Bundle BCU Planning, Population Health and Partnerships Committee 5 March 2026

1 09:15 - PRELIMINARY MATTERS

1.1 09:15 - PP26.23 Welcome and Apologies
Clare Budden, Chair

1.2 09:16 - PP26.24 Declarations of Interest
Clare Budden, Chair

1.3 09:17 - PP26.25 Unconfirmed Minutes of Meeting held on 15.01.26
Clare Budden, Chair
PP26.25 Minutes from PPHP Committee 15.01.26 V0.2 (Public)

1.4 09:20 - PP26.26 Matters Arising & Action Log
Clare Budden, Chair
PP26.26 Summary Action Log PPHP Committee (Updated 26.02.26) Public

2 09:25 - STRATEGIC PRIORITIES

2.1 09:25 - PP26.27 Director of Planning Report
Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning
PP26.27 Director of Planning Report - 2026-03-05 FINAL

2.2 09:40 - PP26.28 Partnerships, Engagement and Communications Delivery Plan: Progress Report
Helen Stevens-Jones, Director of Partnerships, Engagement and Communications
PP26.28 PEC Delivery Plan - Progress Report March 2026

2.3 09:55 - PP26.29 Population Health Delivery Report
Jane Moore, Executive Director of Public Health
PP26.29 Coversheet Population Health Delivery Report Q3 25-26 JM
PP26.29.1 Population Health Delivery Report Q3 25-26 JM

2.4 10:10 - PP26.30 BCUHB Homelessness Reduction Insights Work
Jane Moore, Executive Director of Public Health
PP26.30 Coversheet BCUHB Homelessness Reduction Insights Work JM
PP26.30.1 BCUHB Homelessness Reduction Insights Report

3 10:25 - GOVERNANCE, RISK AND ASSURANCE

3.1 10:25 - PP26.31 Corporate Risk Register Report
Pam Wenger, Director of Corporate Governance
PP26.31 PPHP Committee Corporate Risk Register Report March 2026 Public

3.2 10:30 - PP26.32 Corporate Governance Report
Pam Wenger, Director of Corporate Governance
PP26.32 Corporate Governance Report
PP26.32.1 Workplan for PPHP Committee (Live Version as at 23.02.26)

4 10:35 - CLOSING BUSINESS

4.1 10:35 - PP26.33 Agree Items for Referral to Board / Other Committees
Clare Budden, Chair

4.2 10:36 - PP26.34 Review of Meeting Effectiveness
Clare Budden, Chair

4.3 10:38 - PP26.35 Date of Next Meeting - 07.05.26

4.4 10:40 - PP26.36 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."

4.5 10:40 - BREAK

Betsi Cadwaladr University Health Board (BCUHB)
UNCONFIRMED Minutes of the Planning, Population Health and Partnerships Committee held in Public on 15 January 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
In Attendance	
Tehmeena Ajmal	Chief Operating Officer
Nesta Collingridge	Head of Risk Management *(part meeting)*
Clara Day	Executive Medical Director *(part meeting)*
Jody Evans	Assistant Head of Risk Management *(part meeting)*
Dave Harries	Head of Internal Audit (via Teams)
Kathryn Lang	Assistant Director - Data, Intelligence and Insight *(part meeting)*
Jane Moore	Executive Director of Public Health
Geraint Parry	Assistant Director of Transformation and Improvement *(part meeting)*
Justine Parry	Acting Director of Digital, Data and Technology (via Teams)
Helen Stevens-Jones	Director of Partnerships, Engagement and Communications
Paolo Tardivel	Interim Executive Director of Transformation & Strategic Planning
Pam Wenger	Director of Corporate Governance
Kamala Williams	Head of Health Strategy and Planning *(part meeting)*
Committee Support	
Laura Jones	Acting Corporate Governance Manager
Philippa Peake-Jones	Head of Corporate Governance

OPENING BUSINESS
PP26.01 Welcome and Apologies The Chair of the Committee welcomed everyone to the meeting and apologies were noted for Gareth Williams and Dylan Roberts.
PP26.02 Declarations of Interest No declarations of interest were raised.
PP26.03 Unconfirmed Minutes of Meeting held on 28.10.25 It was agreed that the minutes of the meetings held on 28.10.25 were a true and accurate record.
PP26.04 Matters Arising & Action Log

Unconfirmed

The Committee reviewed the action log and agreed to close the actions that were proposed for closure.

STRATEGIC PRIORITIES

PP26.05 Health Board Strategic Intentions

Members received the report and the Interim Executive Director of Transformation and Strategic Planning highlighted:

- The Strategic Intent for North Wales is one of the core products in the Health Board's wider strategy programme and will underpin the development of the Ten-Year Strategy, the Clinical Services Plan and the Integrated Medium Term Plan.
- The feedback received will help to structure the Integrated Medium Term Plan around the four strategic intent products.
- The draft vision statement and four strategic intent objectives have been developed to outline the journey required by the Health Board.
- The report provides an overview of the engagement that has taken place and the testing and refinement of the draft Strategic Intentions that has been completed as a result of the feedback received to date.
- Feedback has been received from the Executive Committee and any further comments will be incorporated prior to be being presented to the Board in January 2026.

In discussing the item, the Committee:

- Recognised the iterative process that has been completed noting the importance of reflecting on the journey.
- Suggested the need for clarity in relation to the language and wording used, particularly in developing a vision statement that actively shapes and creates the future, encouraging boldness in its approach by using more active wording.
- Referred to the concept of giving people a fair chance suggesting a move beyond fairness, as there are significant levels of health inequality and there is a need to deliver equitable outcomes for all. It was confirmed that the intention was around equity therefore the wording may need to be revised to provide clarity.
- Noted that the vision statement should focus on the people of North Wales as well as referring to staff suggesting the need to be more ambitious.
- Confirmed that this will form part of the overall Ten-Year Strategy and the direction of travel for the Health Board therefore wider Board discussion is required before the documentation is finalised.
- Agreed that the paper to the Board would confirm that feedback from the Executive Committee and the Planning, Population Health and Partnerships Committee has been incorporated.
- Reflected on the feedback provided suggesting clearer and bolder wording and language is used and reference is made to staff within the vision statement.

Action:

- **PP26.05.1** Interim Executive Director of Transformation and Strategic Planning and Head of Health Strategy and Planning to revise the Strategic Intentions based on the feedback received and circulate outside of the meeting for any final comments ahead of the paper being submitted to the Board in January 2026.

Unconfirmed

It was resolved that the Committee:
- **COMMENTED** on the four revised draft Strategic Intentions, which have been updated to reflect stakeholder feedback.
- **SUPPORTED** the submission of the Strategic Intentions, subject to any final amendments suggested by Planning, Population Health and Partnerships Committee to Board for approval in January 2026.

PP26.06 Key Programmes Report

Members received the report and the Assistant Director of Transformation and Improvement highlighted:
- There have been a range of issues encountered across the Key Programmes including National challenges in relation to the Laboratory Information Management System (LIMS) noting that the team continue to support the work being completed.
- Work on the Integrated Health and Well-being Hubs continues to progress, the Chief Operating Officer has been appointed as the Executive Sponsor and discussions are taking place around implementing the necessary infrastructure to provide support.
- The Health Board have now received planning approval for the North Denbighshire Hub at the Royal Alexandra site in Rhyl and the team are mobilising plans for construction to commence once funding approval is received from Welsh Government.
- Issues relating to the Electronic Prescribing and Medicines Administration (ePMA) system have now been addressed and the system is in the process of being fully rolled out across the organisation.
- The Radiology Information System Programme (RISP) went live in September 2025 and is now transitioning to business as usual, with a post-implementation review planned.
- The Llandudno Orthopaedic Hub continues to face challenges with no confirmed opening date and possible completion in the next financial year, work is required to realise the full-year benefits and identify the lessons to be learnt.
- There is a reliance on partners for many projects which presents inherent challenges in relation to projects including the Ablett Mental Health Unit and Digital Maternity System.
- A recent paper has been developed on the Health and Well-being Hub: Bangor which proposes a more affordable, reduced scope, therefore there may be an opportunity to revisit the prioritisation exercise to progress this work.
- The overall position of the Key Programmes has improved since the report was first presented to the Board in May 2025 and this report is due to go back to the Board in January 2026.

In discussing the item, the Committee:
- Raised concerns in relation to the delays encountered with the Mental Health Electronic Health Record programme. It was confirmed that resource delays are limiting progress, and additional work is required to coordinate the implementation.
- Acknowledged the delays in relation to the Llandudno Orthopaedic Hub and queried the implications for waiting lists and staff. It was confirmed that there is a need to ensure the building is completed appropriately to provide a safe clinical space. The

Unconfirmed

activity can then transfer from Abergele Hospital therefore impact on waiting lists is minimum. Staff are aware of the changes and are being supported however the delay does impact the reputation of the organisation.
- Noted that future reports should be provided for assurance and that the Board should be alerted to the concerns raised via the Chair's Assurance Report.

Action:
- **PP26.06.1** Future Key Programmes Reports to the Committee to provide assurance rather than to be noted.

It was resolved that the Committee:
- **NOTED** the content of the report.

PP26.07 Director of Planning Report

Members received the report and the Interim Executive Director of Transformation and Strategic Planning highlighted:
- The report provides an update on the key strategic, planning and transformation activities taking place within the Planning Directorate.
- Progress has been made in developing the strategic direction, advancing the discovery phase of the Ten Year Strategy and preparing for the Clinical Services Plan taking into consideration the Foundation for the Future programme.
- The internal service change programmes for Tywyn and Penley Community Hospitals are progressing. Tywyn Community Hospital was reported to the Board in November 2025 noting that the timeline has been revised based on advice from Llais to implement a formal consultation post the election period. A report on Penley Community Hospital will be presented to the Board in January 2026.
- A Joint Planning, Population Health and Partnerships Committee and Performance, Finance and Information Governance Committee is taking place on 20 January 2026 focused on the Integrated Medium Term Plan with a more comprehensive report being presented to the Board in January 2026.
- Feedback from last year's Integrated Medium Term Plan is being incorporated by developing more focussed priorities and service level plans.
- An assessment has been completed in relation to the performance trajectories and delivery expectations aligned to Special Measures de-escalation and the Planning Framework which will allow informed decisions to be made around what can be achieved.
- Work continues to provide a more unified approach to the Plan taking into account areas such as demand, skill mix and performance to improve triangulation.
- Amendments are being made to the prioritisation and investment approach by adjusting the prioritisation exercise to address cost pressures and assess delivery capability.
- In relation to the financial position, it was noted that if this is not going to be achieved, the Chief Executive as the Accountable Officer will need to provide a letter to Welsh Government by 13 February 2026 to confirm the Health Board's position.
- A written statement has been received from Welsh Government in relation to Special Measures to confirm the Health Board will not be de-escalated from level 5 status at

Unconfirmed

this point in time however questions are being raised in relation to de-escalation of two Challenged Services.
- An additional letter has been received from Welsh Government dated 6 January 2026 noting positive progress, Board cohesion and the need for focussed attention on specific areas.

As part of the discussion, the Committee:
- Expressed disappointment in remaining at level 5 escalation due to the progress made in a number of areas suggesting that de-escalation where evidence supports this could increase confidence in the organisation.
- Referred to the delivery confidence across the priority areas highlighted in the report and queried whether there are plans in place to make improvements where required. It was confirmed that delivery confidence has been reviewed against the milestones and the potential to achieve the targets by the end of quarter four. There have been some improved positions but not consistent delivery against the targets.
- Confirmed that the focus for the Joint Committee meeting needs to be around the future aims, current position and required resources. There is a need to establish a realistic timeframe for progress by identifying short, medium, and long-term steps and identify how resources can be aligned to priorities to provide clarity ahead of the Board meeting in January 2026. There is also a need to consider the Cabinet Secretary's letter to set achievable objectives.

It was resolved that the Committee:
- **COMMENTED** on the content of the report.

PP26.08 Citizen Experience and Engagement Report

Members received the report and the Director of Partnerships, Communications and Engagement highlighted:
- The paper provides a strategic overview of the citizen feedback received and will inform the report that is presented to the Board in January 2026.
- The information focuses on the key themes emerging from patient interactions, surveys, stories, community conversations, digital engagement, political correspondence and the work of Llais.
- The dominant themes being highlighted remain consistent and relate to Urgent and Emergency Care, delays in Planned Care, access to NHS Dentistry, Neurodevelopmental assessments, access to GP appointments and Mental Health services.
- Assurance was provided to the Committee that citizen feedback is being captured systematically and shared continuously to help shape improvements across the Health Board.

As part of the discussion, the Committee:
- Highlighted that the report provides a useful, evolving perspective from the population noting that a limited number of opinions are represented and queried how insights from less vocal groups can be captured moving forward. It was confirmed that focus is based on areas where a high volume of feedback is received however an amendment can be made to address the less vocal communities.

Unconfirmed

- Noted that the paper should focus on areas of improvement whilst also recognising achievements and lasting change however social media often highlights negatives therefore how can the Health Board balance the need to be open and honest about the current challenges and also systematically showcase sustained improvements. It was confirmed that although patients often face lengthy waits in Emergency Departments, their experience of the care and treatment received is generally positive. The team routinely share good practice across all communication channels, pre-election discussions are taking place and a plan is being developed to ensure balanced information is provided. Efforts are ongoing to correct inaccurate stories online.
- Stated that the organisation lack clear insight into the citizens providing feedback and require more balanced input across all communities. There is a need to build trust through community dialogue and gather broader feedback. It was confirmed that work is taking place to enable staff to mature in this space and work is taking place to co-produce a consultation toolkit.

It was resolved that the Committee:

- **NOTED** the key themes from citizen feedback.
- **ASSURED** itself that citizen voice is shaping organisational objectives and decision-making, as well as operational improvements.
- **ENDORSED** the continued strengthening of citizen voice mechanisms, ensuring lived experience is embedded in service planning and transformation.

PP26.09 Community Co-Production Report

Members received the report and the Executive Director of Public Health highlighted:

- The report highlights the beginning of a collaborative journey, working at Public Service Board level involving a wide range of partners.
- The focus will be on improving engagement with vulnerable communities; noting that these communities possess significant strengths and valuable perspectives.
- Funding has been received from the Bevan Commission to support joint working using an asset-based approach, enabling communities and individuals to assemble the building blocks necessary for improved health.
- There will be an emphasis on empowering people to take greater responsibility for their health and to support them in this process.
- Initial work will be conducted with a small number of areas which will then inform broader engagement and transformation in relation to the prevention and inequality agenda across the Health Board in conjunction with regional partners.
- The intention is to develop an approach that recognise and builds upon community strengths, fostering meaningful conversations.

As part of the discussion, the Committee:

- Acknowledged the importance of reflecting on the ‘Community by Design’ work to understand its current messages as it may offer fresh insights and new perspectives that could be integrated into the ongoing work.
- Confirmed that there is a sense of renewed willingness and enthusiasm among partners, which is considered essential to drive this work forward and identify key areas for further development.

Unconfirmed

- Emphasised the benefits of co-production noting the need to focus on effective engagement with the population to broaden participation and gain a positive outcomes perspective.
- Noted the need for clarity regarding the purpose of the process, identifying where people can proactively contribute to improvements suggesting a need to reach out to all communities including parents and children.
- Referred to a possible change in environment following the elections in May 2026 noting the need to collaborate with partners to ensure all communities are represented.
- Agreed that this work aligns with the Citizen Experience and Engagement Report particularly in relation to engagement, service change and co-production. Communication efforts must focus on what matters to people locally, ensuring their views and perspectives are valued and considered and the benefits are recognised by communities following their contribution.
- Recognised that support needs to be provided to people within communities to enable and enhance quality of life and health and wellbeing outcomes.

It was resolved that the Committee:

- **ACKNOWLEDGED** that this is very much a long-game and that we must invest time and effort into building relationships and re-establishing trust with local stakeholders which will be of mutual benefit to the Health Board and our communities in the longer-term.
- **SUPPORTED** the commitment to work across the Health Board Strategy, Transformation, Partnerships and Public Health Directorates to embed these ways of working into our programmes.

PP26.10 Population Health Delivery Report

Members received the report and the Executive Director of Public Health highlighted:

- The report provides data for quarter two noting the challenges around access to current data and confirming a change in indicators initiated by Welsh Government.
- Work continues on the Health Outcomes Framework which will provide an overview of the delivery of core Public Health programmes across the Health Board.
- Performance remains strong in areas including vaccinations for over 65s and childhood immunisations which is currently at 94% against the National target of 95%.
- Efforts to maintain smoking cessation rates are ongoing and Welsh Government have recently released guidance on obesity and weight management, noting that weight is influenced by more than just behaviours.
- Public Health Wales has been commissioned to review current services to identify where improvement can be made.

As part of the discussion, the Committee:

- Recognised areas where performance is not meeting expectations and suggested going forward these areas are highlighted and the report identifies what action is required to address these challenges within local communities. It was confirmed that work is being conducted around place-based weight management initiatives and suggested deep dives could be completed in specific areas to provide more detailed information.

Unconfirmed

- Referred to the input and output data in relation to Public Health screening and how this information can be balanced in terms of the elements provided and the improvements required. It was confirmed that the alignment between uptake and provision of screening is being discussed in further detail with the Executive Medical Director and the Chief Operating Officer to identify the improvements required.
- Acknowledged the statistics relating to teenagers which highlight increased pressures faced by this generation. It was confirmed that there is a need to gain an understanding of evolving trends amongst young people and identify the support required in the short, medium and long term.

Action:

- **PP26.10.1** Conduct deep dive exercises into specific areas to identify and address challenges where performance is not meeting expectations and report the outcomes via the Committee.

It was resolved that the Committee:

- **NOTED** the content of the report.
- **AGREED** the proposed items for the Q3 report.

GOVERNANCE, RISK AND ASSURANCE

PP26.11 Referral to Treatment Data Governance and Accuracy Review

Members received the report and the Assistant Director of Data, Intelligence and Insight highlighted:

- In November 2025, an issue was identified in relation to Referral to Treatment (RTT) data and as a result, National reporting of Health Board waiting lists was suspended whilst an investigation was conducted.
- Referral to Treatment data for all patient pathways in medical and surgical specialties is available daily to operational teams and reported on a monthly basis, at month end to Welsh Government in line with National standards.
- All patients are tracked daily and weekly therefore no patients were "lost" or missed as a result of this issue.
- The issue arose following the September month end report where it was identified that a generic code for cohorts of patients seen by outsourcing providers was found to be omitted in error from the monthly report, affecting around 45,000 patient records.
- The error was rectified ahead of the October month end report, which led to apparent fluctuations in the waiting list figures.
- The issue was escalated for external review, and the team responded to questions regarding technical issues, processes and data sign-off.
- A technical data review confirmed the 'ConsG' code was the sole issue with no additional issues identified. As a result, advice and guidance were issued and additional checks were implemented to prevent recurrence.
- Additional internal and external checks were also conducted which verified this was an isolated error that has now been rectified.
- A Standard Operating Procedure has been developed to provide detailed information and demand trends are being monitored and discussed with Executive colleagues to agree and sign off data before being submitted to Digital Health and Care Wales (DHCW) for onward reporting.

Unconfirmed

- Work is ongoing to improve patient identification methods, including implementing dual identification processes and additional validation prompts to strengthen the process.
- Given the complexity of Referral to Treatment data, a review of reporting has been recommended to take place in the new financial year to reflect service changes.
- Reconciliation and sign-off processes have been enhanced, with error tracking built into data quality dashboards and direct engagement has been taking place with users.
- Data audits are ongoing and lessons will be shared across the organisation and externally with the Heads of Information National Group to promote shared learning across Health Boards.

As part of the discussion, the Committee:

- Acknowledge the team's prompt and effective response to address and rectify the issue.
- Highlighted that referring to the actual figures alongside the percentages within the report would have been beneficial to identify the number of patients affected. It was confirmed that the team process the full waiting lists however only publish data for the Welsh element therefore to avoid discrepancy with the press reports the figures were not identified.
- Noted that the key issue highlighted is that no patients were harmed as a consequence of this issue, the matter was strictly related to reporting. The review of reporting mechanisms completed has been beneficial and the lessons learned will inform future practice.
- Agreed that this would be reported in the Chair's Assurance Report to the Board to provide assurance that this matter has been reviewed and the Committee were assured that the matter has been fully and transparently investigated.
- Referred to the Board Assurance Framework noting that monthly data governance reviews are in place and this is now documented.
- Queried how assurance will be provided to the public. It was confirmed that the report clearly states the issue encountered, the steps taken to resolve the matter and the measures in place for the future. There is a need to emphasise that no patients were harmed as result of this issue, work is taking place to disseminate key messages and the external review report is due to be published next week, aiming to provide the Board with assurance regarding its findings.
- Agreed that the recommendations should highlight that the Committee provide assurance to the Board that this issue has been addressed.

It was resolved that the Committee:

- **NOTED** the reporting error and the immediate corrective action taken.
- **PROVIDE ASSURANCE** to the Board that the issue in relation to the data accuracy had been reviewed.

PP26.12 Board Assurance Framework

Members received the report and the Head of Risk Management highlighted:

- The Board Assurance Framework was last reviewed in April 2025 and all risks, excluding those aligned to the Executive Medical Director have been considered by Risk Scrutiny Group.

Unconfirmed

- The Digital risk includes delayed actions, these will be reviewed and updated to ensure alignment.
- The Planning risk has been reviewed by Risk Scrutiny Group, updates have been completed and assurance has been provided.
- The Citizen Engagement risk has also been reviewed by the Risk Scrutiny Group, the score has been challenged however it was agreed that the risk should remain open due to the upcoming Elections noting assurance and progress in this area.
- The Population Health risk has two delayed actions as well as external risks therefore this is being reviewed by the Executive Committee.
- The Improvement and Innovation risk is progressing well however further assurance is required going forward.
- There is a need to realign the Board Assurance Framework with the Integrated Medium Term Plan going forward and identify smart objectives.

As part of the discussion, the Committee:

- Noted that ownership of certain areas could be stronger, particularly in relation to those risks with longer timescales. It was confirmed that this has been identified as an area that needs to be strengthened in terms of ease of use for Executives to enable increased ownership of the process.
- Referred to the introduction of a dynamic quality concerns register which is reported to the Executive Committee and covers clinical and operational issues. It was confirmed that discussions are taking place around providing deep dives in specific areas to address service issues.
- Highlighted that discussions are ongoing in relation to resetting the Board Assurance Framework and aligning to the Integrated Medium Term Plan noting the need to integrate with service plans to improve management and mitigate risks.

It was resolved that the Committee:

- **RECEIVED** the report and assurance rating of the Board Assurance Framework noting the progress in the areas that fell within the responsibility of the committee

PP26.13 Corporate Governance Report

Members received the report from the Director of Corporate Governance and it was resolved that the Committee:

- **NOTED** the summary of business considered in private session to be reported in public.
- **NOTED** the forward workplan.

CLOSING BUSINESS

PP26.14 Agree Items for Referral to Board / Other Committees

It was agreed that the Chair's Assurance Report would alert the Board on the Community Co-Production and Key Programmes Report items. The report would also provide assurance that the Referral to Treatment Data and Governance and Accuracy report was reviewed and the Committee were assured that the matter had been fully and transparently investigated and resolved.

Unconfirmed

PP26.15 Review of Meeting Effectiveness

It was confirmed that following a previous action it has been agreed to nominate an Independent Member and Executive Director at the start of each meeting to provide feedback on the tone and approach to values during the meeting. The Independent Member noted the openness and transparency of officers and the Executive Director noted the positive tone and open discussions conducted with Board members.

PP26.16 Date of Next Meeting

Thursday 5 March 2026, 9.15am

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 26.02.26

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	**PP26.10.1**	15.01.26	**Population Health Delivery Report** Conduct deep dive exercises into specific areas to identify and address challenges where performance is not meeting expectations and report the outcomes via the Committee.	Jane Moore	May 26	**Remain Open** **26.02.26** The Q3 Population Health Delivery Report being presented to the March 26 meeting will highlight areas of underperformance and associated actions to get back on track. It has been proposed that the team will bring a new suggested format to the May 26 meeting as part of the Q4 Delivery Report for approval, this will then be established from the Q1 Population Health Delivery Report 2026/27.
2	**PP25.97.2**	28.10.25	**Matters Arising and Action Log** Director of Corporate Governance to escalate concerns in relation to the Third Sector engagement and commissioning to the Chief Executive and refer this to the Executive Committee for further discussion.	Russell Caldicott	May 26	**Remain Open** **24.02.26** This area of work has been discussed with the Chief Executive and is being taken forward by the Interim Executive Director of Transformation and Strategic Planning, Executive Director of Public Health and

						Director of Partnerships, Engagement a Communications. A meeting took place on 12.02.26 with the Reaffirming Our Commitment to Third Sector Steering Group where work is taking place to co-develop a framework on strategic partnership.
ACTIONS PROPOSED FOR CLOSURE						
1	**PP26.05.1**	15.01.26	**Health Board Strategic Intentions** Interim Executive Director of Transformation and Strategic Planning and Head of Health Strategy and Planning to revise the Strategic Intentions based on the feedback received and circulate outside of the meeting for any final comments ahead of the paper being submitted to the Board in January 2026.	Paolo Tardivel	March 26	**Action Proposed for Closure** **23.02.26** This was completed and the paper was submitted to the Board meeting in January 2026.
2	**PP26.06.1**	15.01.26	**Key Programmes Report** Future Key Programmes Reports to the Committee to provide assurance rather than to be noted.	Paolo Tardivel	March 26	**Action Proposed for Closure** **23.02.26** The comments have been noted and future reports will provide this assurance.
3	**PP25.105.1**	28.10.25	**Corporate Governance Report** Director of Corporate Governance to follow up the actions noted as part of the PPHP Committee Development Session held in September 2025.	Pam Wenger	Jan 26	**Action Proposed for Closure** **19.01.26** A meeting took place with the Director of Corporate Governance and the relevant Executive Directors to discuss the actions and agree where further action and discussion was required.

