professional and Higher Certificate training across BCUHB via the Cardiff University Teach and Treat Centres, and those expected to join the next cohort:

Training Pathway	Current Number of Trainees	Planned Additions (Next Cohort)
Independent Prescribing	5	+4
Higher Certificate – Glaucoma	2	Seeking 4 students
Higher Certificate – Medical Retina	2	+3

The scope and range of service provision will continue to increase as more Optometrists undertake their qualifications. The Health Board will continue to regularly repeat its workforce audit to ensure information is up-to-date in terms of Optometrists with the Higher Qualifications and also capture Optometrists who have commenced training.

5. Assessment of the effectiveness of the provision of WGOS 1–5

The graphs below show the number of claims processed under each WGOS service between April 2025 and March 2026 together with a comparison to the same period in 2004/25.

WGOS Pathway	2024/25	2025/26	% Increase
WGOS 1	181,956	191,468	**5%**
WGOS 2 – Band 1	25,954	29,270	**13%**
WGOS 2 – Band 2	15,363	17,814	**16%**
WGOS 2 – Band 3	6,926	9,920	**43%**
WGOS 3 – Low Vision	1,100	1,643	**49%**
WGOS 4 – HCQ	0	149	N/A
WGOS 4 – Med Ret	0	1,262	N/A
WGOS 4 – Glaucoma	0	519	N/A
WGOS 5 – IPOS	2,553	3,983	**56%**

In summary, WGOS activity has grown across all pathways this year, showing strong engagement from both patients and practices. The largest increases are seen in WGOS 3 (+49%) and WGOS 5 IPOS (+56%), indicating substantial growth in these areas.

A key success in 2025/26 has been the rollout of WGOS 4, with activity now recorded across all pathways. This reflects increasing clinical confidence within primary care and a continued shift towards managing more eye care needs closer to home.

Overall, the data shows a clear upward trend, with growing capacity, an expanding clinical scope, and stronger integration between primary and secondary care.

6. Identified gaps in service provision

The primary care team has recently completed an exercise to identify service gaps, to help us determine where to focus efforts to increase availability and support the 'care closer to home' ethos. The aim remains a minimum of two practices per cluster delivering each modality under WGOS 3, 4 and 5.

The heat map below shows the percentage of practices providing WGOS 1-5 by cluster and highlights the gaps in the current service provision:

	Heat map showing the % of practices providing WGOS 1-5 across BCUHB Clusters						
Cluster	**WGOS 1**	**WGOS 2**	**WGOS 3**	**WGOS 4 HCQ**	**WGOS 4 Med Ret**	**WGOS 4 Glaucoma**	**WGOS 5**
Anglesey	100%	100%	57%	29%	43%	43%	0%
Arfon	100%	100%	57%	0%	43%	43%	43%
Dwyfor & North Meirionydd	100%	100%	100%	0%	40%	40%	20%
South Meirionydd	100%	100%	100%	0%	100%	100%	100%
Conwy East	100%	100%	50%	0%	50%	50%	25%
Conwy West	100%	100%	57%	29%	57%	14%	14%
Central & South Denbighshire	100%	100%	33%	0%	33%	33%	33%
North Denbighshire	100%	100%	33%	0%	66%	17%	50%
Central Wrexham	100%	100%	30%	10%	50%	57%	40%
North West Wrexham	100%	100%	0%	0%	0%	0%	0%
South Wrexham	100%	100%	50%	0%	50%	0%	50%
North East Flintshire	100%	100%	17%	17%	17%	17%	33%
North West Flintshire	100%	100%	33%	66%	100%	33%	33%

South Flintshire	100%	100%	14%	0%	33%	14%	43%

Key:	100% provision	>50% provision	<50% provision

The Health Board will continue to work towards ensuring sufficient WGOS coverage, particularly in areas where the health needs of the local population indicate a requirement for WGOS 3–5 services. Currently, some patients may need to travel outside their local cluster area to access WGOS 4 and 5 provision.

To address this, the Health Board is maintaining close collaboration with key stakeholders and engaging with the optometry community to encourage increased participation and sign-up. We are also working closely with the primary care academy, cluster leads, HEIW and Teach and Treat centre to promote qualifications where needed.

The Health Board remains fully committed to ensuring that WGOS services are delivered appropriately, consistently, and equitably for the population of North Wales.

Additionally, information from the BCUHB Eye Health Needs Assessment, and the workforce toolkit submitted by practices as part the Quality for Optometry practice will inform future planning, with consideration being given to those cluster areas with the greatest needs. Eye Health Needs Assessment - Betsi Cadwaladr University Health Board (nhs.wales)

7. Identified need and proposals for service improvement pathways (including transition to WGOS 4 & 5 pathways)

Betsi Cadwaladr University Health Board (BCUHB) has now fully implemented all WGOS 4 and WGOS 5 pathways. These services are well established and operational across the Health Board footprint, with ongoing expansion to ensure equitable access and sufficient capacity across all clusters.

WGOS 4 Hydroxychloroquine (HCQ)
The WGOS 4 Hydroxychloroquine pathway commenced in December 2024 and is provided by seven practices across North Wales (ensuring provision across each of the 3 IHC areas). The pathway is now in its second stage of delivery with Patient Booking Centres now directing patients to their nearest WGOS4 HCQ practices for screening. Service capacity is projected to expand to 12 practices in early 2026/27.

Our aim is for all HCQ screening referrals to be generated by specialty administration teams or by GPs for patients within shared-care arrangements. We will also review recall processes, noting that the current system requires a prescribing clinician request, whereas England operates an automatic 12-month recall model.

WGOS 4 Medical Retina
Forty practices across BCUHB are currently approved to deliver WGOS 4 Medical Retina services, providing coverage in 12 of the 13 clusters with more practices expected to be onboarded in the coming months, further increasing coverage and supporting equitable service provision across all 13 clusters.

We will continue to strengthen the medical retina workforce and, following the launch of the revised WGOS 4 handbook, will arrange clinical meetings with sites to clarify

lower - versus higher-risk MR conditions and agree which conditions can be appropriately monitored within the community.

WGOS 4 Glaucoma
Nine practices are currently approved to deliver WGOS 4 Glaucoma Monitoring services, with a further five providing Glaucoma Filtering services. Plans are underway to onboard additional practices, which will strengthen capacity and resilience across the pathway.

Our long-term aim is to increase the number of Higher Certificate–qualified Optometrists within BCU, supported either through HEIW training programmes or through targeted recruitment for practices seeking employed Optometrists to deliver glaucoma filtering services.

WGOS 5 Independent Prescribing (IPOS)
Sixteen practices are approved to deliver WGOS 5 Independent Prescribing services, alongside one domiciliary provider. There is comprehensive coverage of IPOS provision across all clusters, supporting timely access to prescribing within community optometry services.

Teach and Treat
From the 1st April 2026, The Teach and Treat in Holywell Hospital for medical retina and IP moved to WGOS provision. This will enable continuation of the great work training Optometrists within these fields.

The Teach and Treat will be remunerated under WGOS for the patients seen. The move is to ensure a fully operable service and sustainability funding for the future, and is a Pan BCUHB opportunity. This will offer timely review of patients and help with long wait follow up or new referrals eligible for review either from the urgent referrals or routine. At present glaucoma is not part of the WGOS delivery.

Electronic Referral System: OPERAi
Betsi Cadwaladr University Health Board went live with the Electronic Referral System: OPERAi on 30 March 2026. This system replaces all paper-based referral routes for routine and urgent optometry referrals into secondary care. It introduces tracking, audit capability, and improved digital assurance across the whole referral journey. All 78 practices across BCUHB have successfully onboarded.

8. Financial forecasts for service delivery

The following table shows the Health Boards' IHC Optometry financial position at Month 12, representing the year-end closing position for 2025/26, subject to audit.

	Full Year 2025/26 Forecast Position		
	Annual Budget £000	Forecast Expenditure £000	Forecast Variance £000
West IHC	1,509	1,194	(315)
Centre IHC	1,936	1,426	(510)
East IHC	2,348	2,049	(299)
Total	**5,794**	**4,669**	**(1,125)**

The full-year position is an underspend of £1.125m. The 2025/26 annual budget is £5.794m, offset by actual expenditure of £4.669m. The underspend reflects the phased introduction of WGOS 4 services, which commenced mid-year and therefore did not incur a full year of expenditure.