4	**PP25/72.1**	04.09.25	**Update on the Digital, Data and Technology Programmes and the Digital and Data Roadmap** Director of Corporate Governance to highlight the issues raised around risks, governance arrangements and financial impact to the Executive Strategic Planning Group.	Justine Parry Pam Wenger	Jan 26	**Action Proposed for Closure** **03.02.26** Governance arrangements for the whole of DDaT has been reviewed and agreed with the Director of Corporate Governance. The list of all digital projects and programmes is regularly presented to the Executive Committee with support and agreement to re-prioritise depending on safe risk-based approach, with the following governance routes now in place: Major digital projects and programmes (national and local) will continue to be reported through to the Strategic Planning and Service Change Group, onwards to Executive Committee and then through to Committees / Board. Information Governance, Patient Records and Cyber will continue to be reported through to the Executive Committee and then through to Committees / Board. Quarterly DDaT wide reports (which will include all national and local projects and programmes) will be reported

						through to Executive Committee and then through to PPHP (report will focus on other areas of performance / assurance and will make reference to other routes of reporting rather than duplicating reporting mechanisms). This will commence in May 2026/27. **16.10.25** Director of Corporate Governance and Interim Executive Director of Transformation & Strategic Planning to discuss how to take this forward.
5	**PP25/82.1**	04.09.25	**Discussion on Primary Care** Discussion to take place outside of the Committee in relation to the assurance required to be provided by the Committee regarding the development of Primary Care.	Pam Wenger Tehmeena Ajmal Paolo Tardival	Jan 26	**Action Proposed for Closure** **19.01.26** Discussions have taken place with the Committee Chair and the relevant Executive Directors and a further Development Session will take place focused on Primary Care during March 2026. **16.10.25** Director of Corporate Governance, Chief Operating Officer and Interim Executive Director of Transformation & Strategic Planning to discuss this in further detail and agree how to take this forward.
6	**PP24/11.3**	23.04.24	**Partnerships, Engagement and**	Russell	~~October~~	**Action Proposed for Closure**

			Communications Update The Committee agreed that a strategic approach to working with the Third Sector should be discussed further with the Executive Team and that this item would come back to the Committee once further work has been completed with proposals on next steps and future strategy to capture themes.	Caldicott ~~Stephen Powell~~ ~~Helen Stevens-Jones~~	~~2024~~ ~~Dec 2024~~ Revised timescale Jan 26	**24.02.26** A paper on Third Sector Commissioning has been included on the private agenda for the March 2026 meeting. **16.10.25** Due to unforeseen circumstances and the retirement of the Director of Performance and Commissioning this work has not progressed. This will be picked up as part of the changes to the Director Portfolios. **28.08.25** The Director of Corporate Governance has escalated this to the Chief Executive, to note the paper on the Annual Delivery Plan Q1 report on the agenda for the September meeting refers to the capacity issues. **23.06.25** It was agreed at agenda setting to put this forward for the next meeting in September 25. **15.04.25** Steve Powell to provide an update on the current position in relation to Third Sector commissioning arrangements. **18.02.25** It was agreed to merge this action with action PP24/49.7

						05.02.25 Further work is required therefore the timescale has been revised to reflect this. **02.12.24** Further work is required; an update will be presented to the Executive Team and will come back to the Committee in the next six months. **04.10.24** Work is ongoing and a paper to the Committee will follow. **20.08.24** HSJ is progressing this action and it will be included as an item for the October meeting. Update in Meeting: have been joined by new colleagues and seen a shift in portfolios – opportunity to bring everyone round the table is opportune.
Closed Actions (as agreed at meeting on 15.01.26)						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	**PP25.97.1**	28.10.25	**Matters Arising and Action Log** Committee Chair to discuss concerns with the Health Board Chair around managing digital internally and externally during the current absence of the Chief Digital and Information Officer.	Clare Budden	Jan 26	**29.12.25** Justine Parry has been appointed as Acting Director of Digital, Data and Technology.
2	**PP25.98.1**	28.10.25	**Key Programmes Report**	Pam Wenger	Jan 26	**29.12.25** The Board received an

			Director of Corporate Governance to circulate the briefing that was shared with the Audit Committee on the Llandudno Orthopaedic Hub with members and also agree outside of the meeting whether a separate session with Board members would be useful to discuss this in further detail.			update on the Llandudno Orthopaedic Hub at the Board Development Session held on 26.11.25. The presentation from the session along with the briefing shared with the Audit Committee at the meeting held on 21.10.25 have been circulated to members outside of the meeting for information. No further action is required.
3	**PP25.99.1**	28.10.25	**Director of Planning Report** Interim Executive Director of Transformation and Strategic Planning to share the information relating to the Planning Maturity Matrix with Committee members ahead of the final report being presented to the Board in November 2025.	Paolo Tardivel	Jan 26	**31.12.25** The Planning Maturity Matrix Self-Assessment was approved by the Board in November 2025.
4	**PP25.101.1**	28.10.25	**Director of Public Health Annual Report** Committee members to provide any additional feedback on the presentation to the Executive Director of Public Health ahead of the report being presented to the Board in November 2025.	Jane Moore	Jan 26	**31.12.25** The Director of Public Health Annual Report was presented to the Board in November 2025.
5	**PP25.102.1**	28.10.25	**Substance Misuse in North Wales Briefing** Outcome of the discussion at the recent Committee Development Session to be reported back to the Committee.	Paolo Tardivel Pam Wenger	Jan 26	**31.12.25** The outcome of the Committee Development Session held in September 2025 to be reported as an appendix to the Director of Planning Report at the January meeting.
6	**PP25.102.2**	28.10.25	**Substance Misuse in North Wales**	Clare Budden	Jan 26	**29.12.25** Chair of PPHP and

			Briefing Chair of the Committee to discuss with the Chair of the Stakeholder Reference Group the areas of work that are being covered to ensure clarity of role for both the Committee and the Group.			Chair of SRG have met to discuss how joint working can be developed and how to ensure that there is no duplication of work between the two Committees. Draft agendas will be shared and any areas for joint work agreed; alongside the best approach to achieving engagement and stakeholder input.
7	**PP25.107.1**	28.10.25	**Review of Meeting Effectiveness** Committee to nominate an Independent Member or Executive Director at the start of each meeting to provide feedback on the tone and approach to values during the meeting.	Pam Wenger	Jan 26	**06.01.26** A schedule highlighting an Independent Member and Executive Director to provide feedback at each meeting has been developed for use.
8	**PP25/72.2**	04.09.25	**Update on the Digital, Data and Technology Programmes and the Digital and Data Roadmap** Director of Corporate Governance and DDaT Team to agree how to provide regular updates to the Committee on National projects from the Digital Health Care Wales (DHCW) Board as well as regular updates from a local perspective.	Pam Wenger DDaT Team	Jan 26	**09.12.25** The DDaT team have agreed with the Director of Corporate Governance that quarterly reports on all Digital Projects and Programmes (national and local), will be presented to Executive Committee and then reported through the appropriate Committees. This will commence from March 2026 onwards. **16.10.25** Director of Corporate Governance to discuss with the

						DDaT Team to agree how to take this forward.
9	**PP25/72.3**	04.09.25	**Update on the Digital, Data and Technology Programmes and the Digital and Data Roadmap** Chair of the Committee and the Chair of the Health Board to discuss how to address some of the digital issues raised from a Board level perspective.	Clare Budden	Nov 25	**29.12.25** Justine Parry has been appointed as Acting Director of Digital, Data and Technology. **16.10.25** Chair of the Committee and Chair of the Health Board to meet and discuss before the end of November 2025.

Planning, Population Health & Partnerships Committee

DIRECTOR OF PLANNING REPORT

Date of Meeting	05 March 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 Noting

Executive Summary
This report provides the Planning, Population Health and Prevention (PPHP) Committee with an update on key strategic, planning, and transformation activities across the Health Board. Whilst challenges persist across each of the Challenged Services a number of improvements are evident. The Challenged Services Oversight Group continues to monitor progress across all services in more detail with highlight reporting through to the Strategic Planning and Service Change Group and onwards to QSE. IMTP development for 2026–29 is entering the final stages of development. Members will today hear an update on the work and receive a draft of the Plan for comment. The major change programmes continue to be overseen by the respective Programme Boards and reporting into the Executive Committee, and the schedule of deep dives at the Executive team have now been agreed for 2026/27. Further work has continued around developing the Organisational Approach to Change, a cross-cutting product from the Foundations for the Future Programme.

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

DIRECTOR OF PLANNING REPORT

1. SITUATION

1.1. The purpose of this report is to provide Committee(s) with an update on a range of strategy and planning matters. This is a regular report to PPHP with any key updates provided directly to the Board, it may also be used in other Committees when required.

2. BACKGROUND

2.1. The first Director of Planning Report to PPHP in July 2025 went into more detail around the background to each area to ensure the reader was orientated around the context. This and subsequent reports are not intending on covering this detail and will therefore be shorter in length.

3. SPECIFIC MATTERS FOR CONSIDERATION

3.1. STRATEGY

3.2. The three principal areas of focus for 2025/26 are:

- **Strategic Intent** – Development of a Strategic Intent for Health and Wellbeing in North Wales, co-created with partners.
- **New 10-Year Strategy** – Collation and synthesis of evidence and insights to inform the Diagnosis and Discovery phases of the new BCUHB 10-year strategy.
- **Clinical Services Plan (CSP) Phase 2** – Building on the 2024/25 work to establish a CSP methodology for the Health Board and drawing on learning from other Health Boards and NHS organisations that have recently developed or are developing CSPs.

3.2.1 Four Strategic Intent statements, co-created with partners, were approved by the Health Board in January. These statements now form the strategic framework for the IMTP, replacing the previous five strategic objectives, and will directly inform development of both the new 10-year strategy and the CSP.

3.2.2 Work to support the diagnosis phase of the Strategy and CSP is underway. An output report from the Community by Design (CbD) – Delivering Integrated Services event held with Health Board senior leaders on the 16th December has been completed. Further strategy development events are planned for

early in 2026/27 focussing on the 'Future Hospital' and formally commence clinical engagement on the CSP.

3.2.3 Other matters of note:

3.2.4 The Health Board will produce a well-being statement, in line with section 8a of the Well-being of Future Generations (Wales) Act, setting out how its well-being objectives were established, how the five ways of working have been applied, and how these objectives maximise the organisation's contribution to Wales' seven long-term well-being goals. The 2025/26 Health Board Annual Report will outline progress against these objectives, including delivery of the well-being statement, actions taken to embed the sustainable development principles, and activity undertaken to improve well-being. As a public body listed under section 6(1) of the Act, the Health Board must also comply with the Social Partnership Duty (effective from the 1st of April 2024) and prepare an Annual Social Partnership Report under section 18, agreed with recognised trade unions and submitted to the Social Partnership Council.

3.2.5 Conwy County Borough Council are currently consulting on their replacement Local Development Plan (RLDP), which sets out how future development will be managed in a planned and sustainable way, ensuring growth meets local needs while protecting environmental and community assets. The RLDP provides the policy framework against which planning applications are assessed. Although not a statutory consultee the Health Board is a key partner and will submit a response to the consultation.

3.2.6 The Health Board has contributed, as both a commissioner and provider of services, to the development of the Hywel Dda UHB (HDdUHB) CSP. At an extraordinary Board meeting on the 18th and 19th of February HDdUHB agreed the next steps for its CSP following extensive public consultation and independent analysis of feedback from over 4,000 respondents. The Board approved future service models for eight of the nine fragile clinical services—critical care, dermatology, emergency general surgery, endoscopy, ophthalmology, orthopaedics, radiology and urology—aimed at improving sustainability, quality, and timely access to care, while recognising that some changes may require phased implementation and business case approval. For stroke services, the Board endorsed taking forward a newly combined option for further assessment and engagement before final decisions are

made. BCUHB will continue to be actively involved in the further development and implementation of the CSP.

3.3. CHALLENGED SERVICES

3.3.1. Whilst challenges persist across each of the Challenged Services a number of improvements are evident. In particular a number of specialties have made substantial reductions in waiting times, which in turn reduces the risk of harm whilst patients are waiting.

3.3.2. Both Dermatology and Plastics undertook clinics at the new Connah's Quay Centre during February which marks an important point for these services. For Plastics in particular the opening of the unit is a key criteria for potential de-escalation.

3.3.3. Within Urology a full tender programme for a commissioned Vasectomy service has been agreed with procurement services, and a tender will be issued by Mid-March. There is also work progressing with the Wirral University Hospital Trust to transition prostatectomy services back closer to North Wales.

3.3.4. Within Oncology there is a much stable workforce position and the potential for this to be further strengthened, with specialist trainees indicating a desire to remain in North Wales post completion of training. All of this is leading to improved performance against chemotherapy treatment targes with over 90% of routine patients being seen within 21 days and 81% of urgent patients within 14 days.

3.3.5. The Challenged Services Oversight Group continues to monitor progress across all services in more detail with highlight reporting through to the Strategic Planning and Service Change Group and onwards to QSE.

3.4. INTERNAL SERVICE CHANGE

3.4.1. Inpatient services at Tywyn and Penley Community Hospitals continue to be the main internal service change areas of focus. Having completed two sets of 'balanced room' engagement events for both service changes in order to co-design and appraise options, there has been a lot of work undertaken on consideration of the best way forward to develop options further.

3.4.2. A paper on Tywyn went to Board in November outlining the options developed and how they had been scored and the resultant Llais representation on the process so far. Given that the option for reinstating inpatient beds hadn't scored sufficiently highly to be short listed, Llais advised that the change would constitute substantial service change and therefore require formal public consultation under the Welsh Government guidance. Given the pre-election period, the consultation could not start until after the May 2026 elections, but that preparatory work, further engagement, impact assessments and the development of consultation materials could be undertaken in the interim.

3.4.3. A paper on Penley is due to be presented to Board in January. This will cover the options developed to date, the latest representation from Llais and associated timelines.

3.5. IMTP DEVELOPMENT – 2026-29

3.5.1. The development of the Integrated Medium Term Plan (IMTP) for 2026–2029 is now entering its final stages. Work continues to bring together service-level plans in line with the NHS Wales Planning Framework, Technical Guidance, NHS Performance Framework, and key expectations arising from Special Measures, MAG recommendations, and the Cabinet Secretary's *Improving Health Together* letter issued in July 2025.

3.5.2. A significant challenge remains in balancing the extensive number of national and local expectations with the need to produce an IMTP focused on a manageable set of organisational priorities. Initial analysis of requirements across the NHS Performance Framework, Technical Planning Guidance, Enabling Actions, Delivery Expectations, Special Measures criteria, MAG recommendations, and the Cabinet Secretary's expectations has identified 366 individual requirements.

3.5.3. Corporate, clinical and operational teams continue to refine service-level plans, which provide the foundation for the IMTP. Working with Executive Leads, critical priorities have been identified to support a clear approach to prioritisation and de-prioritisation, informed by demand and capacity modelling. This approach will ensure each service has a single, coherent plan that aligns directly with the IMTP, which itself will focus only on the highest priority programmes requiring Board oversight.

3.5.4. The NHS Wales Planning Guidance and Financial Allocation Letter, received shortly before Christmas, confirmed the Ministerial delivery expectations and the mandatory "adopt or justify" enabling actions. A comparison of the 2026/27 requirements, previously shared with Board Members, highlighted the significant level of change. The final NHS Performance Framework was received in early February; however, the supporting technical guidance confirming detailed measures is still awaited. The financial settlement remains challenging. While the national pay award is being covered centrally, the allocation is considered a *zero-investment budget*, which is insufficient to meet inflationary pressures. This creates a requirement for difficult choices to achieve statutory financial balance while continuing to meet performance expectations.

3.5.5. The joint PPHP and PFIG session held on 20 January was an important milestone in shaping the IMTP. The session considered current performance against ministerial requirements, what is needed to close identified gaps, the level of challenge in doing so, how resources might be shifted to close the gaps, and the implications and trade-offs compared to local priorities and financial balance requirements.

3.5.6. Work is near completion on modelling work around demand, workforce, skill mix, productivity, activity, performance and. This is being developed using the likely 2025/26 outturn, updated intelligence on 2026/27 demand, assessments of core capacity at current efficiency levels, and planned improvements from operational and transformation programmes. This represents a considerable improvement on previous years, where triangulation of activity, performance, workforce and finance typically occurred at the end of the planning cycle.

3.5.7. The work to date does not currently provide line of sight to being able to submit a financially balanced IMTP for 2026/27. As a result, the Chief Executive's Accountable Officer letter has been submitted to the Director General for Health and Social Care and Early Years, confirming an anticipated deficit position of £43m.

3.5.8. Consistent with the collaborative approach to planning, regular updates on IMTP progress and key milestones have been presented throughout January and early February to PPHP, PFIG, SPSCG, the Executive Committee, and operational and partnership forums including OLT, HPF and SRG. This reflects learning from Board Development and PPHP sessions during 2025

and has supported earlier engagement and stronger corporate ownership of the plan.

3.5.9. Despite the good progress made, there is still a fair amount to do to knit together all critical components into a single, coherent numerate plan. The timeline for completing the final stages of integration and governance remains tight. The draft final IMTP will be considered at PFIG (private session) on 17 March, ahead of submission to the Board for approval on 26 March, and onward submission to Welsh Government by the end of March.

3.6. ANNUAL DELIVERY PLAN REPORTING 2025/26

3.6.1. Due to the timing of Board meetings in relation to the end of quarter reporting schedule, the quarter 2 Annual Delivery Plan (ADP) report was presented to PFIG in December. This represented a new reporting format, focused on progress of delivery against the priority areas (e.g. Planned Care, Challenged Services, Primary and Community Care etc) and the outcomes they are trying to achieve by the end of the financial year. Further feedback has been collected and will be incorporated into quarter 3 reporting.

3.6.2. The full report can be found in the PFIG papers, but to provide a high-level picture of the delivery confidence across the priority area:

- High Delivery Confidence: Effective Governance (1A), Foundations for the Future (1B), Legislative Compliance (1C), Quality Management System (1D), Culture Development (3A), Leadership Development (3B), Welsh Language (3D), Prevention and Early Intervention (4A), Adult Mental Health and Learning Disability (4F), CAMHS (4G), Neurodevelopment (4F), Plastics (4J), Oncology (4J), Womens (4K), Childrens and Young People (4L), University Partnerships (5A), Academic Careers (5C), Learning Organisation (5E).
- Medium Delivery Confidence: Strategy & CSP (2A), Planning & Commissioning (2B), Estates & Facilities (2C), Digital & Data (2D), Value & Sustainability (2E), Workforce Planning (2F), Citizen Engagement (3C), Primary Care (4B), Dementia (4I), Vascular (4J), Ophthalmology (4J), Dermatology (4J), Trauma & Orthopaedics (4J), Pharmaceutical Services (4M), Palliative – End of Life & Bereavement Care (4N), Dental (4O), Diabetes (4P), Research and Innovation (5B), Intelligence-Led (5D).

- Low Delivery Confidence: Community Care (4C), Planned Care / Cancer / Diagnostics (4D), Urgent & Emergency Care (4E), Urology (4J), Orthodontics (4J)

3.6.3. Similar to quarter 2 the timing of the quarter 3 reporting will mean it will be presented to PFIG in February.

3.7. SPECIAL MEASURES

3.7.1. A written statement was published by Welsh Government on 16th December containing confirmation of the escalation statuses of all Health Boards following the recent Tripartite meeting. The only changes were for Aneurin Bevan (escalated from Level 3 to 4 on finance/strategy/planning and UEC performance) and Hywel Dda (de-escalated from Level 3 to 1 for Leadership and Governance).

3.7.2. Disappointingly, despite providing lots of evidence and receiving encouraging feedback in a number of areas including Quality, Governance, Planning and two of the Challenged Services (Oncology and Plastics), Betsi Cadwaladr received no de-escalation from Level 5 (Special Measures). A letter was received on 6th January providing further feedback on this, which calls out positive progress in Quality, Governance and cohesion and integration of the Board, citing continued issues in operational delivery meaning further evidence of organisation wide embedding of improvements is required. Specific issues are referenced relating to: Planned Care, UEC, operational structure, Cancer, confidence in achieving financial balance, Clinical Services Plan.

3.7.3. Special Measures de-escalation criteria will be incorporated into the IMTP priority actions but made more identifiable than last year. There will also be more discussion in relation to performance trajectories and the delta between Special Measures de-escalation criteria and the NHS Wales Planning Guidance targets.

3.7.4. A fuller report on progress against the Special Measures de-escalation criteria is being planned for March Board.

3.8. MAJOR CHANGE PROGRAMMES

3.8.1. The major change programmes continue to be overseen by the respective Programme Boards and reporting into the Executive Committee, and the schedule of deep dives at the Executive team have now been agreed for 2026/27.

3.8.2. Following Board approval to proceed in January the Foundations for the Future Programme has been mobilising key activities in relation to the structures workstream. There was a co-ordinated set of cascade sessions led by Executive Directors with their teams to provide an additional informal engagement opportunity prior to formal consultation. The Executive team is currently reviewing the feedback from these discussions and assessing the best way to incorporate into the process. The Programme Board also a held a deep dive on the Strategy workstream during January where assurance was provided across a number of the products including confirmation that the work on developing the Strategic Intent is now complete.

3.8.3. An internal audit review has been a considerable recent focus for the Planned Care programme team. A range of other workstream progress is evident with the clinical validation policy now launched alongside a chat-bot patient validation solution which has been tested in Orthopaedics and Gastroenterology and is now progressing into Gynaecology. WAP-Full (Welsh Admin Portal) is now live in six services with work underway to introduce into a further six specialties, alongside preparation for an exit strategy from the nationally funded Consultant Connect.

3.8.4. Within Urgent and Emergency Care (UEC) targeted improvement work on hospital discharge, delivered through two agile sprints has produced measurable gains, including a 28.9% reduction in package of care delays. £35,000 of national funding has also been received to support work around community-based falls response, which will be utilised to train existing community resource teams, strengthening staff confidence and capability in managing falls safely and effectively, supporting sound clinical decision-making and reducing unnecessary conveyance to Emergency Departments.

3.8.5. The Value and Sustainability programme continues to enhance its focus on non-financial benefits through the development of a Value Benefits Framework. A value funded project on Cancer Pre-habilitation has delivered a saving of 1,200 bed days and a 30% reduction in post-operative complications and thus demonstrating improvements in clinical quality and outcomes. The clinical variation workstream led by the Executive Medical

Director will ensure a wider focus on value metrics including productivity, efficiency, outcomes and experience. From a financial perspective the programme is forecast to over-deliver by £4.9m, contributing positively to the Health Board's financial position.

3.9. KEY PROGRAMMES

3.9.1. The first year of reporting these programmes within this categorisation is drawing to a close and improved oversight of the portfolio is now evident and where delays have occurred more timely intervention has been possible.

3.9.2. Many of the programmes are multi-year change initiatives however a number are coming to fruition. The Radiology Informatics System Project (RISP) is now formally preparing to close down following the successful go-live in September 2025. The Electronic Prescribing and Medicines Administration (EPMA) system is actively in implementation phase and after successful go-lives in Heddfan, East and now West, the team are undertaking readiness activities for the Central implementation on the 7th March. Feedback from clinical staff is very positive and the engagement approach and sharing learning across sites has been critical to the ability to deploy in a number of areas in quick succession.

3.9.3. The Digital Maternity System is also scheduled for Go-live during March. The Cellular Pathology element of the Laboratory Information Management System (LIMS) was deployed during February however the overall programme remains delayed due to external factors outside Health Board control and will roll forward into 2026/27. This does have financial implications which are currently being assessed and there is a requirement to implement by August 2026 due to support arrangements ceasing for the current system.

3.9.4. Work on the Health and Well-being hubs continues to progress and following appointment as the Executive Sponsor the Chief Operating Officer held a scoping workshop on the 23rd February with executive colleagues and their teams to begin the process of managing as a single portfolio, ensuring sequencing and interdependencies are fully managed. Colleagues are continuing to advance arrangements for the Waunfawr procurement following Board direction in January and the announcement of the funding for the Royal Alexandra Hospital marks a significant step forward for

provision in North Denbighshire and the programme team are mobilising activities for both Phase 1 and Phase 2.

3.9.5. The Planned Care Hub at Llandudno Hospital is now scheduled for contract completion on the 20th March with the first patient on the 13th April. There is a proposal to name the hub as the 'North Wales Surgical Centre'.

3.10. ORGANISATIONAL CAPABILITY

3.10.1. Further work has continued around developing the Organisational Approach to Change, a cross-cutting product from the Foundations for the Future Programme.

3.10.2. A multi-professional team spanning Transformation and Planning, People Services and DDaT have been undertaking key discovery work and presented the initial findings to an Informal Executive session on the 4th February. Key drivers include an acknowledgement that the Health Board does not have a strong track record in this area and there is a need to strengthen the way in which we work with colleagues and partners to ensure change is meaningful and that it will embed into everyday practice.

3.10.3. A set of principles have begun to emerge with a core focus on change being people-centred, including an investment in our people and also creating the right conditions for them to thrive. This must be integrated with strategic intentions whilst also unleashing the potential in our workforce to drive forward the changes in their area that they are best placed to understand and deploy.

3.10.4. Research has identified that changes are up to seven times more likely to meet their objectives when the approaches remain closely connected to the people behind the change, as opposed to being imposed upon them.

3.10.5. The work remains at a relatively early stage and during 2026/27 will be further developed into an Organisational Change Framework. As part of the continuation of the discovery work a key session has been arranged with the Stakeholder Reference Group on the 2nd March to gather their insights which will feed into the next iteration of the report.

3.11. THIRD SECTOR UPDATE

3.11.1 Following a recent discussion with Third Sector partners, where there was collective support for strengthening and clarifying our partnership approach, we agreed to progress development of a co-produced Third Sector Partnership Framework, with a dedicated workshop scheduled for Q1 of the new financial year to shape this in detail. The direction of travel is toward longer-term, priority-aligned and outcomes-focused partnerships, with earlier involvement of Third Sector organisations in pathway and service design, alongside clearer governance and more consistent routes for dialogue and influence. This work aligns with our refreshed strategic direction, prevention focus and Community by Design principles, and will ensure partnership with the Third Sector is embedded more systematically within planning, commissioning and delivery.

4. KEY RISKS / MATTERS FOR ESCALATION

4.1. 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.

4.2. 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.

4.3. Meeting the full set of Ministerial expectations within the IMTP given the challenging financial landscape.

4.4. De-escalation from any area of Special Measures now looks unlikely until after the election and a new Government has settled in and can make their own assessments.

5. RECOMMENDATIONS

5.1. The Committee is asked to:

- **COMMENT** on the content of the report.

ASSESSMENT	
Link to Strategic Priorities	2. Developing strategy and long-lasting change 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:	

<table>
<tr><td rowspan="3">Socio-Economic Impact Assessment
Have you undertaken a Socio-Economic Impact Assessment</td><td>Yes: ☐</td><td>No: ☒</td></tr>
<tr><td>Outcome:</td><td></td></tr>
<tr><td>If no, please include rationale:</td><td></td></tr>
<tr><td rowspan="3">Quality
Have you undertaken a Quality Impact Assessment Screening?</td><td>Enablers of Quality All Apply</td><td>Domains of Quality All Apply</td></tr>
<tr><td>If more than one applies, please list below:</td><td>If more than one applies, please list below:</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Wellbeing of Future Generations Act – Wellbeing Goals</td><td colspan="2">A Healthier Wales</td></tr>
</table>

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

PARTNERSHIPS, ENGAGEMENT AND COMMUNICATIONS (PEC) DELIVERY PLAN: PROGRESS REPORT (Q3 2025/26 AND FORWARD LOOK TO Q4)

Dyddiad y Cyfarfod **Date of Meeting**	05 March 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 Partnerships, Engagement and Communications
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Helen Stevens Jones Director Partnerships, Engagement and Communications

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol **Executive Summary**
Progress during Quarter 3 has remained steady, with delivery of the PEC Delivery Plan continuing broadly on track. Key milestones have been achieved, particularly in strengthening engagement infrastructure, delivering community engagement activity, improving coordination with partners and political stakeholders, and preparing for implementation of the Betsi Way Engagement Framework. There is evidence of increasing organisational maturity, with more systematic approaches to engagement planning, improved reporting and assurance, and continued strengthening of relationships with communities, partners and elected representatives. Work during Quarter 3 has also focused on preparing the organisation for wider embedding of engagement principles and toolkits, ensuring sustainability and consistency.

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	

PROGRESS REPORT – QUARTER 3 (2025/26) AND FORWARD LOOK TO QUARTER 4

1. SITUATION

1.1 This report provides an update on delivery of the Partnerships, Engagement and Communications (PEC) Delivery Plan for Quarter 3 of 2025/26, alongside an overview of progress in strengthening engagement, communication and public affairs functions. It builds on the progress reported for Quarters 1 and 2 and provides assurance on delivery against key actions, including development of the Betsi Way Engagement Framework and Co-production, Engagement and Consultation Toolkit, implementation of improved systems and processes, and continued support to service change, transformation and partnership working.

1.2 The report also outlines priorities and anticipated progress for Quarter 4, including embedding new frameworks, completing key structural and process improvements, and strengthening organisational capability and assurance.

2. SPECIFIC MATTERS FOR CONSIDERATION

2.1 Progress in Quarter 3

Engagement and involvement

Good progress has been made in expanding and strengthening engagement activity across North Wales.

A wide programme of community engagement activity has been delivered, including participation in regional and local events, targeted rural engagement, and stakeholder-led forums. These activities have enabled meaningful dialogue with a diverse range of communities, including rural populations, younger people, and groups less heard from. This has strengthened insight and supported ongoing service planning and improvement.

Engagement programmes supporting service change have progressed during Quarter 3, including ongoing engagement in Tywyn and Penley, ensuring local communities, stakeholders and partners are involved in shaping future service models. These programmes demonstrate improved consistency and structure in engagement planning, delivery and reporting.

The draft Betsi Way Engagement Framework and Co-production, Engagement and Consultation Toolkit have been further refined and aligned with planning and strategy processes, in preparation for formal governance consideration and organisational rollout. The framework and toolkit represent key milestones in establishing a consistent, evidence-based model for engagement across the Health Board.

Structured reporting mechanisms continue to mature, providing greater visibility of engagement activity and strengthening assurance through regular reporting, including contributions to the Citizens Experience Report.

The Community of Engagement Practice is continuing to develop, supporting peer learning, capability building and preparation for rollout of engagement toolkits and training.

Communications and digital engagement

Communications delivery has continued to support organisational priorities, service change and public health campaigns.

Digital channel reviews have been completed and are informing improved use of analytics, audience insight and channel effectiveness. Work has progressed on reviewing internal communications channels, including BetsiNet, to improve staff communication and engagement.

Communications support has been provided for major transformation programmes, including Foundations for the Future, service change programmes, and organisational priorities, ensuring clear and coordinated communication with staff, stakeholders and the public.

Media management, digital monitoring and proactive campaign activity have continued to protect organisational reputation and support public understanding of services and priorities.

Public affairs and partnerships

Public affairs activity has continued to strengthen relationships with elected representatives, partners and key stakeholders.

Regular engagement with Members of the Senedd, MPs, councillors and political offices has continued, supporting improved understanding of organisational priorities and developments.

New approaches to political engagement have been piloted, including targeted local authority engagement sessions, with initial feedback demonstrating improved dialogue and shared understanding.

Improved systems for managing correspondence, including coordination of Llais representations, continue to strengthen organisational responsiveness, transparency and assurance.

Partnership working through Regional Partnership Boards, Public Services Boards and wider stakeholder networks continues to support integrated working and alignment with strategic priorities.

2.2 Priorities and forward look Quarter 4

Quarter 4 will focus on embedding improvements and transitioning from development to full implementation of key frameworks and processes.

Key priorities include:

Embedding the Betsi Way Engagement Framework/Co-production, Engagement and Consultation Toolkit

- Formal governance approval and organisational launch
- Implementation of engagement toolkits and supporting guidance
- Delivery of staff briefings and training through the Community of Practice/Networks
- Integration into service change, planning and decision-making processes.

Enhancing communications and public affairs capability

- Completion of internal communications improvements, including intranet enhancements
- Continued proactive communications supporting organisational priorities and transformation
- Strengthening political engagement and stakeholder relationships
- Preparing for post-election with political engagement planning
- Improved correspondence tracking and analytics systems

Delivery of the PEC Delivery Plan remains on track, with strong progress made in Quarter 3 and clear plans in place for Quarter 4.

The Health Board is now transitioning from developing new frameworks and systems to embedding them in routine organisational practice. This will ensure engagement, communication and partnership working are consistently applied, well evidenced and fully integrated into decision-making and service improvement.

3. RECOMMENDATIONS

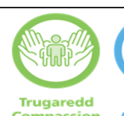
PPHP Committee members are asked to:

- Note progress during Quarter 3 in delivering the PEC Delivery Plan
- Note priorities and planned delivery for Quarter 4
- Receive assurance that delivery remains on track and continues to strengthen organisational capability, governance and partnership working

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	1. Focus on Health and Wellbeing
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: This work directly supports the Health Board's strategic objectives by strengthening meaningful engagement, transparent communication and effective partnership working as core enablers of high-quality, person-centred care, good governance, workforce engagement and public confidence. Specifically aligned to: • Developing strategy and long-lasting change • Creating compassionate culture, leadership and engagement • Improving quality, outcomes and experience
Yr Egwyddorion Dylunio **Design Principles**	People First Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	Delivery of the PEC Delivery Plan supports mitigation of key risks relating to engagement, governance, reputation and service change. Strengthened engagement systems, structured reporting and implementation of the Betsi Way Engagement Framework and Co-Production, Engagement and Consultation Toolkit provide improved assurance and support compliance with BAF and Corporate Risk Register requirements. This work directly supports BAF risk 24.05 (Not Engaging with Citizens, Partners and Communities) and contributes to mitigating risks associated with service change, public confidence and governance.

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):** [Public Sector Equality Duty [HTML] | GOV.WALES]	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	
	Engagement activity is designed to be inclusive and accessible, ensuring people with protected characteristics have opportunities to participate and influence decision-making.	
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:	
	Engagement activity includes targeted work with rural communities and seldom-heard groups, ensuring socio-economic factors are considered in planning and decision-making. This supports fair and equitable service development.	
Have you completed an Integrated Equality Impact Assessment WP8a? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	Naddo/No: ☒
		Equality Impact Assessments are undertaken where required for specific service change and engagement activity
Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	WP8a not needed for this paper. Engagement and communications activity promotes transparency, inclusion and participation, supporting the organisation’s



		commitment to respecting and protecting individual rights.
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	N/A. All engagement and communications activity complies with Welsh Language Standards, ensuring information and opportunities to participate are available in Welsh and English.	Naddo/No: ☐
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:	
	Engagement processes are inclusive and ensure veterans and Armed Forces communities can participate where relevant, supporting the principles of the Armed Forces Covenant.	
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:	A standalone Impact Assessment is not required for this report. Impact Assessments are undertaken where appropriate for individual service change and engagement programmes.
	Galluogwyr Ansawdd **Enablers of Quality** All Apply	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	Not Applicable	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	

Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	The PEC Delivery Plan has a neutral to positive impact, with increased use of digital engagement and coordinated activity helping reduce environmental impact.
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:	A DPIA screening is not required for this report. DPIAs are undertaken where engagement activity involves personal or sensitive data.
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:	No specific counter fraud risks arise from this report. Strengthened governance and reporting support transparency and accountability.
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
	The PEC Delivery Plan supports compliance with statutory engagement, equality and consultation duties.	
Enw Da **Reputational**	Yes (Include further detail below)	
	Delivery of the PEC Delivery Plan has a positive reputational impact by strengthening transparency, engagement and stakeholder confidence.	
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.	
	Delivery is being achieved within existing resources. Strengthened systems and frameworks support more efficient and effective use of staff time and organisational capacity.	

Planning, Population Health & Partnerships Committee

POPULATION HEALTH DELIVERY REPORT (Q3 25/26)

Dyddiad y Cyfarfod Date of Meeting	05 March 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 Noting

Crynodeb Gweithredol Executive Summary

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**
Prevention, Population Health and Early Intervention Executive Delivery Group (PDG)	23/01/26	Noted and performance information is being considered as part of developing core indicators.
Executive Committee	11/02/26	Noted

Acronymau / Rhestr Termau Acronyms / Glossary of Terms	

Population Health Delivery Report (Q3 25/26)

1. **Y SEFYLLFA**
   SITUATION

1.1 This is an established, routine report produced quarterly which reflects progress in relation to the population health of North Wales, with Committee approved standard format. The report focuses on key performance indicators, population health priorities, use of grant funds which target population health and key programmes of work which aim to delivery improved population health.

2 **Y CEFNDIR**
BACKGROUND

2.1 The report has been established since 2023/24. As part of each submission specific items (additional to the standard items) are proposed for the next submission.

3 **MATERION PENODOL I'W HYSTYRIED**
SPECIFIC MATTERS FOR CONSIDERATION

3.1 This report provides an update against standard items:

- Key Population Programmes – Performance Indicators
- Population Health updates
- Risk
- Proposed items for Q3 report

3.2 The Committee are asked to note the following items as the Q3 additional specific items:

- Report item 3.1 – Screening activity update
- Report item 3.2 – Health Travel Charter & Public Service Boards update
- Report item 3.3 – Diabetes programme update
- Report item 3.4 – Health Protection support to Flu Programme update
- Report item 3.5 – Exec Director of Public Health Annual Report Actions

Further to feedback from the agenda setting meeting (Jan 26) ahead of March PPHP, it is proposed to develop a new report format from Q1 Report 2026/27 with draft template submitted as part of the Q4 25/26 Report.

4 **RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO**
KEY RISKS / MATTERS FOR ESCALATION

4.1 The report provides assurance in relation to delivery actions associated with the population health Corporate Risk (CRR25-03).

5 ARGYMHELLION RECOMMENDATIONS

5.1 Gofynnir i'r Pwyllgor:
The Committee is asked to:

AGREE the proposed items for the Q4 Report:

- Year-end report on use of Grant Funds 25/26
- Review of Annual Delivery Plan 25/26 – Prevention and Diabetes
- Headline priorities 26/27-28/29
- Draft format 26/27 reporting (from Q1 26/27)

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 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. Prevention and Population Health are noted as a Ministerial priority for 25/26. The Population Health quarterly Delivery Report supports governance and reporting associated with the Health Board's commitment and responsibility to improve the health and wellbeing of the North Wales population.
Yr Egwyddorion Dylunio **Design Principles**	Choose an item. 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	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.*

Corporate Risks and Board Assurance Framework	*This may be caused by a failure to take appropriate health prevention responses in areas such as immunisation, outbreak management and screening, failure to deliver interventions that improve people's health, increasing pressures in primary care, rising demand for chronic condition management, and insufficient capacity in children's, dental, and mental health services.* *This may lead to unmet health needs, preventable and communicable diseases, poorer health outcomes and widening inequalities for the North Wales population.* BAF24-06 - *There is a risk of not delivering the required improvements to transform care and enhance outcomes*
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 for information to update the PPHP Committee in regards to prevention and early intervention activity undertaken by the Public Health Directorate. Specific projects and programmes of work are subject to EQIA in accordance with health board policy.
Asesiad o'r Effaith Economaidd-gymdeithasol	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

<table>
<tr><td>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?
Socio-Economic Impact Assessment
Have you undertaken a Socio-Economic Impact Assessment</td><td>Os naddo, dylech gynnwys y rheswm:
If no, please include rationale:</td><td>This paper is for information to update the PPHP Committee in regards to prevention and early intervention activity undertaken by the Public Health Directorate.

Specific projects and programmes of work are subject to SEIA in accordance with health board policy.</td></tr>
<tr><td rowspan="3">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?</td><td>Galluogwyr Ansawdd
Enablers of Quality
Whole-systems Perspective</td><td>Meysydd Ansawdd
Domains of Quality
Person Centred</td></tr>
<tr><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant
Wellbeing of Future Generations Act – Wellbeing Goals</td><td colspan="2">A Healthier Wales</td></tr>
</table>

<table>
<tr><td rowspan="3">Effaith Amgylcheddol / Cynaliadwyedd (5Rs)
Environmental /Sustainability Impact (5Rs)</td><td colspan="2">Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td></tr>
<tr><td colspan="2">Choose an item.</td></tr>
<tr><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny:
If more than one applies, please list:</td><td></td></tr>
<tr><td></td><td>Do/Yes: ☐</td><td>Naddo/No: ☒</td></tr>
</table>

<table>
<tr><td rowspan="2">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?</td><td>Canlyniad/Outcome:</td><td></td></tr>
<tr><td>Os naddo, dylech gynnwys y rheswm:
If no, please include rationale:</td><td>This paper is for information to update the PPHP Committee in regards to prevention and early intervention activity undertaken by the Public Health Directorate.

Specific projects and programmes of work are subject to impact assessment in accordance with health board policy.</td></tr>
<tr><td rowspan="3">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?</td><td>Do/Yes: ☐</td><td>Naddo/No: ☒</td></tr>
<tr><td>Canlyniad/Outcome:</td><td></td></tr>
<tr><td>Os naddo, dylech gynnwys y rheswm:
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A ydych chi wedi ystyried yr effeithiau ar atal twyll?
Counter Fraud Impact Assessment
Have you considered the counter fraud impacts</td><td>Do/Yes: ☐</td><td>Naddo/No: ☒</td></tr>
<tr><td>Canlyniad/Outcome:</td><td></td></tr>
<tr><td>Os naddo, dylech gynnwys y rheswm:
If no, please include rationale:</td><td>This paper is for information to update the PPHP Committee in regards to prevention and early intervention activity undertaken by the Public Health Directorate.</td></tr>
</table>

		Specific projects and programmes of work are subject to impact assessment in accordance with health board policy.
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)*	Yes (Include further detail below) There are risks to the preventative programmes of work which are largely funded through grant/non recurrent funds. These are captured as part of the Corporate risk and also within specific tier 1-2 risks managed via the Public Health Performance and Risk Management Group. There are a number of operational service staff who are on fixed term contracts due to the uncertainty of grant funds continuing. CFOs and Service leads remain informed in order to consider in plans and this has been identified as an area of concern in the recent Public Health Grant Audit (details included in the report). Workforce implications are considered as part of wider Programmes of work.	

Population Health – Q3 2025/26 Delivery Report

Produced by the Public Health Directorate (January 2026)

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1.0 Quarterly Progress Update (to January 2026)

The Health Board Plan 25-28 continues to support the commitment to delivering the shift towards prevention, improving population health and delivering health and wellbeing service which reduce avoidable health inequalities and improve long-term population outcomes. Current work plans are focused on the delivery of key priority programmes and the development of focused, intelligence led approaches.

During Quarter 3 2025/26 there has been significant focus on:

1.1 Governance and Assurance

- Establishment of the Prevention, Population Health and Early Intervention Executive Delivery Group (PDG).
- November Meeting – provided focus on performance updates from Health Inequalities Programme and the Public Health Intelligence Research and Evidence programme. There was good discussion in regards to developing a set of core indicators and metrics to inform the cycle of business and which could become and established data set for the health board to monitor progress against its prevention and population health improvement goals and objectives. Key updates were received from Planning, Womens and Mental Health Directorates.
- Future meetings will continue to review a range of activity and reports from across the health board which relate to Ministerial priorities, local targeted programmes of work and performance metrics which will support future Population Health Quarterly Delivery reports to PPHP Committee.

1.2 Delivery 25/26

- Quarter 3 has progressed key deliverables associated with the 25/26 components of the current Health Board Plan (2025-20287).
- Ministerial Priorities in 25/26 - Two have been classed as ‘prevention’ which have required outline plans:
- Delivery of Vaccination and immunisation targets (national performance framework)
- Increase % those aged 12+ receiving the 8 Care Processes for Diabetes

An update in relation to the 8 Care Processes can be reviewed in 2.1.

The Health Board has made significant progress against all key deliverables within the Prevention and Population Health Sub Category of the Annual Delivery Plan. During the year to date we have completed a weight management service review which will provide the basis for developing plans into 26/27-28/29 to help support the population to achieve and maintain a healthy weight through targeted approaches.

We have also been delivering our grant funded plans which are focused towards healthy weight, smoking cessation, healthy schools and arts in health and wellbeing.

There has been collaborative working with our partners to develop plans for co-commissioned social prescribing from 26/27 which will deliver wider access to support across a range of services. In addition, we have worked closely with our Regional Partnership Board to co-produce the basis for a North Wales Wellbeing and Prevention Anchor Framework, identifying the the important role of anchor organisations in delivering improve wellbeing in the population.

There has been progress in strengthening the population health intelligence, research and evidence, with a number of evidence reviews which support development of services and approaches to prevention and tackling health inequalities. The development of the population needs assessment will support the development of the Health Board Strategy.

Much of what has already been achieved in 25/26 establishes strong foundations for delivering positive health improvement and impact for our population.

1.3 Planning 26/27-28/29

Development of the Health Board plan has commenced. Within the Public Health Directorate the existing key programmes of work (Health Improvement, Health Inequalities, Healthcare Public Health, Health Intelligence & research, Health Improvement and Vaccination and Immunisation will continue to work to the established three year plan with the forward look to 28/29. Key milestones for the forthcoming year will be detailed and build on what is achieved in 25/26 across all programmes.

These programmes of work will help to inform the wider health board plan, where there are opportunities for prevention and population health improvement. A draft Directorate plan has been produced with focus on delivery and impact, building on what is achieved in 25/26. We note the ministerial increased focus on reducing health inequalities between our most and least deprived areas for vaccination, screening and diabetes, improving childhood weight and falls and frailty for 26/27.

2.0 Key Population Programmes - Performance Indicators (Metrics)

The following 25/26 National indicators are currently off track with the following actions to improve the position:

Indicator	*Up to*	Current	Target	Wales position	Action
HPV	Sept 25	72.3%	90%	74.9%	• Exploring low uptake areas and vaccine equity to develop targeted interventions.
Covid 19	30/12/25	53.31%	75%	52.27%	• Exploring low uptake areas and vaccine equity to develop targeted interventions. • Review lessons learnt from Winter Respiratory Programme
U65 Years at risk group Flu	30/12/25	37.7%	75%	42.1%	• Flu debriefs sessions • Exploring low uptake areas and vaccine equity to develop targeted interventions.
Pre-School (2–3-year-olds)	30/12/25	44.90%	75%	44.3%	• Efforts to increase vaccine literacy for Health Visitors and Practice Nurses through training • Flu debriefs sessions • Exploring low uptake areas and vaccine equity to develop targeted interventions. • Exploring addressing parental vaccine hesitancy through either motivational interviewing or ERI. • Use of BCUHB translation service for transfers into BCUHB where there is limited immunisation history
Primary School Children	30/12/25	62.30%	75%	56.2%	• E-consent form is ready for use for the 2026/27 programme. • Development of BCUHB equity strategy • Flu debriefs sessions • Efforts to increase vaccine literacy for school nurses and school immunisers and through training • Working with schools to finalise school visits earlier. • Provide and plan more clinics for catch ups. • Development of a local uptake data dashboard

					• Exploring addressing parental vaccine hesitancy through either motivational interviewing or ERI. • Use of BCUHB translation service for transfers into BCUHB where there is limited immunisation history.
Secondary School	30/12/25	51.90%	75%	44.5%	• E-consent form is ready for use for the 2026/27 programme. • Development of BCUHB equity strategy • Flu debriefs sessions • Efforts to increase vaccine literacy for school nurses and school immunisers and through training • Working with schools to finalise school visits earlier. • Provide and plan more clinics for catch ups. • Development of a local uptake data dashboard • Exploring addressing parental vaccine hesitancy through either motivational interviewing or ERI. • Use of BCUHB translation service for transfers into BCUHB where there is limited immunisation history. • Working with PHW with the development of using Gillick consent
HPV Year 8	30/12/25	66.30%	90%	74.2%	• Development of e-consent • Development of school nurses offering information to the year groups regarding the importance of vaccination. • Implementation of the ISSAC standards once they are approved by PHW • Working with DHCW as they complete their discovery work, ensuring BCUHB insights are captured. • Implementation of the needle anxiety toolkit.
HPV Year 9	30/12/25	78.80%	90%	75%	• Development of e-consent • Development of school nurses offering information to the year groups regarding the importance of vaccination. • Implementation of the ISSAC standards once they are approved by PHW • Working with DHCW as they complete their discovery work, ensuring BCUHB insights are captured. • Implementation of the needle anxiety toolkit.

					• Offer catch ups in various locations, school, clinic, home, ensuring histories are checked and all outstanding immunisations offered.
Meningitis ACWY (MenACWY) Year 10	30/12/25	69.60%	95%	74.5%	• Development of e-consent • Development of school nurses offering information to the year groups regarding the importance of vaccination. • Implementation of the ISSAC standards once they are approved by PHW • Working with DHCW as they complete their discovery work, ensuring BCUHB insights are captured. • Implementation of the needle anxiety toolkit. • Offer catch ups in various locations, school, clinic, home, ensuring histories are checked and all outstanding immunisations offered.
Meningitis ACWY (MenACWY) Year 11	30/12/25	72.40%	95%	72.9%	• Development of e-consent • Development of school nurses offering information to the year groups regarding the importance of vaccination. • Implementation of the ISSAC standards once they are approved by PHW • Working with DHCW as they complete their discovery work, ensuring BCUHB insights are captured. • Implementation of the needle anxiety toolkit. • Offer catch ups in various locations, school, clinic, home, ensuring histories are checked and all outstanding immunisations offered.
Colonoscopy	Nov 2025	30%	90%	19.7%	• PHW working with BCU Cancer Network Manager • Updated performance figures 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 ◦ **Note: these figures are the wait time for index colonoscopy within 4 weeks of booking (tgt to achieve is 90%)**

Further detail can be found in the relevant section below and the Appendix A.

2.1 Ministerial Priorities 25/26

Diabetes 8 Care Processes

The NICE eight care process are check that people with diabetes aged 12 and over should have on an annual basis as part of their clinical management and care. The eight NICE care processes for diabetes are:

- Blood pressure
- Body mass index
- Smoking Status
- Urine albumin
- Serum cholesterol
- Serum creatinine
- HbA1c
- Foot checks

Completion of these checks is associated with a reduction in risk of complications of diabetes developing and provides an opportunity for early intervention around both risk factors and treatment. There is a continued upward trend in the delivery of all eight NICE care processes compared to position at the same at month in 2024. However, BCU HB continues to rank 7th out of 7 in Wales against this metric, with just under 42% of people with diabetes having all eight care processes recorded in their GP patient record. There has been a continued trend of improved performance compared to the same month in 2024 within all 14 of the cluster areas in BCUHB. Though performance of urine albumin and foot checks appears to have to lowest overall uptake, all checks show continued improvements with all showing completion rates of over 60%. This indicates a pattern of random variation rather than systematic issues with a specific elements of the clinical review process. Work is being undertaken with the BCU HB managed practices to understand any challenges to data quality and performance.

Integrated Vaccination Service

Covid-19

The Covid-19 Programme 2025-26 commenced on 1st October 2025 and will conclude on 31st January 2026. A total of 106,543 eligible citizens aged 75 years and over and/or those who are clinically immunosuppressed have been offered a single dose of the Covid-19 vaccine.

The target population uptake assigned by Welsh Government is 75%.

As of 13th January 2026, a total of 65,892 (61.85%) Covid-19 vaccinations has been administered to eligible citizens

Total Covid-19 vaccinations administered per area		
Areas	Total	%
BCUHB	**65,892**	**62%**
East	26,055	63%
Centre	22,360	62%
West	17,477	59%

Influenza

A collaborative programme approach between the health board vaccination team and primary care (GP Practices and Community Pharmacists) with a focus on co-administration for citizens eligible for both the flu and Covid -19 vaccines underpins the planning for the winter 2025 -2026 influenza campaign.

The programme will continue to be delivered at multiple locations, including GP surgeries, vaccination centres, mobile clinics and community pharmacies. This model supports a coordinated and efficient approach to service delivery, with a particular emphasis on the co-administration of the Covid-19 and influenza vaccines. This work is integral to the local implementation of the National Immunisation Framework (NIF), ensuring alignment with national priorities and enhancing resilience of the vaccination infrastructure. The winter 2025-26 influenza programme is running from 1st October 2025 until the end of March 2026. A Welsh Government target of 75% has been set for eligible cohorts.