In month positional movements by IHC shown below:

Division/Service	FY Spend Forecast	Forecast Variance	Division/Service	FY Spend Forecast	Forecast Variance	FY Spend Forecast Movement	Forecast Variance Movement
Optometry West	1,193,955	-315,062	Optometry West	1,200,253	-308,764	-6,297	-6,297
Optometry Centre	1,426,105	-510,262	Optometry Centre	1,450,403	-485,964	-24,299	-24,299
Optometry East	2,049,138	-299,335	Optometry East	2,090,646	-208,827	-41,508	-90,508
Total Optometry	**4,669,198**	**-1,124,659**	**Total Optometry**	**4,741,302**	**-1,003,555**	**-72,104**	**-121,104**

Payment breakdown of Cash Ltd payments to Optometrists are summarised below:

Sum of Amount	Payment by Month														
GMS CASH LTD PAYMENTS TO OPTICIANS	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-25	Feb-25	Mar-25	Grand Total	2024/25 Monthly average	2025/26 Monthly average	Variance
WECS Total	253,333	257,908	299,927	272,161	314,822	243,755	307,392	301,795	311,373	244,101	292,526	275,603	3,374,696	237,185	281,225	44,039
Low Vision Total	7,713	6,338	13,695	8,579	10,922	11,151	8,155	17,321	25,042	14,512	17,837	20,730	161,996	10,176	13,500	3,324
IPOS Total	33,525	28,635	31,656	30,556	34,461	28,534	34,355	41,696	43,054	38,923	50,726	50,002	446,122	19,675	37,177	17,302
WGOS 4 (Glaucoma Medical Retina and Hydroproxychlorine)	0	2,162	4,324	1,572	3,845	9,332	20,141	28,245	26,166	23,962	35,705	40,914	196,368	0	16,364	16,364
Cluster Total	12,425	3,217	10,253	12,940	2,490	5,538	8,846	10,236	16,467	10,466	5,295	14,103	112,275	6,231	9,356	3,125
CPD Total	15,636	57,530	5,443	3,240	1,606	1,070	2,170	42,012	38,734	10,619	26,790	23,915	228,766	2,428	19,064	16,636
QualityTotal	2,500	0	0	93,750	0	0	88,750	0	0	80,000	1,250	102,800	369,050	15,208	30,754	15,546
Consumables Total	0	0	0	23,833	0	0	33,638	8,871	8,068	6,968	8,199	7,952	97,529	6,215	8,127	1,912
Grand Total	**325,131**	**355,791**	**365,297**	**446,632**	**368,146**	**299,380**	**503,447**	**450,177**	**468,904**	**429,551**	**438,328**	**536,019**	**4,986,802**	**297,319**	**415,567**	**118,248**

Note: Other payment categories including Sight tests have been coded to Non-Cash Limited (NCL). NCL costs budgets are held direct by WG, BCU don't hold any budgets or any financial risk for these prescribing activities.

Claims are routinely monitored on a monthly and quarterly basis by the Primary Care Contracting Team in liaison with NWSSP and individual contractors where appropriate.

9. Summary of the Local Health Board's communications activity relating to WGOS 1–5

(a) Communication relating to WGOS Pathways

Discussions and presentations in relation to WGOS 1-5 continue to take place at various meetings including GP, Community pharmacy and cluster meetings across North Wales.

Educational events for optometrists have now begun, with a programme of sessions scheduled throughout 2026. These include a series of 'lunch and learn' events delivered

in collaboration with the Primary Care Academy, covering key topics such as Help Me Quit, DATIX, Safeguarding, and Preparing for Quality in Optometry.

The Health Board continues to engage positively with the Regional NWROC group on a quarterly basis through the Optometry Liaison Group.