A permissive early start for certain cohorts including pregnant women and health care staff aged 65 years and under has been encouraged this year to ensure the early protection ahead of peak respiratory illness. The opportunity to vaccinate health care staff early also supports the health boards winter resilience planning.

Staff Uptake

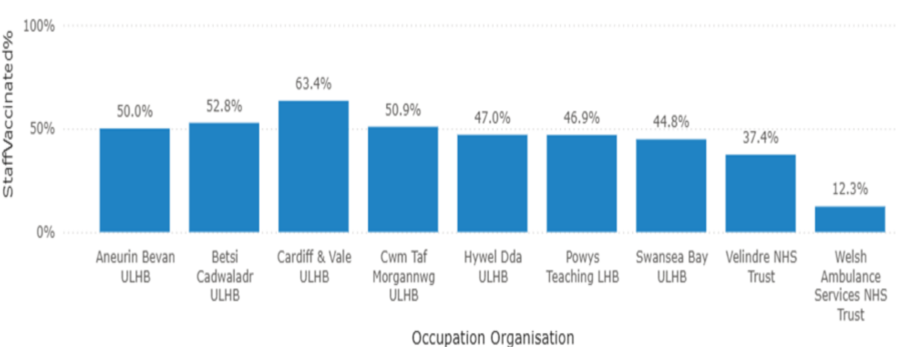
The Staff Influenza 2025/26 Programme commenced on 11th September 2025 with a total of 21,222 staff eligible to receive a single dose of the flu vaccine.

In line with a national directive, there is an emphasis this year on reducing barriers to vaccination and achieving the 75% uptake target set by Welsh Government

BCUHB are currently second amongst Welsh health boards with a 52.8% uptake.

Staff Uptake by Occupation Organisation

Occupation Organisation	Denominator	Vaccinated	StaffVaccinated%
Aneurin Bevan ULHB	15,944	7,979	50.0%
Betsi Cadwaladr ULHB	21,424	11,303	52.8%
Cardiff & Vale ULHB	17,585	11,150	63.4%
Cwm Taf Morgannwg ULHB	13,426	6,829	50.9%
Hywel Dda ULHB	12,190	5,728	47.0%
Powys Teaching LHB	2,656	1,246	46.9%
Swansea Bay ULHB	14,672	6,569	44.8%
Velindre NHS Trust	1,969	736	37.4%
Welsh Ambulance Services NHS Trust	4,480	551	12.3%
Total	**104,346**	**52,091**	**49.9%**



HPV

Welsh Government set a 90% target uptake for the school based HPV programme. A directive to increase uptake identified schools with low vaccination rates occurred during July and August 2025.

There is a correlation between low uptake and poor attendance at schools within areas of higher deprivation and individual invites were issued for vaccination at local clinics. Uptake in response to this intervention was low and highlights the requirement to consider strategies to improve uptake in lower demographic areas.

The following schools were escalated in Betsi Cadwaladr where uptake is lower than other schools in Wales: Health Board Local Authority Area School Betsi Cadwaladr Denbighshire Christ the Word Catholic School Betsi Cadwaladr Denbighshire Rhyl High School.

RSV
The Respiratory Syncytial Virus (RSV) vaccine for older adults and pregnant women was introduced in September 2024. In BCUHB, delivery of the older adult programme is primarily managed through General Practitioner (GP) practices, while the maternal programme is administered by the health board's vaccination team in collaboration with midwifery colleagues.

The time sensitive catch-up programme targeting individuals already aged between 75-79 years of age at the start of the programme terminated at the end of August. The IVS supported practices who had not achieved the 65% target by inviting all eligible citizens who had not received a vaccination to a local vaccination centre.

BCUHB uptake for the catch up and routine cohorts (Public Health Wales data) (December 2025)

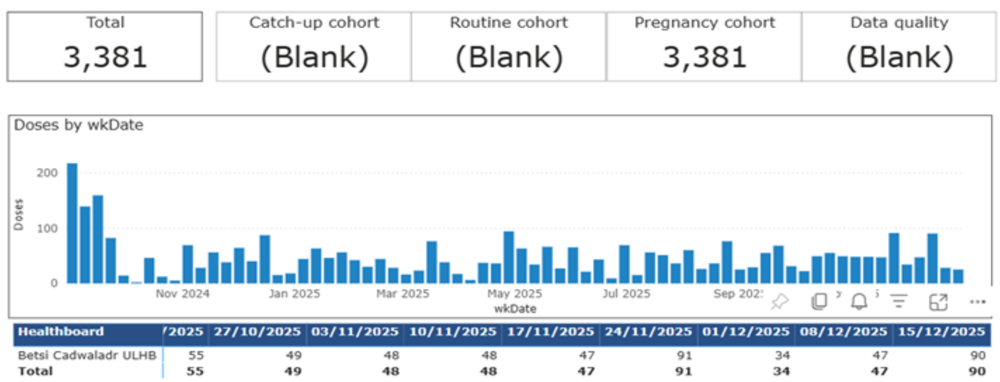
Campaign Group	Catch-up cohort			Routine cohort		
VaccinatingLHBName	Denominator	Doses	Uptake	Denominator	Doses	Uptake
Betsi Cadwaladr ULHB	38,835	26,278	67.7%	10,673	3,616	33.9%
Total	**38,835**	**26,278**	**67.7%**	**10,673**	**3,616**	**33.9%**

Uptake of RSV immunisation in resident population aged 75 to 79 years old, as of 1st September 2024 by Health Board of residence

Local Health Board	Denominator	Vaccinated	Uptake (%)
Aneurin Bevan UHB	28,623	18,302	63.9%
Betsi Cadwaladr UHB	39,162	26,335	67.2%
Cardiff and Vale UHB	19,526	13,303	68.1%
Cwm Taf Morgannwg UHB	21,259	14,032	66.0%
Hywel Dda UHB	23,318	13,281	57.0%
Powys THB	8,902	5,977	67.1%
Swansea Bay UHB	18,703	11,249	60.1%
Unknown	946	322	34.0%
Wales Total	**160,439**	**102,801**	**64.1%**

Challenges remain to invite citizens who turn 75 years of age with BCUHB only achieving a 34% uptake in this cohort. Continued partnership with GP practices provides an offer to support uptake for the RSV programme.

BCUHB RSV Maternal Programme uptake



Healthboard	/2025	27/10/2025	03/11/2025	10/11/2025	17/11/2025	24/11/2025	01/12/2025	08/12/2025	15/12/2025
Betsi Cadwaladr ULHB	55	49	48	48	47	91	34	47	90
Total	**55**	**49**	**48**	**48**	**47**	**91**	**34**	**47**	**90**

Pre-School Childhood Immunisation Programme

Childhood Immunisation Changes

From 1st July 2025, changes to the UK childhood immunisation schedule were implemented to optimise early-life protection and streamline vaccine delivery. The second meningococcal B (MenB) dose was brought forward from 16 to 12 weeks, providing earlier protection during a period of highest vulnerability. In parallel, the first pneumococcal conjugate vaccine (PCV) dose was moved from 12 to 16 weeks. The Hib/MenC vaccine was phased out, reflecting sustained high herd immunity and the discontinuation of the combined vaccine.

These changes apply to babies born on or after 1 July 2024 and aim to enhance early MenB protection while reducing the number of injections required at early visits.

Implementation across BCUHB has been successful, supported by an intensive programme of communication, training, and clinical guidance. This approach enabled practices to effectively manage the clinical and logistical challenges associated with transitioning to the revised schedule.

A further update to the programme is planned for January 2026, with the introduction of the varicella vaccine, integrated into the existing MMR vaccination programme.

2.2 Quadruple Aim

Charts can be found in Appendix A. Headline information below:

Colonoscopy Screening

Whilst the performance for index colonoscopy is below target, BCUHB is above the target for both coverage (63.2%) and uptake (65.9%), and in line with other health boards (see Figure 1, Appendix A). BCUHB has slightly higher uptake than the Wales average (65.5%). During 26/27, BCUHB Public Health Directorate will work collaboratively with partners to develop a Regional Screening Equity Plan to reduce variation in uptake across the national screening programmes. Additional capacity requirements will be discussed as part of implementing the Screening Equity Plan.

Colonoscopy figures improved by 3.5% in August 2025, compared to August 2024. BCUHB is 83.3% lower than the national average for the percentage of adults offered a colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner appointment (90%).

Newborn Hearing Screening

In August 2025, 98.6% of babies who entered the Newborn Hearing Screening Programme were screened within 4 weeks (see Appendix A, 2.2). This position is 8.6 % higher than the national target (90%) and is higher than the all-Wales average of 97 %. In July 2025, BCUHB ranked 4 out of 7 Health Boards in Wales.

Newborn bloodspot screening

In September 2025, 97.1 % of babies who entered the bloodspot screening programme received a conclusive blood spot screening result by day 17 of life. This position is 2.1% higher than the national target of 95%. In August 2025, BCU ranked 4th out of 7 Health Boards for performance against this metric, 0.9 % lower than the Health Board ranked 1st.

Smoking

To date during Q1-Q3 25/26 (Q3 data is not complete) 2,890 smokers were treated by HMQ Services, with the treated target rate at 5.93%, with Tier 1 treated target of 5% achieved by the Services. Comparison of this metric at end of Quarter 2 25/26 against other Health Boards identified BCU as 3rd of the seven Health Boards. The CO-validated quit rate is 23.0% and the self-reported quit rate

is 45.6%. The percentage of CO-validated quit rate remains low against a target rate of 40%, as telephone support remains a popular choice with service users. Comparison of the CO validated metric at end of Quarter 2 25/26 against other Health Boards identified BCU as 4th of the seven Health Boards, however BCUHB was above the Wales average.

There is a delay in the implementation of the national Pharmacy Level 2 local enhanced service which will support achievement of this target, it is expected that this service will be implemented in Q1 26-27. Pharmacies will be offering CO validation to service users upon collection of their stop smoking medications.

The protocol for the Administration of Nicotine replacement Therapy for Adult Inpatients will be tabled at the Medicines Policy and Procedures group in February, when agreed training will be provided to relevant health professionals. This will support the delivery of the national Smoking in Secondary care programme. The Service continues to support the delivery of all other national recommendations. HMQ Advisors continue to work in Mental Health Units supporting in-patients and raising awareness with staff and providing training and education.

For all staff funded by PEY non-recurrent grant funding HR conversations around contracts have now commenced; which affects 7.5 WTE Band 5 HMQ practitioners and 1.0 Band 6 Health Improvement Specialist. Some of the staff are eligible for re-deployment and have been placed on the re-deployment register, one team member has already left the Service, and another has secured a 4-week trial working in another team. In addition, there are on-going discussions with HMT in Ysbyty Glan Clwyd re: office accommodation as current premises is being demolished.

The HMQ Services meet regularly with Women's Service to deliver the Reducing Smoking in Pregnancy programme which is embedded within the Saving Babies Lives (SBL) delivery plan, with a focus on outcomes. The current focus is on understanding the performance data which is held in Women's Service with a view of improving its accuracy. However, it should be noted that introduction of Badgernet will improve the accuracy, and the frequency of the smoking in pregnancy prevalence in North Wales.

Planning is underway with primary care clusters and GP practices to roll out the Help Me Quit in Primary Care pilot in 24 practices across North Wales. Discussions are ongoing with the communications department and the HMQ Service national team in Public Health Wales to ensure that data collection from the national HMQ Service website is available to enable project evaluation. The intention is to roll out this programme in at the end of January.

The health board's communications team continue to deliver a broad programme of communication and engagement activities in support of local Help Me Quit services as outlined in the agreed annual communications plan. During Q3, this has included renewed

local radio, online audio and social media advertising targeted to areas of high prevalence. This work dovetails and supports national communications activity delivered by partners at PHW and helps to drive uptake of smoking cessation support here in North Wales. Further work is planned in Q4.

2.3 Weight

To date in 25/26 the Weight Management Service has received 4,952 referrals for 4,456 individual patients. The Service has supported the following:

- 920 patients started the Kind Eating programme (adult level 2)
- 279 patients accessed Second Nature (digital adult level 2)
- 131 new patients were supported by the pregnancy weight management service
- 94 new patients started the Help me to be Healthy programme (Level 3 children and young people)
- 191 new patients were assessed by the adult Level 3 weight management service including 45 patients started on weight management medication supported pathways and 24 patients for post-bariatric surgery follow-up.

Of the 920 patients who started the KindEating programme between 1st Jan- 30th Sept 2025, 411 completed the core 12-week programme and provided data achieving an average weight loss of 4.6kg (3.9%) at 12 weeks. Data is available for 629 patients who have attended a 12-month follow-up appointment since programme inception with an average weight loss of 8.62kg (7.07%) at 12 months. Of the 337 patients who started the Second nature digital programme between 1st Jan- 30th Sept 2025, data for 90 patients who completed and provided data shows patients achieved an average 6.7kg (7.0%) weight loss at 12 weeks. One hundred and fourteen children and young people have completed the 12-month Help me to be Healthy programme since service inception with 74% maintaining or reducing BMI z score.

In October 2025 the Welsh Government issued a circular regarding the use of weight loss drugs in the NHS outlining urgent criteria (such as patients requiring urgent weight loss for organ transplant or cancer treatment) under which Tirzepatide can be prescribed by other specialist services outside of specialist weight management services in Wales. BCUHB have not yet implemented this. New clinical pathway for treating and managing obesity (WHC/2025/043) [HTML] | GOV.WALES

Public Health Wales have completed a review of weight management services in BCUHB. The review found that costs and outcomes of current services are broadly in line with, or compare favourably with, national NHS England and Scotland benchmarks. Six recommendations were made to support a greater proportion of the population to access effective weight management interventions. The health board have requested support at national level to implement the recommendations, including the development of hybrid

services, a new digital referral system, automated triage and data collection. The health board will re-establish a weight management steering group and clarify governance structures.

Weight management will be added as a referral destination on WCCG for referrals from primary care on 15th Jan 2026. The CITO weight management referral e-form is now live for referrals from secondary care. From 1st Feb the service will no longer accept referrals in outdated formats. Updates have been sent to referrers in primary and secondary care aiming to reduce the number of inappropriate referrals and ensure patients are referred when they are ready to engage. Referral criteria from adult level 2 to the adult level 3 weight management service have been agreed.

The recently recruited data-coordinator funded by PEY grant funding has made significant progress with data collection, permitting reporting of Q3 data in a shorter time frame. Input from the DDAT team is awaited to create the requested SharePoint and Dashboard for the adult level 3 service and a summary dashboard for weight management services including commissioned provider data.

Public Health Wales have submitted a proposal to Innovate UK's Obesity Pathway Innovation Programme to develop a 'Once for Wales' digital infrastructure for weight management. The outcome of this application will be known at end Jan 2026

An additional 268 adult level 2 digital places have been procured to broaden the criteria for access to BMI 30-45 utilising PEY grant underspend owing to recruitment challenges.

There are staffing challenges in the Service which include the departure of permanent staff and temporary grant funded staff. PEY funded staff are awaiting confirmation of this funding, and this may result in further departures. This has resulted in increased challenge of ensuring timely triage of referrals. In addition, work is on hold on the development of a replacement to Therapy Manager clinical record system as DHCW are reviewing the minimum data set.

2.4 Health Protection Indicators

Key indicators from Quarter 3 include:

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 – 12th Dec)
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 interventions. 18% complete.	148 out of 222 care homes have received an IPC review 64.2 % complete.	203 out of 219 care homes have received an IPC review (93%), with 55 IPC reviews completed in the quarter 3
			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 have received IPC follow up contact 42.79 % complete	178 out of the 203 completed IPC reviews have received a follow-up (88%), with 83 follow ups completed in quarter 3
			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 care homes have engaged with IPC champions training sessions 22.52%	110 out of 219 care homes have a registered champion (50%)
2.	Enhancing the delivery of Health Board services to protect people in North Wales against	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	63/200 31.5%	134/200 67%	147/200 73.5%

	existing, new and emerging health protection threats and hazards.		Wales by 31st March 2026			
			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%
			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%
		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%
			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%
3.	Developing capacity within the Health Board to prepare for and respond to health protection threats	Establishing a robust Health Board response to communicable disease incidents/outbreaks	Delivery of an approved Health Board plan for the management of communicable disease incidents and outbreaks by 31st March 2026	A strategic preparedness group has been established and terms of reference produced. Group are to commence a mapping exercise to	Focus of the strategic group has moved from the development of plans to focussing on preparedness activities (there already exists plans	The Strategic Communicable Disease Preparedness Group has been stood down due to a lack of capacity in key

				consider current resources within the Health Board	within BCUHB for managing communicable diseases, however awareness of, and compliance with these plans requires improvement. Work undertaken to improve preparedness measures for measles cases in North Wales.	services/divisions within BCUHB. However, Exercise Pegasus has highlighted weaknesses within BCUHB's preparedness measures, especially for High Consequence Infectious Diseases. Simulation exercise to be planned for April 2026. Rabies Post-Exposure Pathway being prepared.
		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%	21 ARI care home enquires have been dealt with in quarter 3, with a 100% responded to within 24 hours

Other Health Protection Data – for information

No.	Health Protection Service – Function	Workstream	Overview	Outputs for Quarter 1 (April – May only)	Outputs for Quarter 2 (July – Sept)	Outputs for Quarter 3 (Oct – 12th Dec)
1.	Sampling and Assessment	Sampling response to outbreaks and wider health protection threats in North Wales	Number of clinical samples obtained to support the health protection response to outbreaks/threats.	12	16	49
2.	Protect	Incident management support	IPC advice provided to care homes in Acute Respiratory Illness incidents.	4	13	21
			Number of COVID-19 incidents managed by the Health Protection Service	1	5	6

2.5 Public Health Outcomes Framework (PHOF)

The Public Health Directorate has recently (Jan 26) been **notified by Public Health Wales (PHW) Observatory that an error has been discovered in the production of indicators within the Public Health Outcomes Framework (PHOF) reporting tool** that uses data from the National Survey for Wales (NSW). PHW have removed these indicators from the PHOF reporting tool in their entirety for now.

BCUHB have been advised by PHW Observatory Team that broadly speaking, the impact will be small when looking at figures for Wales as a whole, but smaller areas such as local authorities may be affected by up to 15 percentage points.

Due to this, and on the advice of PHW Observatory, the decision has been made to remove affected indicators from reports we are currently working on and we will also look to update reports that we have produced over the last year. Each affected report will provide a statement explaining which data has been affected and why data has been removed or replaced within the report. We are also working to find alternative data sources or proxy measures that we can used instead.

This may have affected the full PHOF update which was provided in the Q2 Delivery Report to PPHP. A full PHOF update is scheduled for the Q4 Delivery Report.

2.6 Local Area Planning

At the end of Q3 the Public Health Directorate responded to and influenced 19 planning applications of public health significance and one Local Development Plan Consultation.

2025 –2026 Planning applications *(quarterly financial year figures)*	**25/26 Q1**	**25/26 Q2**	**25/26 Q3**	**25/26 Q4**	**Total**
Total	10	6	**3**		19

3.0 Population Health Updates

3.1 Updated screening uptake figures

Release of the national data update has been delayed. Health Board, Local Authority and GP Cluster data will be available by end of Q4 2025/26.

The latest uptake and coverage figures for screening programmes are outlined in the table below.

Screening programme	All Wales target %	BCUHB %	Wales %	Uptake or coverage data available
Cervical (2023/2024)	80	69.5	68.7	Coverage
Bowel (2023/2024)	60	65.9	65.5	Uptake
Breast (2022/2023)	70	72.1	69.5	Uptake
AAA (2023/2024)	80	77.3	77.6	Uptake
Diabetic Retinopathy (2022/2023)	80	83.8	81.9	Coverage (uptake in annual report)

- **Cervical Screening** coverage in North Wales is higher than the national average of 68.7% and lower than all Wales target of 80 %.
- **Bowel Screening** uptake in North Wales is higher than the national average of 65.5% and higher than the national target of 60%.
- **Breast Screening** uptake in North Wales is higher than the national average of 69.5% and national target of 70%.
- **AAA Screening** uptake in North Wales is slightly below the national average of 77.6% and is lower than the all-Wales target of 80%.
- **Diabetic Retinopathy** uptake in North Wales is higher than the national average of 81.9% and the national target of 80%.

3.2 Progress update – Healthy Travel Charter (HTC) and Public Service Boards (PSBs)

Quarter 3 has progressed implementation of the Healthy Travel Charter (HTC) across Wales. BCUHB officially signed the Charter on 27 November 2025, following Executive Team approval. The Health Improvement HTC Lead also supported North Wales Housing Association in signing up and delivered a presentation to their forum on 10 December. Partnership support remains secure, with Walk Wheel Cycle Trust successfully securing funding to continue administration and partnership through 2026–27.

Across Public Services Boards (PSBs), engagement is growing. Conwy & Denbighshire PSB held its fourth sub-group meeting, with partners progressing baseline assessments. Flintshire & Wrexham PSB has established a practitioners' group, meeting again in January to report into their Workplaces Board. Gwynedd & Môn PSB is advancing well, with most organisations signed up and delivering actions such as walking route guides, a bus app for cost-effective travel, and youth engagement on college transport. Planning is underway for a Healthy Travel Charter event in March 2026 in Bangor. BCUHB continues to support the 'sign-up' processes through contributing to shaping the 'Missions' within the Health Inequalities Prevention Framework.

3.3 Diabetes Programme Update

Within the Diabetes Programme work continues with primary care to understand challenges and opportunities around delivery of insulin initiation through the DES and the completion of the eight care processes. Building on insights gained through the 2024/25 consensus work, we are working with the National Tackling Diabetes Together Programme to run an event aimed at people living with diabetes.

3.4 Health Protection – Staff Influenza Programme Support

The BCUHB staff flu vaccination programme began on the 29th September, with Health Protection Service support commencing on this date. The Health Protection Service have been organising and providing drop-in clinics at each of the three hospital sites, whilst

also supporting any services/areas identified as having low uptake with dedicated vaccinator visits. The Service has taken every effort to maximise opportunities for vaccination, including providing twilight clinics in the early mornings and evenings, and also at weekends.

3.5 Director of Public Health Annual Report Actions

The 2025 Director of Public Health Annual Report 'Building Health' was presented the Health Board in November 2025. Th Report focuses on an asset-based approach to improving health and wellbeing in North Wales at a societal, community and at an individual level. The Report sets ambitions and next steps for partners in North Wales.

https://bcuhb.nhs.wales/about-us/key-documents/public-health/public-health-reports/director-of-public-health-annual-report-2025/building-health-report/:

- **Build strong foundations**: enabling babies, children and young people to thrive - We will work with organisations across North Wales to build in the Marmot Principles into ongoing priorities and agendas.
- **Build fairer communities**: amplifying voices and unlocking local strengths - We will bring organisations together to identify and share best practice around community engagement approaches that can be used to build in the voice of the community and those who are seldom heard.
- **Build healthy places:** designing environments that support wellbeing - We will work with a wide range of partners, including the arts and culture sector, to find opportunities to address the wider determinants of health, and to look for effective ways to build wellbeing into our communities.
- **Build health and wellbeing across the system**: making wellbeing part of everyday life - We will work with partners across North Wales to identify opportunities for plans and actions that deliver the greatest health and wellbeing benefits for our population, drawing on intelligence and insight from the Regional Population Needs Assessment and the Public Services Boards' Wellbeing Assessments currently in development.
- **Create a collaborative network for building health** - We will develop a network that brings together partners focused on creating the foundations for better health and wellbeing for everyone in North Wales
- Progress across the system and within the Health Board against these ambitions are to be taken forward by the Executive Committee and reported back to the Planning, Population Health and Partnerships Committee.

4.0 Key Risks

Corporate risks are reviewed as part of the Corporate Risk governance structure and are supported by action plans and programmes of work. A deep dive of Public Health risks is scheduled for March 2026 with the BCUHB Risk Management Group.

Prevention and Population Health risks are also scheduled for review at PDG and via the Public Health Directorate performance and risk management group.

5.0 Quarter 4 25/26 Delivery Report

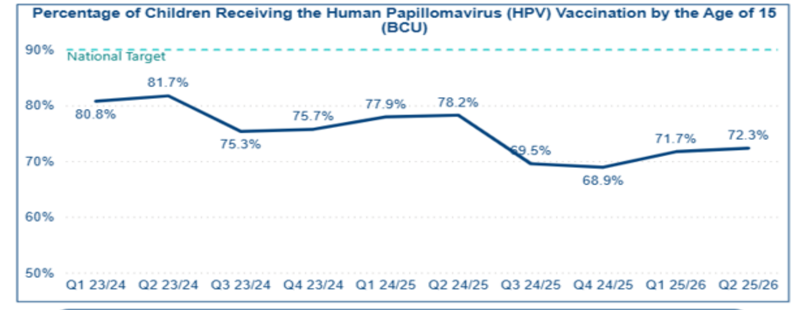
In the next report we will provide:

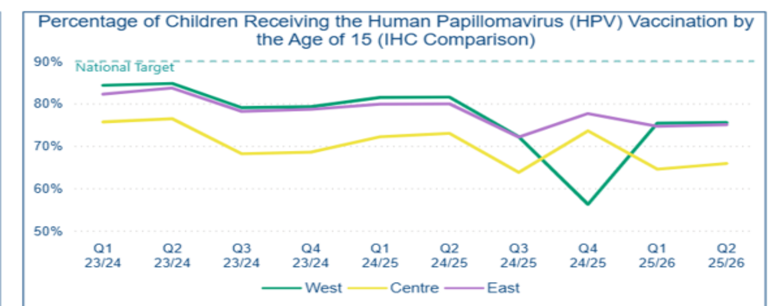
- Year end report on use of Grant Funds 25/26
- Review of Annual Delivery Plan 25/26 – Prevention and Diabetes
- Headline priorities 26/27-28/29

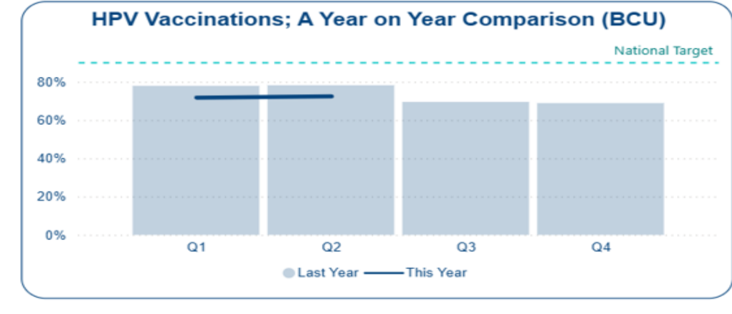
Appendix A – National Performance Metrics

Vaccination & Immunisation:

Ministerial Priorities 25/26: HPV Vaccinations







At Quarter 2 2025/26 the BCU position against this metric was 72.3% (17.7% below the National target of 90%, and 5.9% below the position in 2024/25)

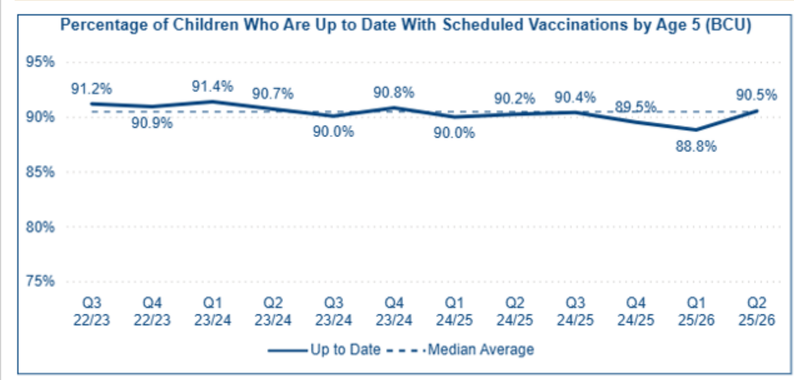
According to the WG Performance Reports, in Q2 2025/26 BCU ranked 6th of 7 Health Boards for performance against this metric, 13.5% lower than the Board ranked 1st.

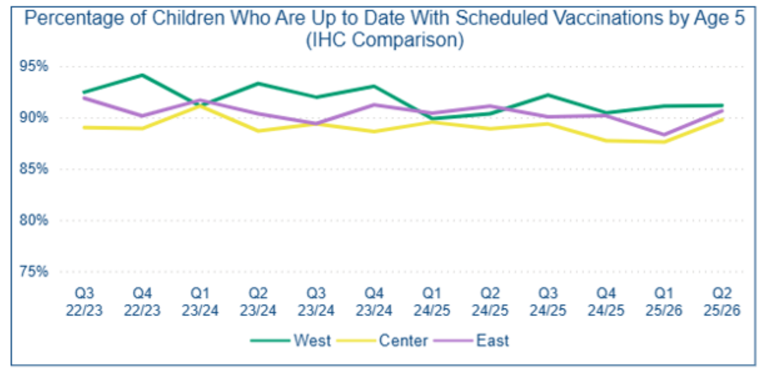
Rank	Board	Position
1	SB	85.8%
2	CTM	81.6%
3	Powys	78.9%
4	HDda	77.1%
5	C&V	72.6%
6	BCU	72.3%
7	AB	66.7%

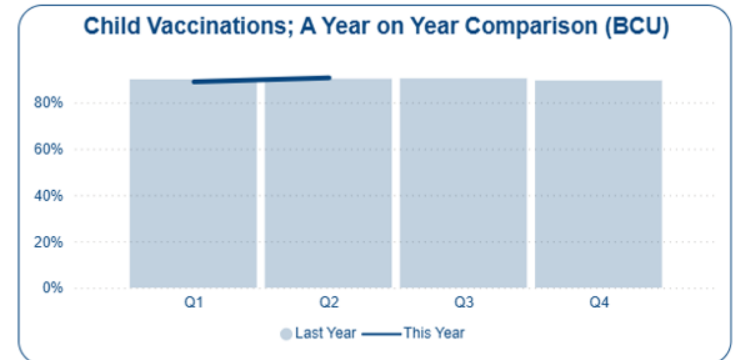
74.9%
All Wales Position

Sources: COVER reports (PHW) and WG Organisation Performance Reports

Ministerial Priorities 25/26: Child Vaccinations







Sources: COVER reports (PHW) and WG Organisation Performance Reports

In Q2 2025/26 the BCU position against this metric was 90.5% (4.5% below the National target of 95%). Local Authority performance ranged from 89.1% (Conwy) to 93.5% (Anglesey).

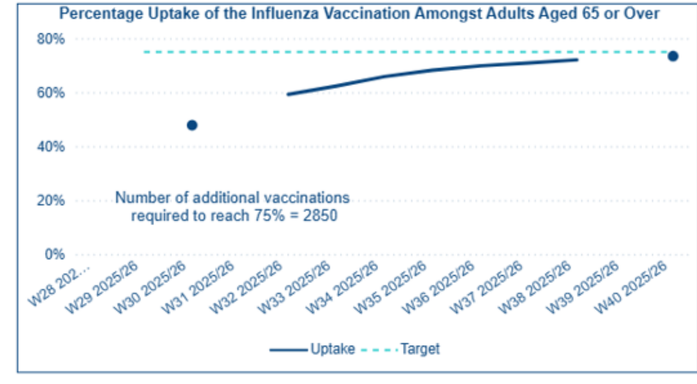
According to the WG Performance Reports, at Q2 2025/26, BCU ranked 2nd of 7 Health Boards for performance against this metric.

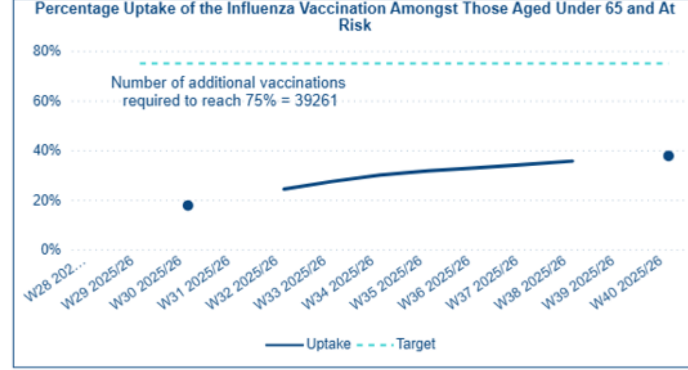
Rank	Board	Position
1	CTM	91.9%
2	BCU	90.5%
3	HDda	89.1%
4	SB	88.4%
5	Powys	87.6%
6	AB	85.3%
7	C&V	83.6%

88.0%

All Wales Position

Ministerial Priorities 25/26: Flu Vaccinations





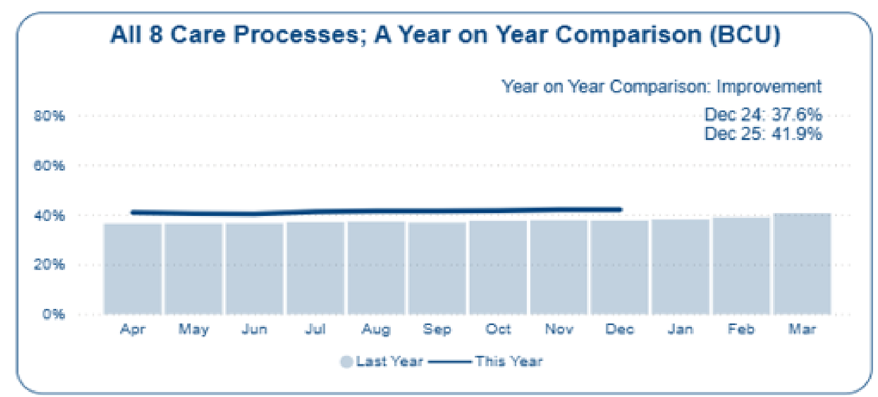
Sources: IVOR report (PHW) and WG Organisation Performance Reports

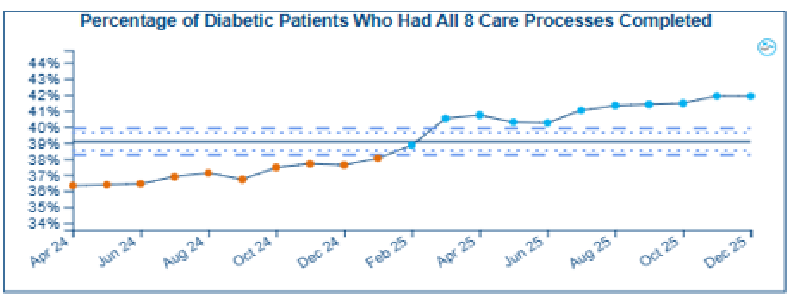
On 30th December 2025 the BCU position against the '65 Years and Older' metric was 73.4% (1.6% below the National target of 75%). Local Authority performance ranged from 72.0% (Denbighshire) to 75.1% (Anglesey).

On 30th December 2025 the BCU position against the 'Under 65 Years and At Risk' metric was 37.7% (37.3% below the National target of 75%). Local Authority performance ranged from 34.8% (Denbighshire) to 41.5% (Anglesey).

Diabetes 8 Care Processes

Ministerial Priorities 25/26: Diabetes Care – Completion of All 8 Care Processes





Performance against this metric continues to improve and achieve the National target of 'improvement compared to the same month in the previous year'.

In December 2025, BCU ranked 7th of 7 Health Boards for performance against this metric, 3.0% lower than the Wales average.

Latest Month Available

Dec 25

Rank	Board	Position
1	CTM	50.4%
2	Powys	49.1%
3	C&V	44.8%
4	AB	44.6%
5	HDda	44.3%
6	SB	42.8%
7	BCU	41.9%

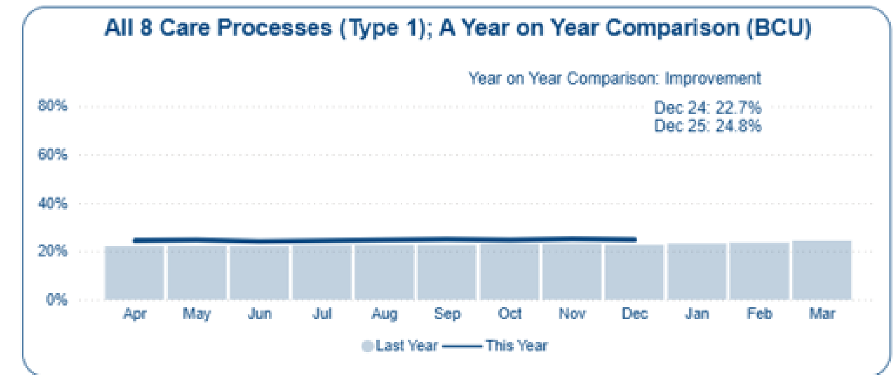
44.9%

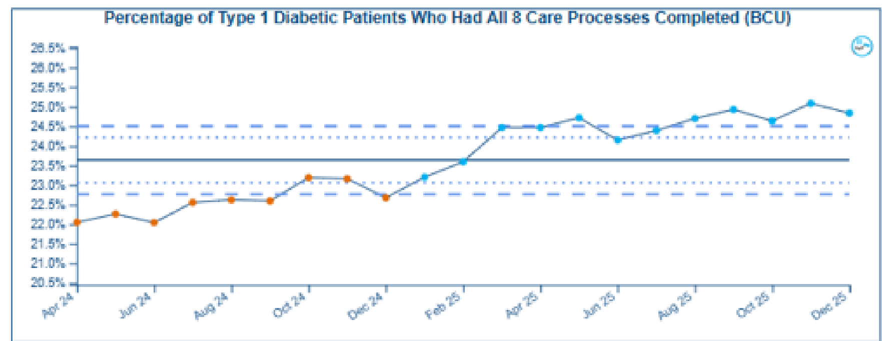
All Wales Position

Produced by the Performance Team
Sources: DHCW Primary Care Portal and WG Organisation Performance Reports

11

Ministerial Priorities 25/26: Type 1 Diabetes Care – Completion of All 8 Care Processes





Performance against this metric for type 1 diabetes specifically continues to improve and achieve the National target of 'improvement compared to the same month in the previous year'.

In December 2025, BCU ranked 5th of 7 Health Boards for performance against this metric, 4.5% lower than the Board ranked 1st, but above the Wales average.

Latest Month Available

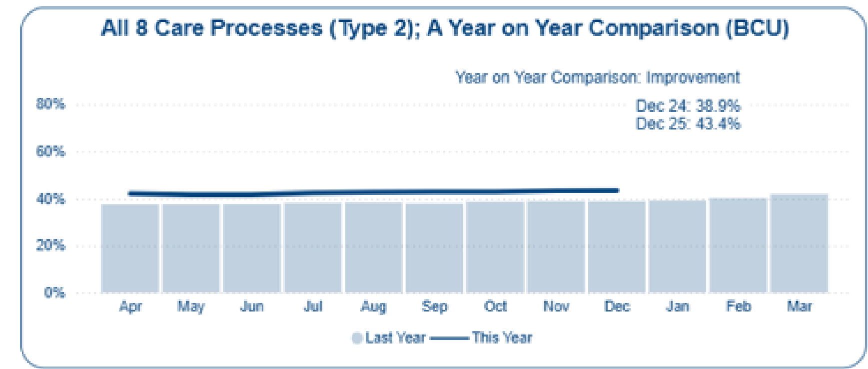
Dec 25

Rank	Board	Position
1	Powys	29.3%
2	C&V	28.8%
3	CTM	26.6%
4	AB	25.0%
5	BCU	24.8%
6	HDda	16.9%
7	SB	9.9%

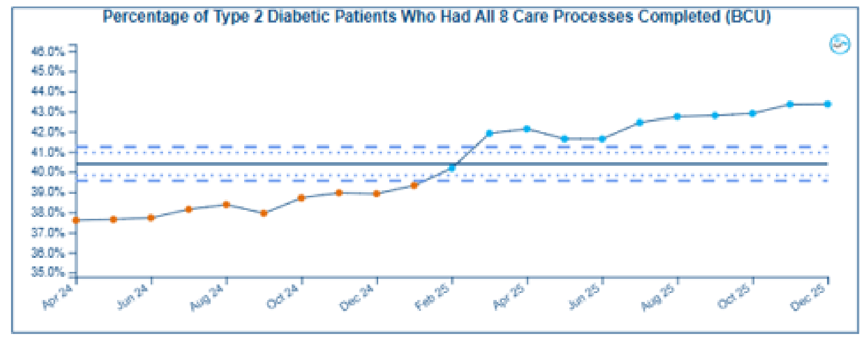
23.0%

All Wales Position

Produced by the Performance Team
Sources: DHCW Primary Care Portal and WG Organisation Performance Reports



Performance against this metric for type 2 diabetes specifically continues to improve and achieve the National target of 'improvement compared to the same month in the previous year'.



In December 2025, BCU ranked 7th of 7 Health Boards for performance against this metric, 3.2% lower than the Wales average.

Latest Month Available

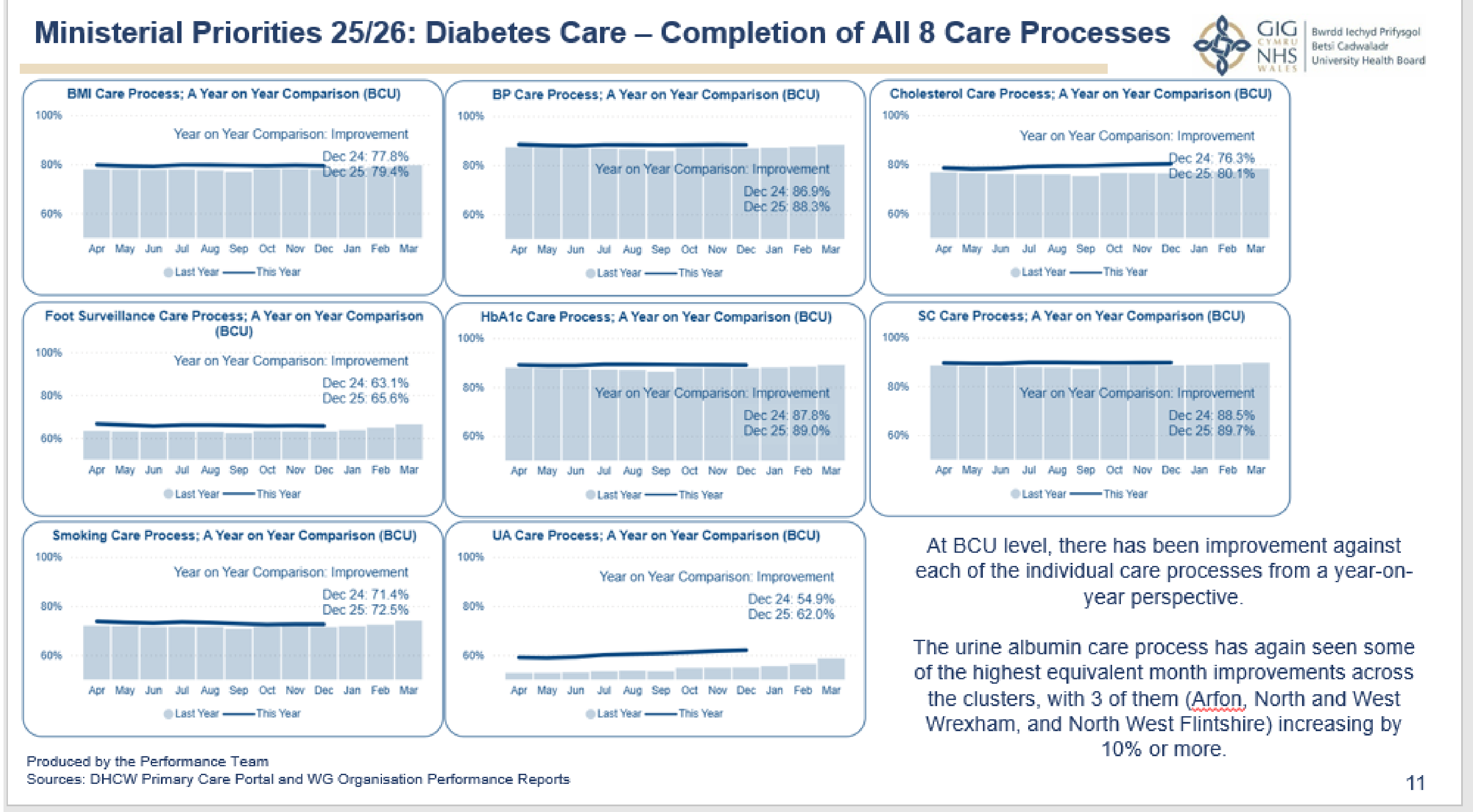
Dec 25

Rank	Board	Position
1	CTM	52.2%
2	Powys	50.8%
3	HDda	46.5%
4	C&V	46.2%
5	AB	46.1%
6	SB	45.5%
7	BCU	43.4%

46.6%

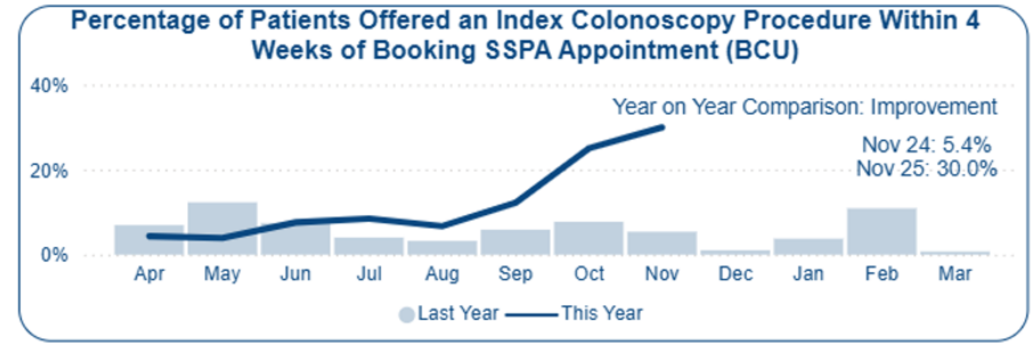
All Wales Position

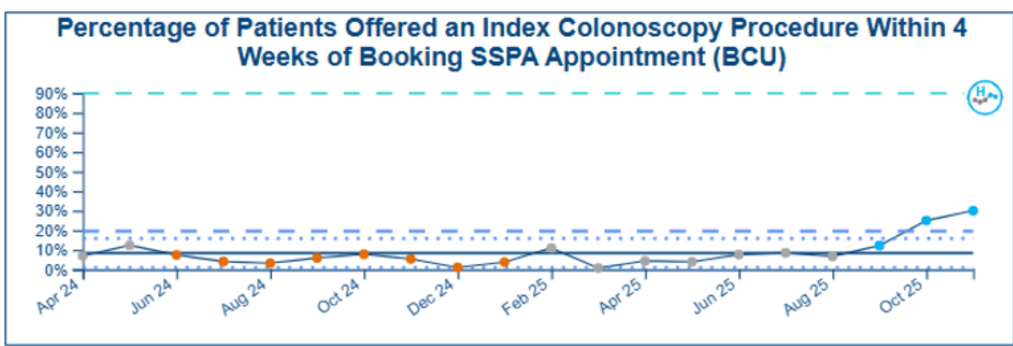
Produced by the Performance Team
Sources: DHCW Primary Care Portal and WG Organisation Performance Reports



Ministerial Priorities 25/26: Diabetes Care – Completion of All 8 Care Processes
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
BMI Care Process; A Year on Year Comparison (BCU)
Year on Year Comparison: Improvement
Dec 24: 77.8%
Dec 25: 79.4%
BP Care Process; A Year on Year Comparison (BCU)
Year on Year Comparison: Improvement
Dec 24: 86.9%
Dec 25: 88.3%
Cholesterol Care Process; A Year on Year Comparison (BCU)
Year on Year Comparison: Improvement
Dec 24: 76.3%
Dec 25: 80.1%
Foot Surveillance Care Process; A Year on Year Comparison (BCU)
Year on Year Comparison: Improvement
Dec 24: 63.1%
Dec 25: 65.6%
HbA1c Care Process; A Year on Year Comparison (BCU)
Year on Year Comparison: Improvement
Dec 24: 87.8%
Dec 25: 89.0%
SC Care Process; A Year on Year Comparison (BCU)
Year on Year Comparison: Improvement
Dec 24: 88.5%
Dec 25: 89.7%
Smoking Care Process; A Year on Year Comparison (BCU)
Year on Year Comparison: Improvement
Dec 24: 71.4%
Dec 25: 72.5%
UA Care Process; A Year on Year Comparison (BCU)
Year on Year Comparison: Improvement
Dec 24: 54.9%
Dec 25: 62.0%
100%
80%
60%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Last Year
This Year
At BCU level, there has been improvement against each of the individual care processes from a year-on-year perspective.
The urine albumin care process has again seen some of the highest equivalent month improvements across the clusters, with 3 of them (Arfon, North and West Wrexham, and North West Flintshire) increasing by 10% or more.
Produced by the Performance Team
Sources: DHCW Primary Care Portal and WG Organisation Performance Reports
11

Quadruple Aim 1: Screening - Colonoscopy





In November 2025, the BCU position against this metric was 30.0%. The position is 60.0% lower than the National target of 90%.

According to the WG Performance Papers, in October 2025 BCU ranked 2nd of 7 Health Boards for performance against this metric.

Latest Month Available

Oct 25

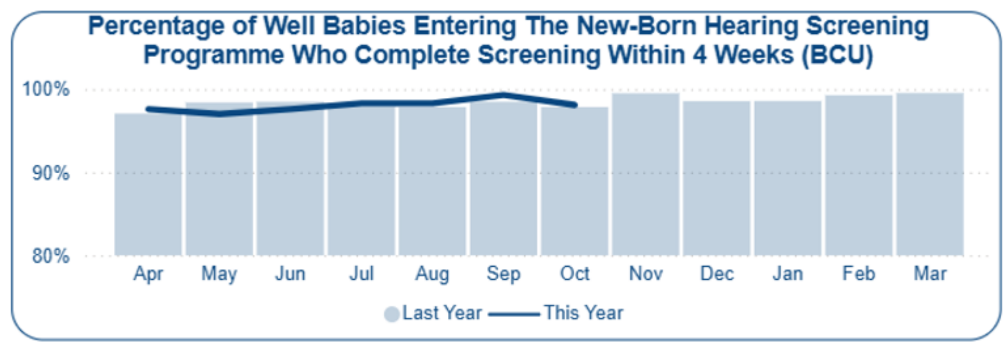
Rank	Board	Position
1	HDda	30.8%
2	BCU	25.0%
3	CTM	20.9%
4	C&V	8.3%
5	AB	6.8%
6	Powys	5.3%
7	SB	0.0%

19.7%

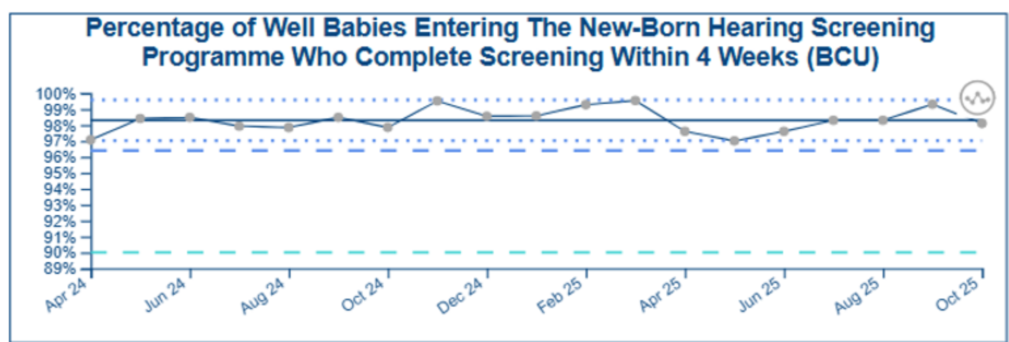
All Wales Position

Sources: LTA Monitoring Report (PHW) and WG Organisation Performance Reports

Quadruple Aim 1: Screening – Hearing Screening



In October 2025 the BCU position against this metric was 98.1%. The position is 8.1% higher than the National target of 90%.