An Optometry intranet page has been successfully launched, providing a centralised hub for resources and updates Optometry (sharepoint.com)

A new Optometry internet page, designed to support patient signposting and improve public access to information has also recently been launched Opticians - Betsi Cadwaladr University Health Board (nhs.wales)

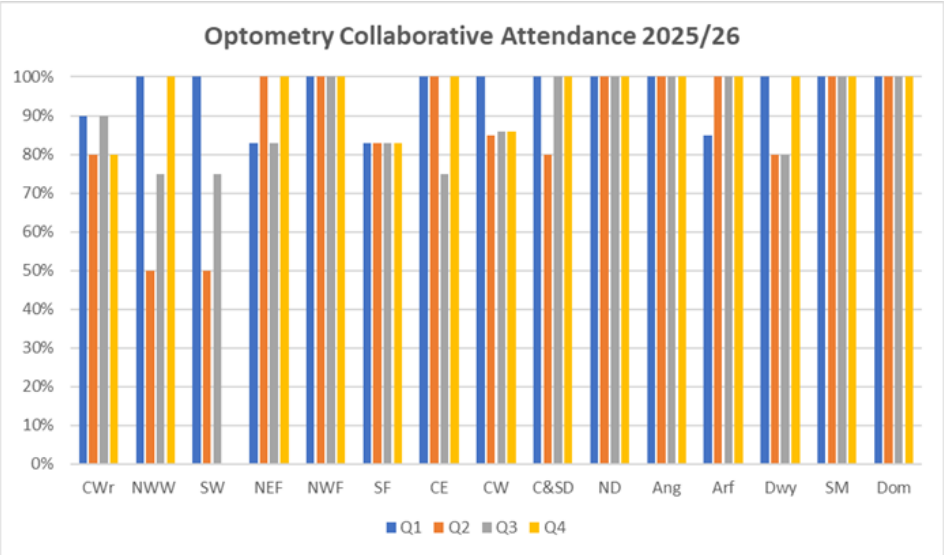
Information for GP, pharmacy, and ED digital screens has also been developed and shared for publication, ensuring alignment and awareness across different care settings.

The Welsh Government WGOS engagement event was successfully delivered for the second consecutive year in March 2026. The session proved to be an effective platform for meaningful engagement with the optometry profession, enabling open discussion and updates on WGOS services. The event featured an expert panel of key speakers and invited guests, and provided valuable insights from Welsh Government, HEIW and NCL.

Attendees also benefited from information on NWROC support and an impactful presentation from the Optometric Advisor on the importance of Optometry Collaboratives in driving community-by-design services. The strong attendance from Optometry colleagues across BCUHB highlighted the sector's continued commitment to collaborative working and service improvement.

(b) Cluster Engagement

Feedback from Health Board's Cluster Teams provides assurance that collaboratives are running well across North Wales. Networking across all 12 Optometry Collaboratives remains strong, and engagement in meetings continues to improve.



County-wide cluster/collaborative development events took place in November 2025 for all North Wales Optometry Collaborative leads and were well attended. Plans for future

events to be held during 2026 are already underway, with suggested topics including falls clinics, RCS Wales, and social prescribing.

Additionally, some Optometrists providing IP support have been attending community pharmacy collaborative meetings to share information and address any issues raised by pharmacists.

Several initiatives are currently being explored or progressed across collaboratives, including:

- Development of an e-booklet featuring Vision Support resources, third-sector support groups, common eye conditions, and safeguarding guidance
- Use of a Padlet to enable easier information sharing among members
- Social prescribing workshops
- Optical Assistant apprenticeship opportunities
- Additional training to expand the range of services offered

10. Conclusion

The Annual Report highlights BCUHB's continued commitment to delivering WGOS services in line with the NHS (Ophthalmic Services) (Wales) 2023 Regulations and the accompanying WGOS clinical manuals. This reflects our ongoing focus on providing high-quality, accessible eye-care across North Wales.

The Health Board's Eye Health Needs Assessment, alongside routine monitoring of WGOS activity, will continue to strengthen service delivery and support future planning.

This work is underpinned by our commitment to collaboration with key stakeholders, including primary care optometry practices, secondary care ophthalmology teams, professional bodies, local partners and Welsh Government colleagues. These strong partnerships help ensure that WGOS services remain clinically effective, sustainable, and equitable for the population we serve.

Our approach aligns closely with ministerial priorities, local Optometry and Professional Collaborative plans, and the wider Ophthalmology improvement agenda. This ensures WGOS delivery remains joined-up, well-coordinated, and firmly embedded within our broader strategy to improve eye care across North Wales.

Appendix 1

The RNIB (2023) Sight Loss Data Tool estimates the prevalence of the number of eyecare conditions across BCUHB. This data has been used to inform the future eye health needs of the population of North Wales:

Age-Related Macular Degeneration (AMD)

Across BCUHB, the RNIB estimate:

- 37,610 people are living with the early stages of AMD
- 2,880 are living with late-stage dry AMD
- 5,900 are living with late-stage wet AMD
- 8,330 combined late-stage AMD
- Between 2022 and 2032 there is estimated to be an increase of 21% in the number of people living with late-stage AMD

Cataract

Across BCUHB, the RNIB estimate:

- 9,300 people are living with cataract

- Between 2022 and 2032 there is estimated to be an increase of 20% in the number of people living with cataract.

Planning, Population Health & Partnerships Committee

BOARD ASSURANCE FRAMEWORK 2026-2027

Dyddiad y Cyfarfod **Date of Meeting**	03 September 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Jody Evans Assistant Head of Risk Management
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Pam Wenger Director of Corporate Governance

Pwrpas yr Adroddiad **Report Purpose**	For Assurance

Crynodeb Gweithredol
Executive Summary

The Board Assurance Framework (BAF) comprises five principal strategic risks aligned to the Health Board's Strategic Intentions and Integrated Medium-Term Plan (IMTP). This report provides an update on the assurance position for the following risks within the Committee's remit:

- **BAF 26_01: Failure to Deliver Improved Population Health and Reduced Inequalities;** 1A Preventative Approaches to Health & Wellbeing, 1B Proactive Strategies for Disease Prevention, Falls & Frailty, 1C Health Inequalities and 1D Health Protection.

- **BAF 26_02: Failure to Deliver Enhanced Coordination of Care for People with Long Term Conditions and Improve Access;** 2A Primary Care, 2B Community Care and 2C Integrated Health & Wellbeing Hubs.

- **BAF 26_04: Failure to Deliver and Create a Modern, People-Centred Healthcare System that is Future Focused;** 4B Strategy & Planning, 4C Clinical Services Planning, Clinical Leadership & Interprofessional Working, 4D Digital, Data & Intelligence, 4I Environment & Estates

The refreshed BAF has been developed to provide a clearer line of sight between strategic objectives, operational delivery, performance management and Board

assurance arrangements. Progress has been made in identifying strategic risks, controls, assurances, assurance gaps and mitigating actions across all priorities within the Committee's remit.

BAF Risks 26_01, 26_02 and the relevant priorities within BAF 26_04 have been validated and published on the Risk Management Portal.

The overall assurance position remains predominantly Limited Assurance, reflecting the maturity of the refreshed framework and the need for further outcome-based and independent assurance evidence. However, some priorities, including Clinical Services Planning, Leadership & Interprofessional Working (4C) and Digital, Data & Intelligence (4D), are currently assessed at Reasonable Assurance

This should not be interpreted as a lack of governance arrangements, oversight or management action. Rather, it reflects the relative maturity of the refreshed framework, ongoing development of controls and assurance mechanisms, and the limited availability of outcome-based evidence demonstrating that mitigating actions are delivering measurable and sustainable improvements.

The Committee is asked to review the current assurance position and determine whether it is satisfied that appropriate controls, assurances and mitigating actions are in place to manage the principal risks within its remit.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome, Evidence and Data**
Executive Directors	June – Aug 2026	Draft BAF risks circulated for review, challenge and validation.
Risk Scrutiny Group	20 July 2026	Draft BAF reviewed and endorsed subject to completion of outstanding Executive Director feedback and amendments.
Transformation and Improvement Team	Ongoing	Collaboration continuing to develop the BAF within the Portal and explore future reporting integration opportunities.

Acronyms / Glossary of Terms	
BAF	Board Assurance Framework
IMTP	Integrated Medium Term Plan
ADP	Annual Delivery Plan
EC	Executive Committee

BOARD ASSURANCE FRAMEWORK 2026-2027

1. Y SEFYLLFA
SITUATION

The Board Assurance Framework has been refreshed to align with the Health Board's Strategic Intentions and Integrated Medium Term Plan and provides a framework through which principal strategic risks are identified, managed and monitored.