In September 2025, BCU ranked 2nd of 7 Health Boards for performance against this metric, when rounded the same as the Health Board ranked 1st, and higher than the all Wales position.

Latest Month Available

Sep 25

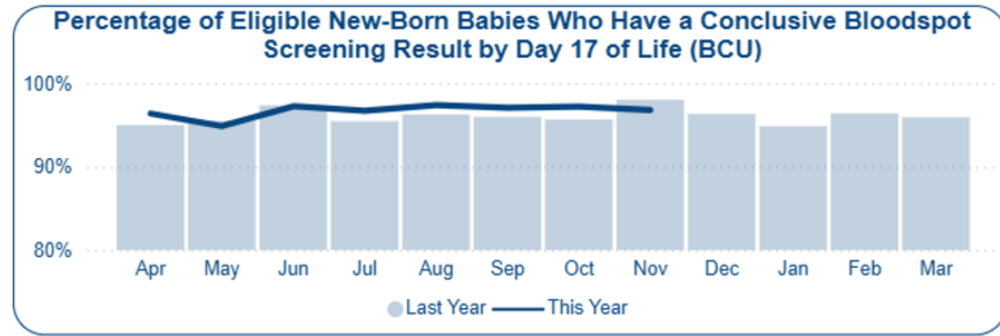
Rank	Board	Position
1	CTM	99.3%
2	BCU	99.3%
3	SB	99.2%
4	HDda	99.1%
5	Powys	98.9%
6	AB	98.1%
7	C&V	98.0%

98.8%

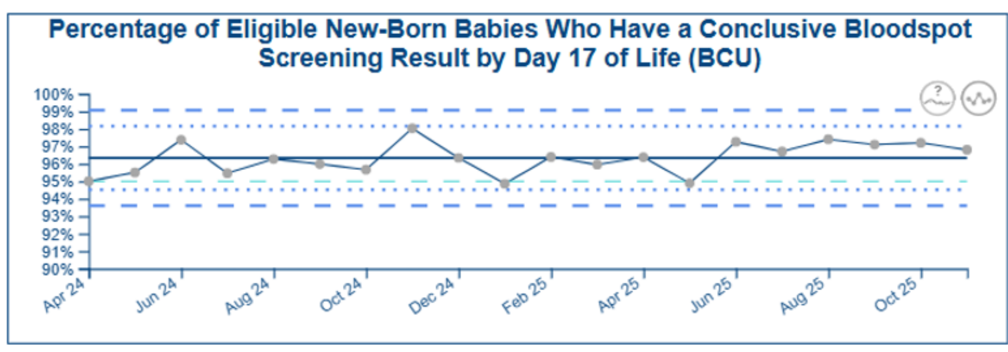
All Wales Position

Sources: LTA Monitoring Report (PHW) and WG Organisation Performance Reports

Quadruple Aim 1: Screening – Bloodspot Screening



In November 2025 the BCU position against this metric was 96.8%. The position is 1.8% higher than the National target of 95%.



In October 2025 BCU ranked 4th of 7 Health Boards for performance against this metric, 0.7% lower than the Health Board ranked 1st, and higher than the all Wales position.

Latest Month Available

Oct 25

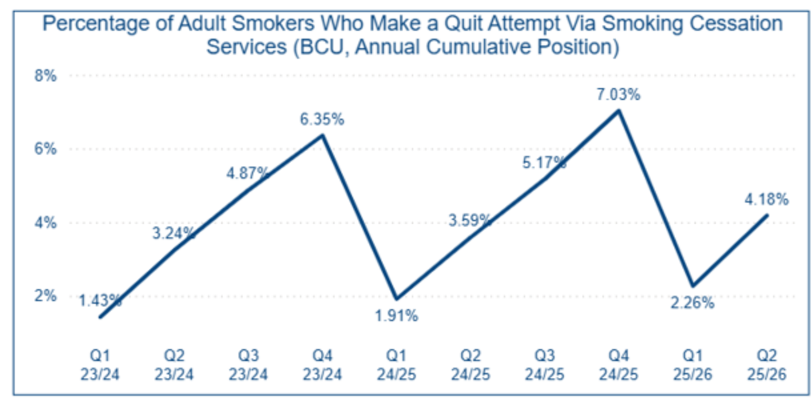
Rank	Board	Position
1	HDda	97.9%
2	Powys	97.8%
3	CTM	97.4%
4	BCU	97.2%
5	AB	97.1%
6	C&V	96.0%
7	SB	96.0%

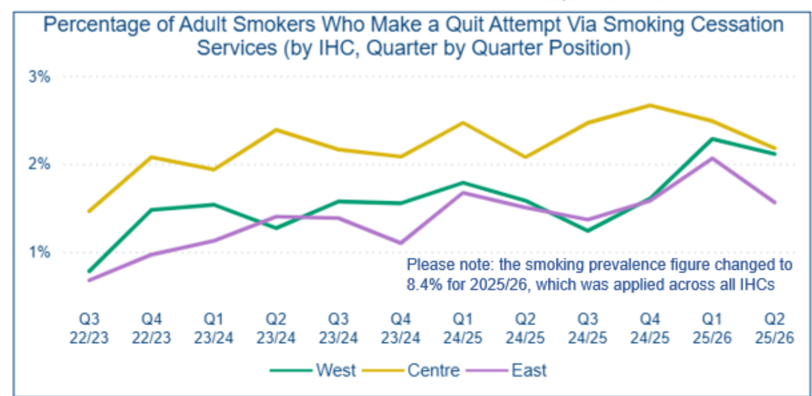
96.5%

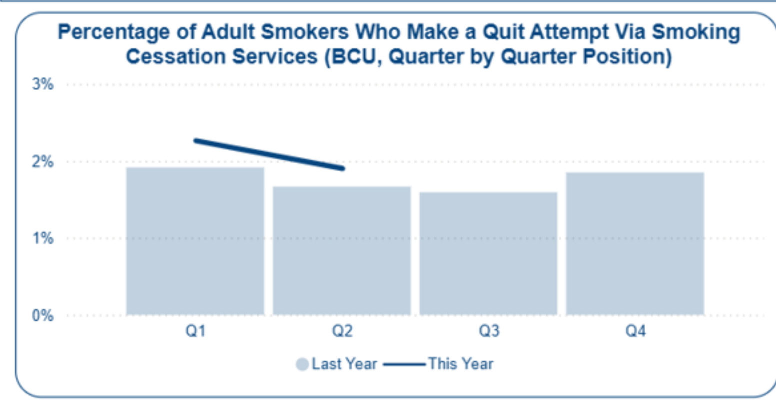
All Wales Position

Sources: LTA Monitoring Report (PHW) and WG Organisation Performance Reports

Quadruple Aim 1: Smoking Quit Attempts







At Quarter 2 2025/26 the BCU position against this metric was 4.18% (1.92% for Q2 alone).

Latest Data Available

Q2 25/26

Rank	Board	Position
1	HDda	5.77%
2	Powys	4.48%
3	BCU	4.16%
4	CTM	3.30%
5	SB	2.37%
6	AB	1.98%
7	C&V	1.63%

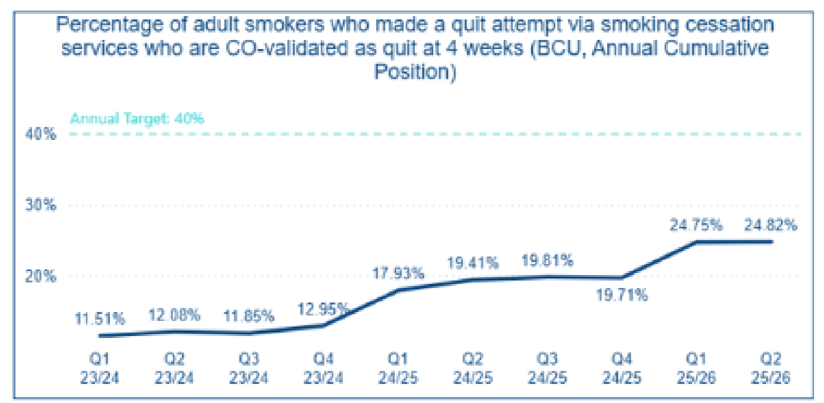
3.05%

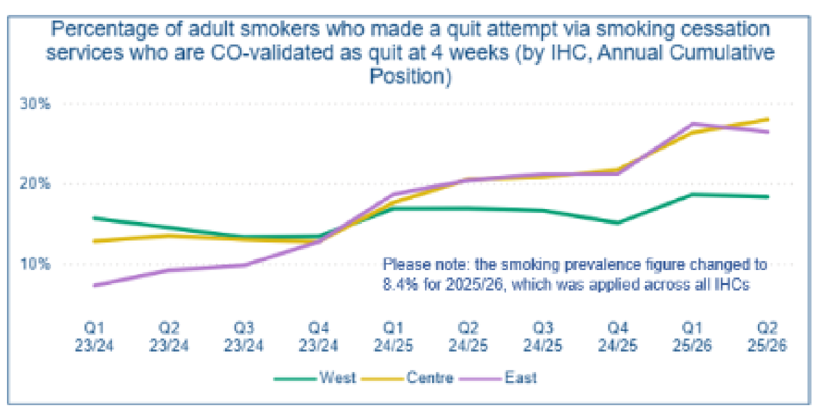
All Wales Position

According to the WG Performance Papers, at Q2 2025/26, BCU ranked 3rd of 7 Health Boards for performance against this metric. It was 1.6% lower than the Board ranked 1st, and above the all Wales average.

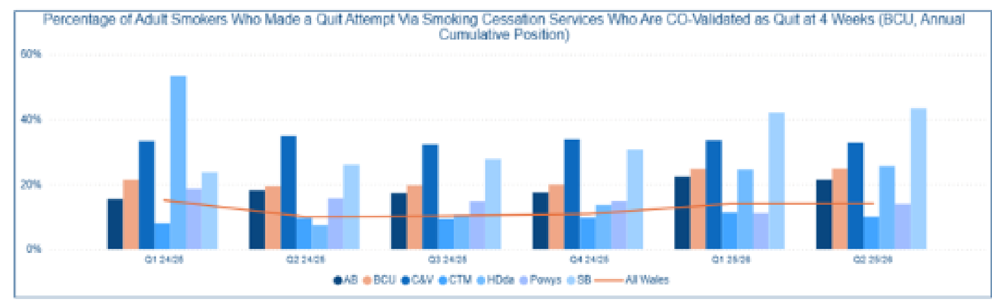
Sources: BCUHB Community Information Hub Tobacco Control Dashboard and WG Organisation Performance Reports

Quadruple Aim 1: Smoking (CO Validated)





At Quarter 2 2025/26 the BCU position against this metric was 24.82% (24.89% for Q2 alone).

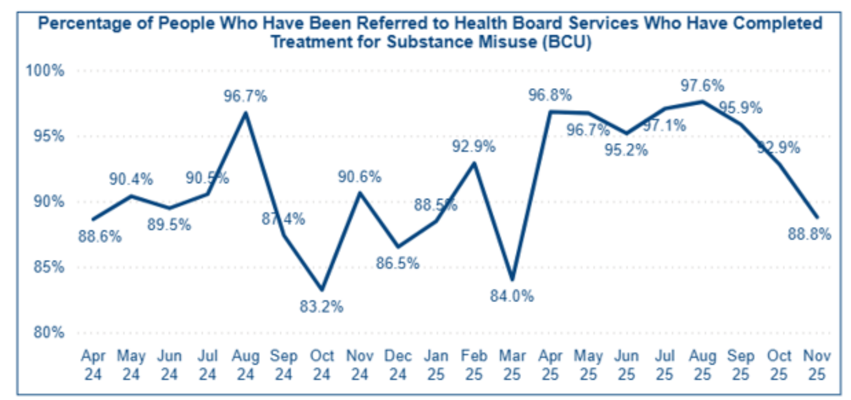


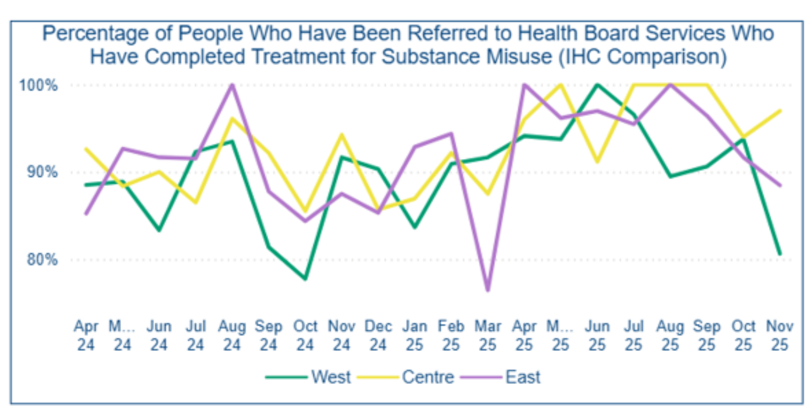
According to the WG Performance Papers, at *Q2 2025/26*, BCU ranked 4th of 7 Health Boards for performance against this metric. It was 18.5% lower than the Board ranked 1st, and above the all Wales average (of 23.4%).

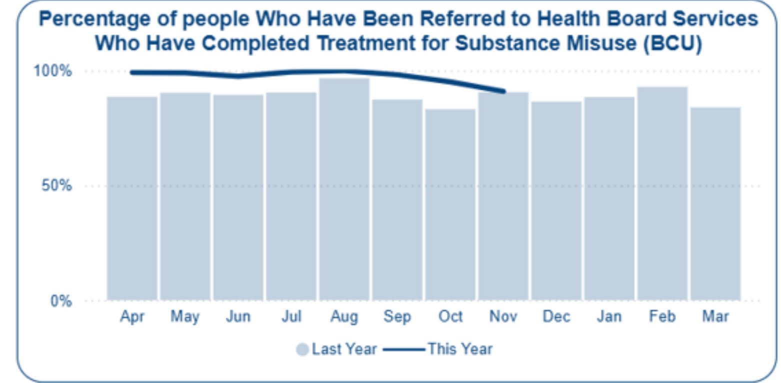
Sources: BCUHB Community Information Hub Tobacco Control Dashboard and WG Organisation Performance Reports

Quadruple Aim 1: Substance Misuse Treatment

Target: 4 quarter improvement trend







At November 2025/26 the BCU position against this metric was 88.8%.

Sources: BCUHB Community Information Hub Tobacco Control Dashboard and WG Organisation Performance Reports

2.3 Weight

Adult Level 2 Service

Capacity April 2025-March 2026 (maximum number of new spaces per annum)	Interventions	New patients started in Q1+Q2+Q3 (Cumulative YTD)	Maximum waiting time from referral to treatment 12/1/26	Number of patients waiting to access the service on 12/1/26
1,050[&] New patients	KindEating face-to-face or remote group programme, 12-week core programme with regular support for 12 months	920	30 weeks	873*
400 New patients (Procurement of additional 268 places via PEY grant)	Second Nature, procured digital service (app with coaching) 12 weeks with ongoing access to app.	279	12 weeks	

[&] Capacity could increase in year dependant on successful recruitment
*Not all of these patients will book on

Adult Level 3 (health board criteria restrictions apply)

Capacity April 2025-March 2026 (maximum number of new spaces per annum)	Interventions	New patients started in Q1+Q2+Q3 (Cumulative YTD)	Maximum waiting time from referral to assessment 15/1/26	Number of patients waiting to access the service on 15/1/26
120-200[@&] New patients (Including 45 new patients for medication assisted intervention for patients meeting health board criteria)[£]	Individualised multi-disciplinary weight management intervention according to assessed need. 12-24 months depending on pathway	167	57 weeks	233*
30[@&] New patients	Post-bariatric surgery follow-up Length of support according to need	24	15 weeks	4*

@Assessed to start treatment
[&] Capacity could increase in year dependant on successful recruitment
[£] Health board has no allocated recurrent funding to cover cost of medications.
*Not all of these patients will book on

Weight Management Services for Children & Young People Level 3

Capacity April 2025-March 2026 (the maximum number of new spaces for treatment)	Offers/services/interventions	Q1+Q2+Q3 (Cumulative YTD)	Maximum time from referral to treatment (for example 8 weeks) 15/1/26	Number of patients waiting to access the service 15/1/26
108 New patients* & **	Level 3 Multi-disciplinary weight management intervention including remote group and individual sessions according to assessed need. Health Board 12 months	94	15 weeks	41*

*Assessed to start treatment

** Capacity could increase in year dependant on successful recruitment

* Not all of these patients will book on

Overall summary of weight management service referrals 1 April 2024 – 31 March 2025 (annually reported by weight services)

Referrals	Type of referral		Deprivation decile				
6,153*	**Self-referral**	**Health professional**	**1 (Most deprived)**	**2**	**3**	**4**	**5 (Least deprived)**
	1,327	4,826	860 (14.1%)	1,274 (20.7%)	1,486 (24.1%)	1,439 (23.4%)	1,042 (16.9%)

*All referrals – some patients may have been referred more than once from different services and via self-referrals

Individual assessments – offered to patients with BMI over 45 or other complexities 1 April 2024 – 31 March 2025

	Booked to attend	
Referred	**In person**	**Telephone**
1,097	320	484

KindEating – In-house 12-week group based in person or online weight management intervention for participants with programmes starting 1 January 2024 – 31 December 2024

Offered KindEating	Attended	Completed intervention & data available	
2,168	1,066		466 (44%)
		Achieved ≥3-5% weight loss	123 (26.3%)
		Achieved ≥5% weight loss	133 (29.3%)

Second Nature – Commissioned App based weight management service for participants starting 1 January 2024 – 31 December 2024 (collated and provided by Second Nature)

Offered Second Nature	Engaged with the intervention	Completed intervention & data available	
1,343	439		107 (24%)
		Achieved ≥3-5% weight loss	24 (22.4%)
		Achieved ≥5% weight loss	53 (50%)

Planning, Population Health & Partnerships Committee

BCUHB HOMELESSNESS REDUCTION INSIGHTS WORK	
Dyddiad y Cyfarfod **Date of Meeting**	05 March 2026
Publication Status	Open/Public
	Draft Status - Final Version will be Published
Report Author name and title	Hannah Lloyd, Principal Public Health Practitioner Jennifer Dowell-Mulloy, Equality and Inclusion Manager
Lead Executive Team Member name and title	Dr Jane Moore, Exec Director of Public Health

Report Purpose	For Noting

Executive Summary

1 Background

North Wales continues to experience deep and persistent health inequalities, with people in the most deprived communities living shorter lives and spending more years in poor health. Inclusion Health Groups, such as people experiencing homelessness, Gypsy, Roma and Traveller communities, asylum seekers and refugees, sex workers, and people in the criminal justice system face the most extreme inequalities and place disproportionate demand on emergency and unplanned care. These patterns reflect longstanding structural and systemic barriers to accessing timely, appropriate healthcare.

The Well-being of Future Generations (Wales) Act (2015) and Ministerial priorities, requires Health Boards to take action to prevent poor outcomes, reduce inequity, and improve the lived experience of vulnerable groups. Welsh Government's forthcoming Ending Homelessness legislation will further introduce a statutory **Ask, Act and Cooperate** duty for all Health Boards, requiring earlier identification of housing risk, proactive prevention, and strengthened multi-agency collaboration.

To prepare for these changes and to inform a more comprehensive Inclusion Health offer for the Health Board, the Public Health Directorate has obtained insights through Health Needs Assessments and evidence reviews across key Inclusion Health Groups. These groups experience poorer access to our services and poorer health outcomes. Their insights reveal outstanding health needs, key

barriers in accessing our services, and based on this we propose evidence-based recommendations to overcome these.

Of particular urgency is the statutory Ask, Act and Cooperate duty on Health Boards under the forthcoming Ending Homelessness legislation (within the Homelessness and Social Housing Allocation (Wales) Bill expected Spring 2026). To inform our Health Board's response to this legislation, the BCUHB Public Health Directorate has collaborated with partners through **Homelessness Insights Work**, involving Local Authorities, BCUHB staff, people with lived experience, and conducted analysis of clinically optimised bed days.

The Homelessness Insights Work builds on the valuable efforts made to date within the Mental Health and Learning Disabilities Directorate to establish housing pathways. Their efforts have created a strong foundation for the Health Board to build upon.

The insights work has been recognised nationally by Welsh Government for the proactive approach in preparing for legislative change. **This paper presents key findings from the work and highlights required next steps.**

2 Key Findings

The Homelessness Insights work highlights significant system barriers, including inconsistent referral pathways, limited data recording, gaps in staff confidence, and delays in discharge caused by fragmented communication. Between March 2023 and March 2025, 50 clinically optimised patients with homelessness recorded generated **£1,077,852.87** in additional bed-day costs, demonstrating the case and need for earlier intervention and coordinated pathways.

Key recommendations generated from the Homelessness Insights Work:

- Develop and deliver comprehensive training for staff across health and housing services.
- Strengthen multi-agency pathways and discharge planning processes.
- Establish central referral points and clearer communication channels.
- Roll out the "Making Every Contact Count" (MECC) initiative to housing/homelessness service and frontline staff in local authorities.
- Continue to engage with people with lived experience to inform service design.
- Develop a regional screening and admissions tool to identify patients at risk of homelessness.
- Explore establishment of Hospital Link Worker roles to strengthen communication and improve patient flow.
- Enhance collaboration with Primary Care clusters, Registered Social Landlords and Third Sector to embed prevention and upstream approaches.

3 Next Steps:

The findings highlight that a system-wide, prevention-focused approach is essential to meet statutory duties, reduce avoidable harm, and improve outcomes for people belonging to inclusion health groups, including those at risk of or experiencing homelessness. This paper sets out the next steps required to ensure organisational readiness for the changes in legislation for those experiencing homelessness, and lays the foundation for a more comprehensive **Inclusion Health Offer** for the Health Board.

This work has been considered and endorsed by the BCUHB Prevention, Population Health and Early Intervention Delivery Group and Executive Committee.

PPHP Committee is asked to:

- Note legislative, policy and strategic requirements to reducing health inequalities
- Note upcoming duty on Health Boards as part of Ending Homelessness Legislation
- Consider the findings from the Homeless Insights work and support plans to progress an Inclusion Health Offer for the Health Board, to be presented to the Executive Committee at a future date.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome, Evidence and Data**
BCUHB Homeless Reduction Implementation Group	07/03/2025 07/07/2025 27/11/2025	Stakeholder engagement, survey development, present findings, and recommendations.
Regional Housing Support Grant Lead Officers Group	19/09/2024	Stakeholder engagement
Local Authority Homelessness/Housing Teams	Jan – July 2025	Stakeholder engagement (outcomes reported in exec summary and final report)
Welsh Government, Beverly Luchmun (Head of Homelessness Prevention)	08/03/2025 07/07/2025	Stakeholder engagement and present national and regional work
BCUHB staff	September 2025	Stakeholder engagement (outcomes reported in exec summary and final report)
People with lived experience	October 2025	Stakeholder engagement (outcomes reported in exec summary and final report)

Prevention, Population Health and Early Intervention Delivery Group (PDG)	January 2026	Endorsed and support received to take to Executive Committee to enable work to progress
BCUHB Executive Committee	February 2026	Endorsed and support received to understand further the impact of and delivery requirements for the Health Board in light of the new legislation

Acronyms / Glossary of Terms	

BCUHB Homelessness Reduction Insights Work

1. Situation:

1.1 The Well-being of Future Generations (Wales) Act (2015) requires public bodies to work towards a "more equal Wales" and a "healthier Wales," by placing a statutory duty on organisations to prevent poor outcomes and collaborate across systems.

1.2 Despite this, people living in the poorest areas of North Wales continue to live longer in poor health and die earlier compared to those living in the wealthiest areas.

1.3 Inclusion Health Groups, defined as populations that experience 'extreme health inequalities' caused by multiple and overlapping social disadvantages are significantly more likely to die earlier and live more years in poor health compared to low-socioeconomic groups and the general population. Inclusion health groups include:

- People at risk of, or experiencing homelessness,
- Gypsy, Roma, and Traveller Communities,
- Asylum Seekers and Refugees,
- Sex Workers and
- People in the criminal justice system

1.4 Inclusion health groups place increased demand and cost on health care services due to their higher utilisation of emergency and unplanned care and higher rates of complex health needs, requiring greater input from specialist health and social care services. Inclusion health groups are least likely to engage in prevention and early intervention services placing them at a greater risk of avoidable ill health.

1.5 The reasons for poorer engagement are complex. Evidence shows that inclusion health groups are significantly more likely to experience structural, social, and systematic barriers to accessing timely and appropriate health care compared to the general population.

1.6 On the 25th of March 2025, Judith Paget, Director General Health, Social Care & Early Years Group / NHS Wales Chief Executive wrote to all Health Boards in Wales outlining expectations on how organisations should reduce inequity and improve the lived experience of vulnerable groups. Within the letter, NHS organisations are expected to develop plans demonstrating - *developing Inclusion Health Services to meet the needs of vulnerable groups.*

1.7 Details outlined in the NHS Wales Chief Executive's letter on the NHS Wales Planning Framework 2026-29 highlights the need for a reduction of inequalities within and across communities to underpin NHS planning.

1.8 To support the Health Board to achieve these statutory duties, the BCUHB Public Health Directorate has led the collation of insights through Health Needs Assessments and Scoping Reviews across key Inclusion health groups including:

- Gypsy, Roma and Traveller Health Needs Assessment
- Approved Premises Health and Social Care Needs Assessment
- Sex Worker Evidence Review,
- Asylum Seeker and Refugee Health Needs Assessment, and,
- Homelessness Insights Work

The aim of the insights work has been to understand the health needs and lived experiences of inclusion health groups when accessing Health Board services, and inform evidenced-based recommendations to improve access, outcomes, and overall experience of our services.

1.9 The purpose of this paper is to present the findings and recommendations specifically from the **Homelessness Insights Work** undertaken across North Wales, to prepare the Health Board for the forthcoming **Ending Homelessness legislation** and the introduction of the statutory **Ask, Act and Cooperate duty**. The paper also highlights the need for a more comprehensive Inclusion Health offer within the Health Board, to ensure statutory duties are effectively met.