The Planning, Population Health and Partnerships Committee has responsibility for oversight and assurance relating to:

- BAF 26_01 Failure to deliver improved population health and reduced inequalities through prevention, population health management, reduction of health inequalities and effective health protection arrangements.
- BAF 26_02 Failure to deliver enhanced coordination of care for people with long-term conditions and improve access to integrated primary and community-based services.
- BAF 26_04 Failure to create a modern, people-centred healthcare system through effective strategy and planning, clinical services planning, digital transformation, data and intelligence development, and sustainable estates infrastructure.

The Committee's role is to seek assurance that these strategic risks are being effectively managed and provide assurance to the Board accordingly.

Whilst governance arrangements, controls and delivery programmes are in place, assurance remains predominantly Limited Assurance across most priorities due to the need for additional evidence demonstrating sustainable improvement, measurable outcomes and long-term reduction in strategic risk exposure. Some priorities demonstrate greater maturity of controls and assurance arrangements and are therefore assessed at Reasonable Assurance.

BAF Risks 26_01 and 26_02 together with the relevant priorities within BAF 26_04 have been validated and uploaded to the BAF Portal.

2 Y CEFNDIR
BACKGROUND

The refreshed Board Assurance Framework has been developed following approval of the Health Board's Strategic Intentions and Integrated Medium Term Plan.

A programme of work has been undertaken with Executive Directors and Risk Lead Owners to identify principal risks, review existing controls, establish sources of assurance and identify gaps requiring further management action. The refreshed

framework is intended to strengthen the link between strategic objectives, operational delivery, performance monitoring and Board assurance.

The framework will continue to mature as further evidence becomes available through performance reporting, audit activity, external review and routine governance processes.

3 MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

The Committee is asked to note:

- The controls, assurances and mitigating actions currently in place to manage risks within its remit.
- That assurance ratings remain predominantly Limited Assurance across the relevant priorities.
- The key gaps in control and assurance relating to population health, prevention, primary and community care transformation, digital maturity, strategic planning and estates delivery.
- Ongoing work to strengthen benefits realisation, outcome measurement and independent assurance.

Cross-Cutting Assurance Themes

Review of the risks within the Committee's remit has identified several recurring themes:

- Workforce capacity, recruitment, retention and sustainability challenges are a consistent theme across many of the priorities within the Committee's remit and continue to impact service resilience and transformation delivery.
- Limited independent validation and outcome-based evidence are available to demonstrate the long-term effectiveness and sustainability of improvement programmes and redesigned service models.
- Variation in access, service delivery, pathway maturity and quality governance arrangements continues to require further standardisation, integration and strengthening of assurance mechanisms.

Whilst governance arrangements and controls are established, further evidence is required to demonstrate measurable improvement in outcomes, long-term sustainability and reduction in strategic risk exposure.

4 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO
KEY RISKS / MATTERS FOR ESCALATION

The Committee should note the following areas of significant concern:

BAF 26_01 – Failure to Deliver Improved Population Health and Reduced Inequalities

The Committee should note:

- Rising prevalence of preventable long-term conditions.
- Persistent health inequalities across communities.
- Variation in vaccination and screening uptake.
- Continued pressure on prevention and early intervention services.
- Limited outcome evidence demonstrating long-term impact of prevention activity.
- Dependency on partnership arrangements to deliver sustainable population health improvement.

BAF 26_02 – Failure to Deliver Enhanced Coordination of Care

The Committee should note:

- Workforce sustainability challenges across primary and community care.
- Increasing demand for community-based services.
- Variability in access to community and primary care pathways.
- Delays associated with Community by Design and Integrated Health & Wellbeing Hub programmes.
- The need for additional evidence demonstrating reduced demand on acute care services through community interventions.

BAF 26_04 – Modern, People-Centred Healthcare System

The Committee should note:

- Strategic planning and transformation programmes remain at varying levels of maturity.
- Clinical Services Planning requires sustained leadership, engagement and organisational capacity.
- Digital transformation programmes remain dependent upon funding prioritisation, workforce capability, organisational readiness and delivery of national and local digital programmes
- Estates programmes continue to face significant capital and infrastructure challenges.
- Additional assurance is required regarding long-term sustainability and benefits realisation.

Overall Assurance Position

The Committee can take assurance that governance arrangements, controls and mitigating actions are in place to manage the principal strategic risks within its remit. However, the majority of priorities remain assessed as Limited Assurance, reflecting the need for further evidence that controls are operating consistently and delivering measurable and sustainable improvements

However, assurance across BAF Risks 26_01 and 26_02, together with the relevant priorities within BAF 26_04, remains predominantly **Limited Assurance**. This reflects:

- The ongoing development and maturity of the refreshed framework.
- Reliance on partnership delivery models.
- The need for stronger outcome-based assurance.
- Limited availability of independent assurance evidence.
- The requirement to demonstrate sustainable improvement and measurable risk reduction over time.

Whilst progress continues to be made, additional evidence is required to demonstrate that controls are operating effectively and that strategic risks are reducing as intended.

5 ARGYMHELLION
RECOMMENDATIONS

a. Gofynnir i'r Pwyllgor

The Committee is asked to:

- **NOTE** the current assurance position for BAF Risks 26_01 and 26_02 and the relevant priorities within BAF 26_04.
- **REVIEW** the proposed assurance ratings and supporting rationale.
- **NOTE** the key control gaps and assurance gaps identified.
- **SUPPORT** continued work to strengthen assurance evidence, benefits realisation and outcome measurement.
- **FOLLOWING DISCUSSION AND SCRUTINY**, determine the level of assurance it is able to provide to the Board regarding the management of the principal strategic risks within its remit.

Appendices:

Appendix 1 – BAF Risks Relevant to Committee

Appendix 2 – Mapped Open Actions from Extant BAF 2024-2025 (Open actions from the previous Board Assurance Framework have been reviewed and mapped to the refreshed framework to ensure continuity of oversight and delivery where appropriate).

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol **Link to Strategic Intentions**	Choose an item. If more than one applies, please list below: Focus on Health and Wellbeing Enhance co ordination of care Improve Access, Outcomes and Experience Create a Modern, People Centred Healthcare System
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	This paper relates directly to the Board Assurance Framework and supports the Health Board's strategic risk management arrangements through the development and implementation of a refreshed BAF aligned to the IMTP.

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 Public Sector Equality Duty: **Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty):** https://www.gov.wales/public-sector-equality-duty-htmlPublic Sector Equality Duty [HTML] | GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report.
Equality Act 2010 - Socio-economic Duty *Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm:	Administrative Report.

economic Duty when making strategic decisions?	If no, please include rationale:	
Have you completed an Integrated Equality Impact Assessment WP8a? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	No
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report
Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒ Administrative report
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant *Have the principles of the Armed Forces Covenant been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative report.
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:	Administrative report.

	If more than one applies, please list below:	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative report.
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative report.
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	Yes (Include further detail below)	
	Positive impact through improved Board oversight, assurance and transparency regarding strategic risk management.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Existing resources have been utilised to undertake the BAF refresh. Efficiencies through integration with Portal reporting arrangements and alignment with ADP reporting processes.	

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Planning, Population Health & Partnerships Committee

CORPORATE GOVERNANCE REPORT

Dyddiad y Cyfarfod Date of Meeting	03 September 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Philippa Peake-Jones, Head of Corporate Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance

Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol Executive Summary
This report presents routine corporate governance matters for the Committee's consideration, including the annual review of the Committee's Terms of Reference, Annual Report and Self-Assessment. These documents support good governance, accountability, continuous improvement and assurance to the Board regarding the effectiveness of the Committee's operation and oversight arrangements.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	**Dyddiad Date**	**Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data**
Not applicable for this report		