2. Background

2.1 Welsh Government's forthcoming Ending Homelessness legislation will introduce a statutory **Ask, Act and Cooperate** duty for all Health Boards. This duty requires secondary care staff to identify patients at risk of homelessness, take appropriate preventative action, and work collaboratively with partners to prevent and relieve homelessness.

2.2 This legislative change aligns with the Well-being of Future Generations (Wales) Act, particularly the goals of A More Equal Wales, A Healthier Wales, and A Wales of Cohesive Communities. It also supports the Welsh Government ministerial requirement for Health Boards to develop an Inclusion Health Offer.

2.4 Homelessness is associated with significantly poorer health outcomes, premature mortality, and disproportionate use of NHS services. North Wales continues to experience high levels of homelessness, including hidden homelessness and sustained reliance on temporary accommodation.

2.5 An overview of the health status of people with lived experience of homelessness, published by Public Health Wales in 2019 shows that people experiencing homelessness are:

- 14 times more likely to die from suicide
- 20 times more likely to die due to drug use
- 55% more likely to be living with HIV
- 3 times more likely to have a chronic disease and additionally

In addition,

- 80% of people experiencing homelessness have poor mental health and;
- the mean age of death for males experiencing homelessness is 45 years, while for females, is 43 years.

2.6 During September 2025, 2,539 people in North Wales were living in temporary accommodation including B&B's, hostels, provide sector, and women's refuge.

2.7 To prepare for the forthcoming legislation, BCUHB has undertaken extensive Homelessness Reduction Insights work across North Wales, involving Local Authorities, BCUHB staff, people with lived experience, and including analysis of clinically optimised bed days.

2.8 The work aimed to understand current practice, system barriers, and opportunities to strengthen the Health Board's response to homelessness and wider inclusion health needs. Key components included:

- **Partnership review** with all six Local Authority Housing Teams
- **Staff insights** through a structured survey on knowledge, confidence, and referral processes
- **Lived experience engagement** to understand barriers to care and discharge
- **Data analysis** of delayed discharges linked to homelessness, including associated costs

2.9 The insights work identified:

- **Discharge delays**: Poor communication between health, housing, and social care contributes to delays and poorer outcomes.
- **High cost:** Between March 2023 and March 2025, 50 clinically optimised patients with homelessness recorded generated **£1,077,852.87** in additional bed-day costs - demonstrating the need for earlier intervention and coordinated pathways.
- **Training and awareness gaps**: Staff report low confidence and limited understanding of homelessness risk and forthcoming duties.
- **Data recording**: Housing status is not routinely captured, limiting prevention and early intervention.
- **Referral pathways**: Processes differ across services, creating inequity and inefficiency.

- **Limited lived experience engagement**: Limited engagement to date demonstrates people who have experienced homelessness have a complexity of health needs and require ongoing engagement to adequately meet these needs.

2.10 The findings highlight the need for a **coordinated, system-wide Inclusion Health approach** to meet statutory duties, reduce inequalities, and prevent avoidable harm and cost.

3. Specific Matters for Escalation

PPHP Committee is asked to consider the key recommendations outlined below, which form the foundation for a wider and more comprehensive Inclusion Health offer for the Health Board:

- Develop and deliver comprehensive training for staff across health and housing services.
- Strengthen multi-agency pathways and discharge planning processes.
- Establish central referral points and clearer communication channels.
- Roll out the "Making Every Contact Count" (MECC) initiative to housing/homelessness service and frontline staff in local authorities.
- Continue to engage with people with lived experience to inform service design.
- Develop a regional screening and admissions tool to identify patients at risk of homelessness.
- Explore establishment of Hospital Link Worker roles to strengthen communication and improve patient flow.
- Enhance collaboration with Primary Care clusters, Registered Social Landlords and Third Sector to embed prevention and upstream approaches.

These actions will support compliance with legislation, reduce health inequalities, and contribute to a sustainable, prevention-focused Inclusion Health Offer.

Key Risks / Matters for Escalation

Risk	Impact	Mitigation
Insufficient staff awareness or training	Noncompliance with statutory duties; inconsistent practice; patient harm	Mandatory training; induction prompts; integration into clinical governance
Lack of clear referral pathways	Delayed support; increased length of stay; higher costs; poorer outcomes	Co-designed pathways; central referral point; strengthened MDT processes

Inconsistent data recording and information sharing	Inability to evidence compliance; fragmented care; missed prevention opportunities	Standardised data fields; digital system updates; information-sharing agreements
Capacity pressures across health and housing	Bottlenecks; reduced ability to respond to referrals	Joint planning; phased implementation; exploration of liaison roles
Limited engagement with lived experience	Services not meeting needs; risk of unintended harm	Ongoing engagement mechanisms; trauma-informed approaches
Financial pressures linked to clinically optimised bed days	Continued high cost; inefficiencies in patient flow	Early identification; improved discharge planning; strengthened community pathways

5. Recommendations

PPHP Committee is asked to:

- Note legislative, policy and strategic requirements to reducing health inequalities
- Note upcoming duty on Health Boards as part of Ending Homelessness Legislation
- Consider the findings from the Homeless Insights work and support plans to progress an Inclusion Health Offer for the Health Board, to be presented to Executive Committee at a future date.

Assessment	
Link to Strategic Priorities	
	4. Improving quality, outocmes and experience
	If more than one applies, please list below: • Building an effective organisation • Developing strategy and long lasting change • Creating a compassionate culture, leadership, and engagement • Establishing an effective environment for learning
Design Principles	Equity and Accessibility If more than one applies, please list below:

	• People first • Inclusive design • Simplify, standardise and Adopt Best Practices
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)
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	If more than one applies, please list below: A Resilient Wales A More Equal Wales

IMPACT ASSESSMENTS		
Equality *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Yes: ☒	No: ☐
	Outcome:	No actions identified.
	If no, please include rationale:	*The recommendations will have a positive impact on people who share protected characteristics.*
Socio-Economic Impact Assessment *Have you undertaken a Socio-Economic Impact Assessment*	Yes: ☒	No: ☐
	Outcome:	No actions identified
	If no, please include rationale:	*The recommendations will have a positive impact on people who experience socio economic disadvantage.*
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:	
	Choose an item.	

<table>
<tr><td></td><td>If more than one applies, please list:</td><td></td></tr>
<tr><td rowspan="3">Armed Forces Covenant Due Regard Duty
Have you considered the Armed Forces Covenant Due Regard Duty?</td><td>Yes: ☒</td><td>No: ☐</td></tr>
<tr><td>Outcome: embedded within the Equality Impact Assessment.</td><td>Veterans are identified as a group who are at higher risk of homelessness.</td></tr>
<tr><td>If no, please include rationale:</td><td>No actions identified</td></tr>
<tr><td rowspan="3">Data Protection Impact Assessment
Have you undertaken a Data Protection Impact Assessment Screening?</td><td>Yes: ☐</td><td>No: ☒</td></tr>
<tr><td>Outcome:</td><td></td></tr>
<tr><td>If no, please include rationale:</td><td></td></tr>
<tr><td rowspan="3">Counter Fraud Impact Assessment
Have you considered the counter fraud impacts</td><td>Yes: ☐</td><td>No: ☒</td></tr>
<tr><td>Outcome:</td><td></td></tr>
<tr><td>If no, please include rationale:</td><td></td></tr>
<tr><td rowspan="2">Legal</td><td colspan="2">Yes (Include further detail below)</td></tr>
<tr><td colspan="2">Once the Bill is passed, Health Boards in Wales will have a statutory duty to Ask, Act and Cooperate. This work aims to prepare BCUHB for the forthcoming legislation.</td></tr>
<tr><td rowspan="2">Reputational</td><td colspan="2">Yes (Include further detail below)</td></tr>
<tr><td colspan="2">The insights work positions BCUHB as an early adopter of the forthcoming legislation which has been recognised by Welsh Government.
This work will enable BCUHB to strengthen its relationship with Local Authority partners through the codesign of pathways, assessment tool, training and strengthening of existing MDT partnership groups.</td></tr>
<tr><td rowspan="2">Resource Impact
(People / Financial)</td><td colspan="2">Yes (Include further detail below)</td></tr>
<tr><td colspan="2">Workforce and training:
• Development and rollout of a mandatory training programme for frontline staff.
• Time and capacity for staff to undertake training and embed new practices.
• Potential need for Homelessness Link workers to support complex cases and MDT</td></tr>
</table>

	coordination (explore possible joint funding with Local Authorities via Housing Support Grant) Operational/Process Requirements: • Development, testing and implementation of regional assessment screening tool and referral pathways. • Improved information sharing mechanisms with Local Authority and Third Sector Organisations to improve coordination of care (MDTs/case notes) • Data collection on housing status, referrals and outcomes Financial Impacts: • Costs associated with training, system changes, and potential new roles. • Potential cost savings from reduced clinically optimised bed days and improved patient flow. • Opportunity to align with existing funding streams (e.g. Housing Support Grant).

Homelessness Reduction Insights work:

Preparing BCUHB for the new Ask, Act and Co-operate duty

January 2026

Authors:

Hannah C Lloyd: BCUHB Public Health Directorate

Jen Dowell-Mulloy: BCUHB Equalities Team

1. Executive Summary

1.1 Aims and Purpose of the Report

To present key findings and recommendations from the Homelessness Reduction Insights work across North Wales and seek support and endorsement for implementing the recommendations in readiness for the forthcoming statutory 'Ask, Act and Cooperate' duty under the Ending Homelessness legislation.

1.2 Background

The Welsh Government white paper *Ending Homelessness in Wales*[1] was published in 2024 with proposed reforms to existing policy and legislation in Wales. The Homelessness and Social Housing Allocation (Wales) Bill is expected to be introduced in Spring 2026. The Ending Homelessness Legislation aims to significantly change the structural barriers faced by homeless people and those at risk of homelessness. The proposed changes will place a statutory duty on all Health Boards in Wales for secondary care services to 'Ask, Act and Cooperate' to prevent homelessness.

The Public Health Directorate has been working closely with Directorates, Local Authorities and Third Sector through a Homelessness Reduction Implementation Group to prepare the Health Board for Welsh Government's statutory duty to "Ask, Act and Cooperate" within the forthcoming Ending Homelessness Legislation. The duty will require secondary health care staff within Health Boards to:

- **ask** patients about their housing situation,
- **act** appropriately by referring them to homelessness support services, and
- **cooperate** with partner organisations and patients to prevent and relieve homelessness.

This report presents the findings and recommendations of the insights work coordinated by the North Wales Homelessness Reduction Implementation Group in readiness of the legislation. The group has been recognised nationally by Welsh Government for its proactive approach in preparing for legislative change.

1.3 Tasks

The tasks related to the insights work have included:

- **Partnership review:** Engagement with six local authority Housing Teams across North Wales to examine current collaboration with BCUHB health services and identify opportunities to strengthen joint working.
- **Staff insights:** A structured survey with BCUHB staff to explore knowledge, confidence, and practice in relation to homelessness, as well as training needs and referral processes.
- **Lived experience engagement:** Semi-structured interviews with individuals who have experienced homelessness to capture their perspectives on barriers

[1] White Paper on ending homelessness in Wales | GOV.WALES

to accessing health services and challenges within hospital discharge pathways.

- **Data analysis:** Examination of delayed discharge cases where homelessness was recorded as a factor, including associated costs and clinically optimised bed days.

1.4 Key findings:

- **Training and education gaps:** BCUHB staff reported limited awareness of forthcoming legislation and low confidence in addressing homelessness risk, highlighting the need for comprehensive training and resources.
- **Data recording:** Housing status is not routinely recorded within secondary care
- **Referral pathways:** Referral pathways into homelessness support services are inconsistent across teams.
- **Discharge delays:** Communication between health, housing, and social care services is often fragmented, particularly around hospital discharge planning, leading to discharge delays and poorer health outcomes.
- **Limited lived experience input:** Limited engagement to date demonstrates people who have experienced homelessness have a complexity of health needs and require ongoing engagement to adequately meet these needs.
- **High costs:** between March 2023 and March 2025 for **50 unique** clinically optimised patients where homeless was recorded, totalled a cost of **£1,077,852.87.**

1.5 Recommendations:

- Develop and deliver comprehensive training for staff across health and housing services.
- Strengthen multi-agency pathways and discharge planning processes.
- Establish central referral points and clearer communication channels.
- Roll out the “Making Every Contact Count” (MECC) initiative to housing/homelessness and frontline staff in local authorities.
- Continue to engage with people with lived experience to inform service design.
- Develop a regional screening and admissions tool to identify patients at risk of homelessness.
- Explore establishment of Hospital Link Worker roles to strengthen communication and improve patient flow.
- Enhance collaboration with Primary Care clusters, Registered Social Landlords and Third Sector to embed prevention and upstream approaches.

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Acknowledgements:

The Homelessness Reduction Implementation Group would like to express its sincere thanks to everyone who contributed towards the development of this report.

We would like to acknowledge the valuable input and commitment from colleagues across BCUHB, Local Authorities, and Third Sector organisations including Shelter Cymru, whose expertise and collaborative working have been essential to shaping findings and recommendations set out in the report.

We are also grateful to patients and people with lived experience who shared their insights with us. Their contributions have been central to ensuring the report provides a person-centred perspective.

1.Introduction

The Welsh Government white paper *Ending Homelessness in Wales*[2] was published in 2024 with proposed reforms to existing policy and legislation in Wales. The Homelessness and Social Housing Allocation (Wales) Bill is expected to be introduced in Spring 2026. This bill aims to transform the homelessness system in Wales, focusing on prevention and providing more tools to support people into longer term homes. It will bring public services together to respond to the varied causes and consequences of homelessness, targeting action at those most at risk.

The proposed changes will place a statutory duty on all Health Boards in Wales for secondary care services to 'Ask, Act and Cooperate' to prevent homelessness. This means staff will be required to *ask* people using health services about their housing situation, *act* by referring them to homelessness support services to avoid them becoming homeless wherever possible and actively *cooperate* with partners and patients to prevent and relieve homelessness. The forthcoming implementation of the Ask, Act and Cooperate duties within Wales's Ending Homelessness Legislation represents a significant shift for health services, placing new expectations on Health Boards to identify, respond to, and help prevent homelessness.

In preparation for the duty, a Homelessness Reduction Implementation Group was established in late 2024 which currently has representation from BCUHB Public Health Directorate, Equalities Team, Mental Health, Substance Misuse Services, Community Dental, Primary Care, Patient Experience, local authority, and Third Sector representation. The membership of the group has grown momentum and has received national recognition from Welsh Government for the pro-active and forward-thinking approach that BCUHB and partners are taking in preparation for the forthcoming legislation.

A key focus of the group has been to understand the opportunities, challenges, and practical implications of the duty across BCUHB and local authority partners. The group has also sought to capture the views of people with lived experience to identify how they can be better supported to access timely information and support and reduce stigma.

To achieve this, the following tasks were undertaken (figure 1):

- **Partnership review:** Engagement with six local authority Housing Teams/Homelessness Teams across North Wales to assess current collaboration and identify opportunities for strengthening joint working.
- **Staff insight:** Consultation with BCUHB staff to explore levels of knowledge around homelessness and ways to improve referral pathways into services.
- **Lived experience:** Engagement with people who have experienced homelessness to understand barriers and challenges in accessing health services.
- **Data analysis:** Examination of delayed discharge cases where homelessness was a factor, including associated costs.

[2] White Paper on ending homelessness in Wales | GOV.WALES

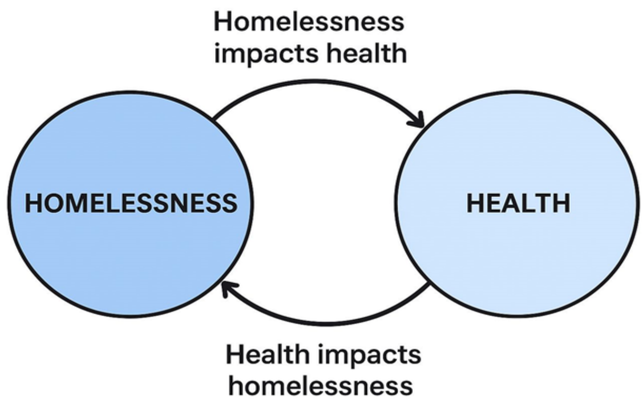
Figure 1. Insights approach:

This paper presents the findings and recommendations arising from these activities to guide future action on homelessness reduction across BCUHB.

2. Background

The relationship between homelessness and health is well-documented. Individuals at risk of, or experiencing, homelessness often face poorer health outcomes, require more frequent use of NHS services, and have an increased risk of early death compared to the general population[3]. Poor health can also contribute to homelessness, with barriers to accessing services, stigma and discrimination, and ineffective communication between health and social care all playing a role[4]. Figure 2 demonstrates the interconnectedness and cyclical nature between homelessness and health.

Figure 2. Relationship between housing and health.



[3] The Relationship Between Poverty And NHS Services | The King's Fund
[4] phw.nhs.wales/files/aces/voices-of-those-with-lived-experiences-of-homelessness-and-adversity-in-wales-informing-prevention-and-response-2019/

Traditionally, homelessness is associated with people sleeping rough on the streets. However, homelessness is a complex issue with differing definitions and understandings. A person can be classed as being homeless or at risk of being homeless in the following circumstances:

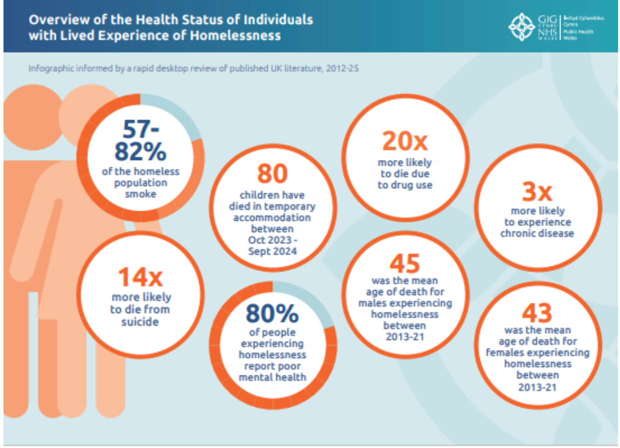
- Temporarily staying with friends or family (also known as sofa surfing)
- Staying in a hostel or bed and breakfast,
- Living in very overcrowded conditions
- At risk of violence or abuse in their home
- Living in poor conditions that affect your health, or your home is unfit to live in
- Living somewhere 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 their family, or someone they would normally live with, because your accommodation isn't suitable or a relationship breakdown.

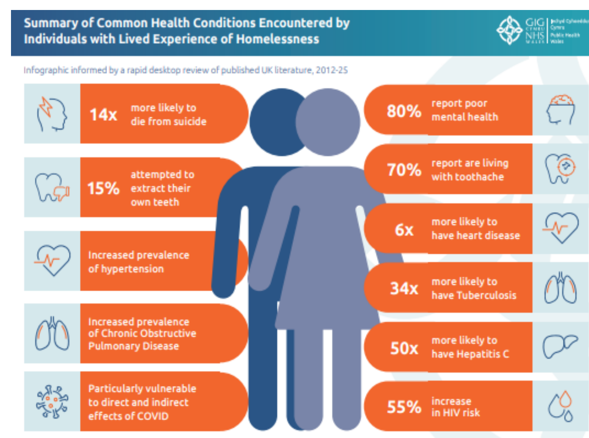
An overview of the health status of people with lived experience of homelessness, published by Public Health Wales in 2019[5] (figure 3 and 4), shows that people experiencing homelessness are:

- 14 times more likely to die from suicide
- 20 times more likely to die due to drug use
- 55 percent more likely to be living with HIV
- 3 times more likely to have a chronic disease and additionally
- 80 percent of people experiencing homelessness have poor mental health and;
- the mean age of death for males experiencing homelessness is 45 years, while for females, is 43 years.

The data provides a strong evidence base highlighting the need for a system wide approach to addressing the root causes of homelessness.

Figure 3 and 4: Rapid desktop review of the literature of the common health conditions encountered by people with lived experience of homelessness (Public Health Wales, 2025)[6].





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Homelessness in North Wales:

Evidence indicates that homelessness is a significant issue across North Wales, impacting on every local authority area. The numbers sleeping rough are relatively low but has significant damaging health impacts. There are significant numbers of people living in temporary accommodation and people threatened with homelessness who present to their local authority (under section 66 of the Housing Act 2014). The following Welsh Government Homelessness data[7] shows:

- The number of people **sleeping rough** in North Wales on the last day of the month in August 2025, identified **23** rough sleepers across the region.
- In September 2025, the total number of homelessness individuals **housed in temporary accommodation** including B&B's, hostels, Registered Social Landlords (RSL's), private sector accommodation, caravans and Womens Refuges across North Wales was **2539** (see chart 1). This figure increased by 42 compared to September 2024. The highest numbers were recorded in Conwy with 603 individuals. A full breakdown of the figures by accommodation type for each local authority can be found in appendix 1.
- In September 2025, the total number of households **threatened with homelessness** was **1149**, with highest rates per 10,000 households in Flintshire and Conwy[8].
- Alongside the homelessness data, **340,000 households** in Wales were estimated to be living in **fuel poverty**, equivalent to 25% of households.
- Additionally, **63,000 households** were estimated to be living in **severe fuel poverty**, equivalent to 5% of households[9].
- Around 30% of 'Excess Winter Deaths' are attributed to living in a cold home 10. Welsh Government state that 11% of households in Wales experience fuel poverty 11.

[7] Homelessness accommodation provision and rough sleeping: August 2025 [HTML] | GOV.WALES
[8] stats.housing@gov.wales
[9] Fuel poverty modelled estimates for Wales (headline results): as at October 2024 [HTML] | GOV.WALES
[10] Fuel Poverty in Wales - National Energy Action (NEA)
[11] Tackling fuel poverty 2021 to 2035 [HTML] | GOV.WALES

Chart 1: Total number of individuals housed in temporary accommodation per local authority area

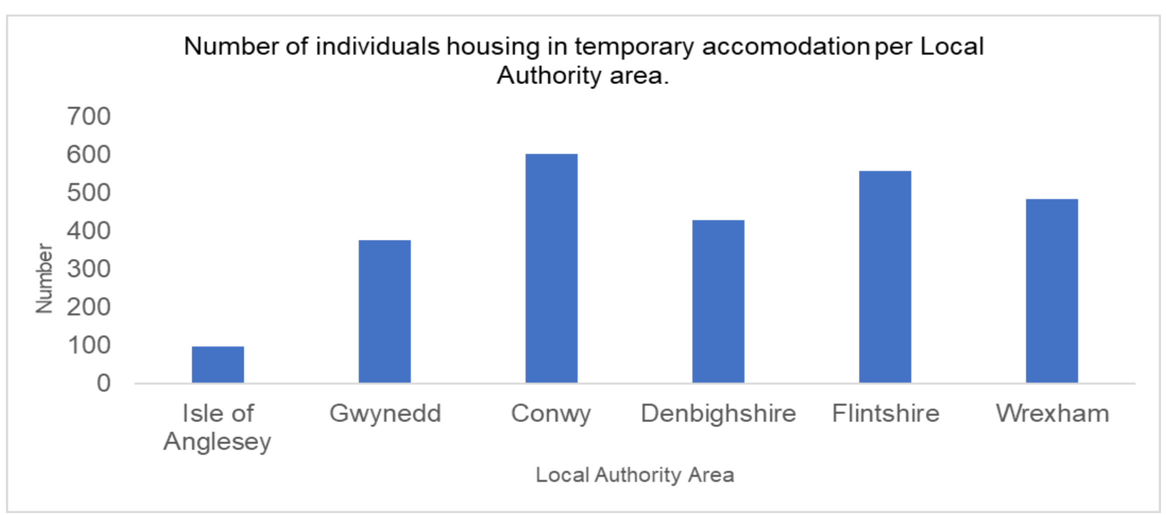
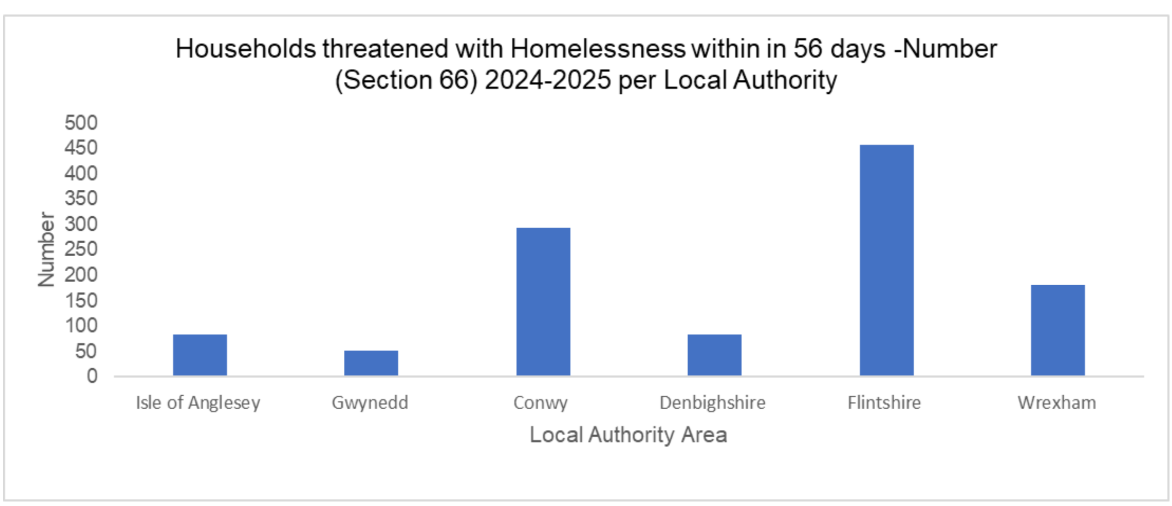


Chart 2: The total number of households threatened with homelessness (section 66)



Within North Wales, early intervention and prevention are embedded into local authority homelessness strategies[12].

[12] Housing Support Programme Strategy 2022-2026

3. Method

This section describes approaches taken for engagement and hospital discharge data analysis.