Acronymau / Rhestr Termau Acronyms / Glossary of Terms	
N/A	

CORPORATE GOVERNANCE REPORT

1. **Y SEFYLLFA**
SITUATION

1 The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this.

2 It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.

3 **Y CEFNDIR**
BACKGROUND

3.1 The purpose of this report is to provide the Committee with an update on key corporate governance matters.

4 **MATERION PENODOL I'W HYSTYRIED**
SPECIFIC MATTERS FOR CONSIDERATION

4.1 **Summary of Business Considered in Private**

4.1.1 Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

4.1.2 The below items were considered in private at the meeting held on 2 July 2026:

Agenda Item	Subject (including narrative)	Committee Resolution	Rationale for item in Private
PP26.87	Corporate Risk Register (Private)	It was resolved that the Committee: • **REVIEWED AND SCRUTINISED** the corporate risks set out in the report, including consideration of the current risk position, existing controls, and identified gaps. • **ENDORSED** the risks for submission to the Board,	Business Sensitive

Agenda Item	Subject (including narrative)	Committee Resolution	Rationale for item in Private
		noting that one risk remains above the Health Board's risk appetite and therefore represent a continued exposure. • **NOTED** that a programme of risk-specific meetings with Executive Leads is being established to further refine individual risks, to ensure actions are sufficiently targeted, and support delivery of measurable reductions in risk scores within the agreed risk appetite.	
PP26.88	Tywyn Community Hospital - Case for Change	• **NOTED** the process undertaken and the development of the case for change. • **APPROVED** the proposed options being taken forward to the Board for the purposes of formal public consultation, noting that no final decision is being sought at this stage.	Draft Status - Final Version will be Published
PP26.89	Cyber Security Assurance Report	• **NOTED** the content of the report.	Business Sensitive

4.2 **Committee Forward Work Plan**

The Forward Work Plan sets out the Committee's priorities and scheduled business outside of the normal Cycle of Business, helping ensure a structured, timely, and transparent approach to decision-making and oversight. It collates suggested referral items from other Committees and the Board and is attached at **Appendix 1**.

4.3 **Committee Terms of Reference**

The Corporate Governance Team has undertaken a review of the Terms of Reference for the Planning, Population Health and Partnerships Committee. The revised Terms of Reference include amendments to clarify responsibilities, strengthen assurance arrangements and improve consistency with the Health Board's wider governance framework. The revised Terms of Reference are attached at **Appendix 2** for consideration.

4.4 **Committee Annual Report 2025-2026**

The Committee Annual Report 2025-2026 is attached at **Appendix 3**. The report provides a summary of the Committee's activity and key areas of oversight during the year, together with an assessment of how the Committee has fulfilled its responsibilities on behalf of the Board.

4.5 **Committee Self Assessment**

The Committee has completed its annual self-assessment, providing Members with an opportunity to review the effectiveness of the Committee's operation, governance arrangements and ability to provide assurance to the Board. The results and proposed areas for improvement are attached at **Appendix 4** for discussion and noting.

5 **RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO**
KEY RISKS / MATTERS FOR ESCALATION

5.1 There are no matters for escalation.

6 **ARGYMHELLION**
RECOMMENDATIONS

6.1 Gofynnir i'r Pwyllgor:
The Committee is asked to:

- **NOTE** the matters considered in private at the meeting held on 2 July 2026.
- **NOTE** The Committee Forward Workplan.
- **REVIEW and RECOMMEND** the revised Committee Terms of Reference to the Board for approval.
- **APPROVE** the Committee Annual Report 2025-2026.
- **NOTE** the outcome of the Committee Self-Assessment and **ENDORSE** the proposed actions to support continuous improvement in the Committee's effectiveness and governance arrangements.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Intentions**	4.Create a Modern, People Centred Healthcare System
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	BAF24-01 Building an Effective and Accountable Organisation CRR-16 – Leadership/Special Measures

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality** *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o'r Effaith Economaidd-gymdeithasol *A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?* **Socio-Economic Impact Assessment** *Have you undertaken a Socio-Economic Impact Assessment*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality**	**Galluogwyr Ansawdd** **Enablers of Quality** All Apply	**Meysydd Ansawdd** **Domains of Quality** All Apply

Have you undertaken a Quality Impact Assessment Screening?	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	Not Applicable	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) **Environmental /Sustainability Impact (5Rs)**	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: **Armed Forces Covenant Due Regard Duty** Have you considered the Armed Forces Covenant Due Regard Duty?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
	Do/Yes: ☐	Naddo/No: ☒

Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	