3.1 Partnership review

To understand the challenges and opportunities experienced by local authority Homelessness Teams in working with BCUHB, a mixed methods engagement approach was taken between April and October 2025.

An engagement meeting was held between members of BCUHB Homelessness Reduction Implementation Group and Housing and Homelessness Prevention Teams in each of the local authority areas across North Wales. The purpose of these meetings was to introduce the aims of the insights work, establish relationships with local teams and create an open forum for discussion. During the meetings, local authority team members were invited to share their reflections on current partnership working, perceived barriers and identify ways to improve working relationships with BCUHB.

Following the meetings, an electronic survey with 17 questions (appendix 2) containing a mixture of closed and open-ended questions was circulated to Housing Support Grant Leads on the 17th of April 2025 to distribute with local team members. The survey questions were designed to explore:

- Current experiences of engagement with BCUHB services
- Perceived challenges in joint working
- Opportunities for future joint working, and
- Training and development needs across Health and Housing staff within local authority

The bi-lingual survey was developed on Microsoft Teams and remained open for six weeks. Information was collected to identify which local authority areas responded to the survey. Qualitative and quantitative feedback from the meetings and survey were reviewed and analysed to identify themes from the insights generated.

3.2 Staff Insights

During July and August 2025, work was undertaken to develop a BCUHB Homelessness Staff Survey. A model called COM-B (Capability, Opportunity, Motivation and Behaviour), was used to structure the survey and questions were informed by the previous engagement with local authorities and members of the Homelessness Reduction Implementation Group. The dissemination was supported by a Communication and Engagement Plan which aimed to reach staff via Betsi Bulletin, targeted engagement via Equality Champions and visits to the acute hospital sites. The survey was bi-lingual and available in electronic format via Microsoft Teams and in a paper version.

The purpose of the Homelessness Staff Survey was:

- To gain insight from BCUHB staff about their current knowledge, practice, and confidence in having conversations with patients if they are at risk of or, experiencing homelessness.

- To identify if staff have training needs, and to identify resource gaps.
- To identify areas of good practice.
- To identify areas of support needed for preparation of the 'Ask, Act and Cooperate' duty as part of the forthcoming Ending Homelessness Legislation.

The 21 survey questions were themed around the following areas:

- Knowledge and Awareness
- Current Practice and Processes
- Training and Confidence
- Discharge and Operational Challenges
- Barriers and Implementation Issues

The survey went live in September 2025. The responses were collated and analysed for the 21 questions contained in the survey. These included both quantitative and qualitative questions. The responses provided the Homelessness Reduction Implementation Group with a baseline of key issues and recommendations directly from staff across a wide range of teams and services.

A detailed report was written for the Homelessness Staff Survey which provides further details on the methodology, findings and recommendations of this work. This was reported to the Homelessness Reduction Implementation Group in November 2025. The full report is available in appendix 4.

3.3 Lived experience - Homelessness Engagement

The Homelessness Reduction Implementation Group identified engagement with people with lived experience of homelessness as a priority. The objective of this was to understand the challenges and opportunities within hospital discharge pathways and access to health services for people at risk of or experiencing homelessness.

This work was carried out during October 2025 in partnership with Shelter Cymru and BCUHB Public Health Directorate. A Participant Information Sheet, consent form, and semi-structured questions were developed to enable the team to conduct semi-structured interviews. Participants were identified through the Lived Experience Coordinator from Shelter Cymru and were given the option to complete the interview over the phone, via video call, or in person. Interviews were conducted by staff from Shelter Cymru and a Public Health Practitioner with a supportive trauma informed lens. Interview questions can be found in appendix 3.

The Public Health Practitioner also linked with a local community hospital in the East IHC to gain direct insights from patients and staff. A flexible approach was taken which included a face-to-face interview with a patient and attendance at a hospital MDT.

A thematic analysis of the feedback was undertaken. The responses provided the Homelessness Reduction Implementation Group with insights which has been triangulated with the engagement work with local authorities and BCUHB staff.

Findings from the engagement work was reported to the Homelessness Reduction Implementation Group in November 2025.

3.4 Data Analysis

To triangulate the insights work, BCUHB data on discharge delays relating to homelessness was requested.

Data counts of delays to pathways to care, with the delay reason coded as 'homeless' were obtained from the BCUHB Digital, Data and Technology (DDaT) team. These data sets described inpatient stays of individuals who had a delay reason of "homeless". The data covered a period between March 2023 and March 2025.

A descriptive analysis of the data was undertaken to identify the average length of stay, number of bed days and clinically optimised bed days to this patient group[13][14].

Data was disaggregated by local authority area, admission specialty, age group and the location of care.

The cost of bed days was calculated by multiplying the number of bed days by a cost-per-day estimate, provided by BCUHB, of £595.17 (correct as of May 2025). The cost of clinically optimised number of bed days was calculated using the same method.

4. Results

The following section provides a high-level summary of the findings from the engagement work with local partners, BCUHB staff and people with lived experience. In addition, delay to discharge costs estimates are included.

4.1 Partnership review

The local authority survey generated eight responses, with five out of the six Local authorities responding. The following themes were identified:

4.1.1 Health and Wellbeing Data Recording and Information Sharing

Four of the five local authorities record health and wellbeing data electronically, while one continues to use paper forms. The most identified needs were mental health and substance misuse, followed by gambling, dental health, respiratory health, and musculoskeletal conditions.

Information about an individual's health status is shared with partner organisations (including health services) through various mechanisms, including Multi-Disciplinary Teams (MDTs), Single Point of Access (SPOA), Mental Health Panels, commissioned housing support providers, and personal housing plans. However, approaches to sharing information differ, with no consistent practice across local authorities.

Only half of survey respondents (four out of eight) were aware of existing health and wellbeing services for referral. Respondents highlighted the need for a central referral

[13] A clinically optimised bed day refers to an inpatient day which is of no added value to a patient, meaning that they do not receive any care that could not be delivered in a non-acute setting, including assessments or procedures that do not require a hospital setting

[14] nhs.wales/sa/six-goals-for-urgent-emergency-care/goal-5/goal-5-resources/safer-national-minimum-standards-for-the-application-of-safer-red2green-and-d2ra-pdf/

point within health services and an up-to-date directory of available services to better support housing teams.

When asked what additional support would help address health and wellbeing needs, respondents suggested:

- Greater understanding among health staff of housing service demands and legislative requirements (x3)
- A hospital link person/team to connect services (x2)
- Better knowledge of resources and waiting lists
- Reduced form filling
- Improved training and communication between services
- Stronger discharge planning into the community

4.1.2 Pathways

Local authorities highlighted several ways in which pathways into healthcare from housing could be improved for people with unmet health and wellbeing needs. The most common suggestion was to streamline referral processes, with four respondents identifying this as a priority. Others pointed to the need for improved access to services, stronger partnership planning, and increased capacity within health services. Respondents also reported challenges in contacting patients about housing support while they were receiving hospital care. These difficulties were linked to unclear points of contact, staff shift changes, poor communication, reliance on local authority officers for complex discharges (which are not available in all areas), and late notification of discharges that limited effective planning.

Barriers to transitioning from healthcare settings into homelessness support were wide-ranging. Communication issues were frequently cited, including incomplete sharing of patient needs and short notice of discharge. Timing was also a concern, with insufficient opportunity for assessment before patients left hospital. Respondents noted that some patients were too unwell to move into temporary accommodation, while others had ongoing medical needs that fell outside the remit of homelessness services. Structural challenges included limited hospital staff awareness of housing constraints, a lack of suitable interim accommodation, and promises of longer-term health outreach that did not materialise. Weaknesses in community support were also reported, often resulting in readmission.

Suggestions for improving the discharge process into homelessness support teams focused on strengthening coordination and communication. Respondents recommended multi-agency meetings (MDTs) before discharge to ensure needs were fully understood, alongside clearer links between housing and health teams. Dedicated roles, such as a central contact point or Housing Solutions/Link Officer, were seen as valuable for joined-up working (an example of this type of role is currently being tested by Anglesey Council, described in the case study below). Improved advance planning, better communication, and a stronger commitment to ongoing

health support within the community were also highlighted as essential to ensuring smoother transitions from hospital into homelessness services.

4.1.3 Case Study: Ynys Mon Complex Case Coordinator

The example provided below illustrates the approach Anglesey Council is taking to strengthen relationships with health services and to test new ways of working to increase referrals into timely support services. A new pathway is being tested in Ysbyty Gwynedd with Isle of Anglesey County Council's Homelessness Team to promote the early identification and prevention of homelessness. To improve patient flow, the Complex Case Coordinator (CCC) who is part of Anglesey County Council's Homelessness Team attends general hospital weekly bed flow meetings.

'Mr X was brought to the attention of the CCC within the bed flow meeting and an MDT was arranged by the CCC between the Homelessness Team, Hospital Discharge team and the ward staff within the hospital. From this meeting it was established that Mr X had suffered a stroke which had changed his life. His mobility had changed dramatically which deemed his current private accommodation unsuitable to occupy.'

'An action from the MDT was set for the Occupational Therapist (OT) within health to visit the accommodation to establish suitability for a potential discharge home if his health improved. It was discovered that Mr X had no running hot water and that it was no longer accessible for him, given his new diagnosis. The CCC arranged for Mr X to be allocated a Homeless Officer, and a joint visit was conducted to Mr X on the ward to complete a homelessness assessment.

Mr X was given advice and guidance in line with the Housing Act 2014 (Wales) and the duties accepted by the Local Authority Housing Homelessness Team were explained to him. Mr X was referred for housing related support through Anglesey's Single Point of Access and was allocated a support worker to support him to complete a housing application form for the social housing register. The OT from housing supported the housing application by providing medical banding which placed Mr X housing application for re-housing in the 'urgent banding'.

Bi-weekly follow up MDTs with the ward were established to keep consistent communication on Mr X's health progress and to establish when he would be optimized for discharge. The CCC and the Homeless Officer managed Mr X's expectations throughout the process and kept clear communication to outline each step. Mr X was offered temporary accommodation when he was optimized for discharge by the ward. Mr X declined the temporary accommodation and returned to live with his daughter for a short period, Discharge planning MDTs including Mr X were held and appropriate steps were taken to provide a stair lift for his daughter's property, ensuring he was able to manage in the property on a temporary basis.

After a short period of time on the social housing register, Mr X was allocated accommodation by the local authority. The OT from housing conducted a joint visit with Mr X at the property and assessed the suitability of the accommodation. It was

confirmed that the bungalow would be suitable for Mr X and appropriate minor adaptions were carried out. Mr X accepted the accommodation offer.

Mr X moved into the property and now lives independently with the support of carers and his Housing Support Officer. His homeless duty was ended, and his case was closed by CCC. Mr X situation would not have been resolved in this way without collaborative efforts and relationship between health and housing on Anglesey. Both key agencies worked towards a common goal with the prevention of homelessness at the heart of supporting Mr X.

4.2 BCUHB Staff Insights

133 responses were received from BCUHB staff. Findings, cross-referenced with the key themes within the survey, are summarised below:

4.2.1 Knowledge and Awareness

Legislation Awareness Gap - over 90% of staff were unaware of the upcoming 'Ask, Act and Cooperate' Homelessness Legislation, showing critical communication needs. Understanding Visible vs Hidden Homelessness - staff generally recognised visible homelessness (rough sleeping) but had limited understanding of hidden forms like overcrowding and sofa surfing.

4.2.2 Current Practice and Processes

Inconsistent Practices - about half of staff responses noted that they did not routinely ask or record patient housing status, indicating no consistent approach or standardised procedures across BCUHB.

4.2.3 Training and Confidence

Low Confidence Levels - 69% of staff rated their confidence 5 or below regarding managing homelessness risks, showing a significant confidence gap.

Training Deficiency - 96% of staff had no homelessness-related training in the past 24 months, revealing a major training deficiency.

4.2.4 Discharge and Operational Challenges and Barriers and Implementation Issues

Need for Clear Guidelines - clearer protocols are essential to equip staff to fulfil responsibilities and support those at risk of homelessness effectively.

Lack of Service Awareness - over half of respondents were unaware of local homelessness services and roles of local authority teams, limiting effective referrals.

Impact on Service Delivery - 62% never referred someone to homelessness support; 26% reported hospital discharge delays due to homelessness.

4.3 Lived experience

Three people with lived experience were interviewed. It is important to recognise that these views are not representative of all people with lived experience of homelessness. The feedback generated offers insights into the challenges faced by individuals and suggests possible solutions. To ensure a more comprehensive understanding, it is recommended that engagement is continuous with people with

lived experience to improve discharge and planning processes and increase access to local services.

Findings from the lived experience work were grouped into the following thematic areas:

- Anxiety and further illness due to delays in hospital discharge
- Larger hospital sites more complex
- Capacity to seek mental health support
- Mobility issues
- Support for families facing eviction
- Little help for parents supporting their families facing eviction to attend healthcare appointments
- Ask the question "is your home at risk, or are you at risk of homelessness?"

"*Healthcare professionals could be asking people about their about living situation at the beginning of a conversation to save the trauma of patients having to tell healthcare professionals, whilst already in a traumatising position*"

4.4 Key themes from the MDT:

- Communication between BCUHB, local authority and social care could be improved.
- The hospital discharge of homeless patients is complex.
- Delays in patient discharge can cause further distress to patients and can cause further deterioration to health.

4.4 Data analysis

Fifty patients were identified as being homeless in the BCUHB Pathways of Care data. 62% of the cohort were male. These patients were identified through patient records.

There were also a high number of 'super-spell' patients in this cohort. These are individuals who move between sites by being discharged from one site, but are readmitted to another site, rather than being transferred. The care pathway for these individuals is therefore relatively difficult to track.

4.4.1 Local authority

All local authorities in North Wales had patients recorded as homeless as inpatients. In addition, one local authority outside the North Wales area cared for a North Wales patient. The average length of stay varied from 71 days in Denbighshire (for a total of 7 patients) to 149 in Wrexham (20 patients).

The numbers of bed days varied between 314 in Gwynedd and 2681 in Wrexham. The total cost of bed days varied from £186,883 in Gwynedd to £1,595,650 in Wrexham.

Clinically optimised bed days[15] to this population varied from 29 in Anglesey, to 910 in Wrexham. The cost of clinically optimised bed days ranged from £17,259 in Anglesey

[15] nhs.wales/sa/six-goals-for-urgent-emergency-care/goal-5/goal-5-resources/safer-national-minimum-standards-for-the-application-of-safer-red2green-and-d2ra-pdf/

to £541,604 in Wrexham. To total cost of this to BCUHB between March 2023 and March 2025 was **£1,077,852.87.**

4.4.2 Average length of stay by admission specialty

Average length of stay was measured in bed days. The majority of patients were admitted to the adult mental illness specialty, followed by geriatric medicine, and rehabilitation. The adult mental illness specialty had the highest number of clinically optimised bed days.

In the period from March 2023 to March 2025, the cost of bed days to the adult mental illness specialty for 22 patients was £558,864, the cost to the geriatric mental illness specialty was £341,032.

4.4.3 Average length of stay by age group

The longest average length of stay was to patients aged 18-25 years, at 118 days, followed by the 25-39 age group (80 days) and the 50-59 age group (73 days). These data must be interpreted with care, however, because of the small numbers, and different types of admission which may necessitate longer or shorter stays.

4.4.4 Average bed days per person by age group

The 70-79 age group had the greatest average bed days per person, at 154 days, followed by the 40-49 age group, with an average bed days per person of 141. The average number of clinically optimised bed days were the highest in the 40-49 age group at 68 days, followed by the 18-25 age group at 58 days.

The cost of clinically optimised bed days by age group ranged from £32,139 for the 80+ age group to £243,424 for the 40-49 age group. The average cost per person of clinically optimised bed days in each age group ranged from £40,570 for the 40-49 age group to £8034 for the 80+ age group.

5. Discussion

Engagement with local authority teams, BCHUH staff and people with lived experience provided valuable insights into the challenges experienced locally by teams and individuals and offered possible solutions on how these could be addressed. The following section discusses the key themes emerging from the insights work that was undertaken.

5.1 Training and Education

Training on homelessness and housing support services was identified as a key theme from the local authority and BCUHB staff insights work. 69 percent of BCUHB staff surveyed reported low confidence in managing homelessness risk, highlighting an opportunity to build confidence and knowledge of local services and how to effectively refer patients into local support. Insights highlighted that 90 percent of staff surveyed from BCUHB were unaware of the upcoming duty to Ask, Act and Cooperate, and had limited knowledge of the causes and types of homelessness known across society. The insights highlight the need for an organisational-wide approach for training on homelessness and local service provision. The training would aim to improve staff knowledge and confidence in the prevention and early intervention of homelessness

within health care services. Such training could be co-developed with local authority and third sector organisations to reflect local pathways and expertise in homelessness prevention and housing options and should take a behavioural insights and trauma informed approach.

Local authority engagement highlighted the complexity of health and wellbeing needs that housing staff were supporting across the region with mental health and substance misuse recognised as the most significant health needs across housing services. Local authority staff emphasised the need for training on health and wellbeing for housing staff and access to a directory of local health services which could be embedded as part of a training package. Options for training should be explored in partnership with Mental Health and Substance Misuse Services (SMS) to increase knowledge and awareness of how housing staff can better support the needs of their clients and improve access into services. Regionally, housing staff should also be encouraged to complete Making Every Contact Count training to equip staff to offer brief intervention health and wellbeing advice to maximise prevention and early intervention support for individuals.

5.2 Communication

The insights work consistently highlighted the importance of strengthening communication opportunities between healthcare and housing services. Solutions provided included developing and strengthening existing MDTs across health care and local authority areas to enable cross sector collaboration and joint coordination of care. This may reduce the cycle of re-admissions for people with unmet health needs and would improve timely discharge of people into appropriate housing options. Further scoping work should be undertaken in partnership with healthcare and local authorities to map current MDT groups and identify gaps in health and housing service representation.

Improving communication was also identified by people with lived experience in helping to reduce anxiety and distress. Late discharge planning and lack of communication on housing options may worsen physical and mental health, leading to an increased risk of deconditioning amongst some patients. To improve communication further, one local authority suggested the creation an in-reach Hospital Link Worker to work with health and housing staff and patients identified as being at risk of or experiencing homelessness in acute settings. The role would act as a connector to support patients to transition into suitable housing and help with any associated health and social care needs in the community. An example of this is being implemented in Anglesey, funded by the Housing Support Grant. It is recommended that the outcomes and benefits of this work are shared regionally with other local authorities. The BCU Unscheduled Care Programme could consider the potential joint funding of roles such as this to improve communication and discharge planning of patients leaving acute settings into homelessness and health and social care services.

5.3 Pathways

BCUHB staff had very little understanding of the pathways into homelessness services. Respondents highlighted the need for clear and consistent guidelines on how patients should be referred into homelessness services. These findings align with local

authority insights, which highlight challenges resulting from homelessness teams receiving insufficient notice of patients' housing situations - in some cases only being notified on the day of discharge. These findings highlight the need for clear and robust pathways into local homelessness services which are embedded as part of the admissions process. Housing status should be reviewed by staff throughout the patient's stay in hospital to reflect any changes in circumstances. It is recommended that pathways should be co-designed with health and local authority stakeholders in each area to reflect the differences between local areas and acute sites. It is also recommended that the Anglesey Council screening assessment tool, which was developed as part of the Hospital Discharge pathway is progressed and co-designed regionally in partnership with health and housing. Testing and embedding the tool more widely across healthcare admissions could help to routinely identify people at risk of, or experiencing, homelessness to enable prevention and early intervention support and prevent further delays to discharge.

5.4 Single Point of Access (SPoA)

Local authorities shared their difficulties in contacting relevant staff and departments across BCUHB due to the complexity and vastness of the health care system. To address this, staff expressed the need for a *single point of access* to help improve and streamline communication and enable Housing Officers to effectively connect health care staff to discuss the health and social care needs of their clients within hospital settings.

5.5 Data discussion

The numbers of patients over the two-year data collection period are small; and the specialties where the patients were cared for are varied. The average length of stay for this cohort tends to be long and is longer than that of an 'average' patient in NHS Wales of 8.3 days[16].

The large number of clinically optimised bed days experienced by this population suggests that there are challenges in discharging or moving patients to non-acute settings if they are identified as homeless. However, there are other factors that may explain some of these differences. The fact that many patients are 'super-spell' patients, who are discharged and then readmitted rather than being transferred to another speciality may also indicate potential fragmentation of care for this population group. This may be one of the causes of longer stays and poorer overall health. It is important to interpret the data with caution due to complexity of pathways and service pressures.

Despite the small numbers in this dataset, the costs associated with their care are relatively large. Again, any conclusions drawn from this must be interpreted with caution, as being admitted into hospital with more advanced disease is likely to increase the cost and length of care.

Engagement work with local authorities also highlighted that temporary accommodation could hinder recovery after a hospital discharge. This is often due to

[16] Hospital admissions data online: April 2023 to March 2024 | GOV.WALES

lack of safe storage / refrigeration for medicines, adaptations needed, and the environment that people are discharged back to.

6. Limitations

6.1 Lived experience engagement

The low representation of lived experience involvement has been recognised as a limitation of this work and the views captured are not necessarily a true representation of people's views and options. The Homelessness Reduction Implementation Group recognises the importance of capturing lived experience and the involvement of people through a 'nothing about me, without me approach'. The Homelessness Reduction Implementation Group and health care services should explore continuous methods of capturing lived experience and active involvement of people to ensure their views are embedded as part of service design and delivery.

6.2 Primary care involvement

The insights work was limited to secondary care services due to the remit of the duty to Ask, Act and Cooperate, which currently does not extend to primary care. The Homelessness Reduction Implementation Group has gained representation from Primary Care and recognises the critical role that Primary Care can play in preventing homelessness by adopting a proactive, upstream approach.

6.3 Registered Social Landlord and Third Sector Engagement

The Homelessness Reduction Implementation Group recognise the important and vital role that Registered Social Landlords and Third Sector organisations play in the prevention of homelessness and improving the health and wellbeing of residents and communities. Engagement with these partners was not in scope for this work, however further engagement work should take place to explore how relationships and partnerships could be strengthened further as part of a regional whole-system approach to preventing homelessness.

7. Conclusion and Recommendations

The insights work demonstrates that homelessness is both an interlinked health and housing issue, requiring a coordinated, and system-wide response. Whilst the remit of the Ask, Act and Cooperate duty currently applies only to secondary care; the findings highlight the vital role of Primary Care and Community Services in prevention and early intervention.

The evidence shows that without consistent training, clear pathways, and stronger collaboration, patients at risk of homelessness face poorer health outcomes, longer hospital stays, and increased costs to BCUHB. Addressing these challenges will require embedding homelessness awareness across all services, ensuring staff are equipped to act confidently, and involving people with lived experience in shaping solutions.

The insight findings also demonstrate that delays linked to homelessness are not only detrimental to patient wellbeing but also create significant financial pressures for BCUHB. Targeted interventions that seek to improve patient flow and discharge processes could have a significant impact on reducing avoidable bed days and costs.

The Homelessness Reduction Implementation Group recognises that meaningful engagement with primary care, local authorities, housing organisations, third sector partners as well as people with lived experience of homelessness will be essential to achieving sustainable outcomes. By implementing the recommendations outlined in this report, BCUHB and its partners can take a proactive role in preventing homelessness, reducing health inequalities, and fulfilling the statutory duty to Ask, Act and Cooperate in a way that delivers lasting impact for individuals and communities across North Wales.

The Homelessness Reduction Implementation Group recommends the following actions:

Theme:	Recommendations:	Costs:	Lead:
Training & Education	**Co-develop and deliver targeted training** for BCUHB staff on homelessness causes, legislation, and pathways to increase knowledge and awareness. Initially targeting clinical areas with the highest rates of homelessness recorded.	In-house costs: Staff time, resource development.	Equality Team
	Deliver specialised training for housing workers (people working with people experiencing homelessness) with MHLD and Substance Misuse Services, to increase knowledge and awareness.	In-house costs: Staff time, resource development	SMS/MHLD
	Roll out 'Making Every Contact Count' (MECC) initiative to housing/homelessness and frontline staff in local authorities to improve health outcomes.	None (available on-line)	Public Health Directorate
Engagement	**Ensure continuous engagement and active involvement** of individuals with lived experience in service design and in providing patient experience feedback.	Staff time	Patient Experience Team/Clinical & Prevention Services

	Strengthen engagement with Primary Care clusters, to identify areas for improving integration and collaboration in addressing homelessness related needs.	Staff time	Homelessness Reduction Implementation Group.
	Strengthen engagement with Registered Social Landlords and Third Sector Organisations to identify areas for improving partnership working, prevention and early intervention work.	Staff time	Homelessness Reduction Implementation Group
	Map multi-disciplinary teams (MDTs) across health and housing to identify good practice, gaps and strengthen collaboration, cooperation, and joint coordination of care - reducing the cycle of readmissions for people with unmet needs and improve untimely discharge.	Staff time	TBC
	Explore establishment of Hospital Link Worker roles (which are not currently consistent across Housing and BCUHB) to strengthen communication channels between health, housing staff and patients identified as being at risk of or experiencing homelessness in acute setting.	Yes: Funding for roles to be explored in WMH and YGC. Costs to be identified.	TBC
Pathways & Processes	**Co-develop and implement a regional screening and admissions tool**, informed by the Anglesey Council example, to identify individuals at risk of or currently experiencing homelessness during the admissions process.	In-house costs: staff time, system development	TBC
	Create clear, consistent and robust referral pathways into homelessness services, embedded in admissions processes.	In-house costs: staff time, system development, resource development	TBC
	Explore the development a Single Point of Access	Staff time (initially) -	TBC

	(SPoA) within health services to streamline and improve communication and information sharing.	future costs to be identified.	
Discharge delay	**Continue monitoring of discharge data where delay is due to homelessness**. (This may increase as hidden homelessness issues identification are improved with increased knowledge via training)	Staff time	Unscheduled Care / Homelessness Reduction Implementation Group.
Governance	**Identify governance routes and leadership** for the implementation of the new legislative requirements and to help identify resources required.	Staff time	Homelessness Reduction Implementation Group

8. Appendices

Appendix 1: Data for people living in temporary accommodation

Data disaggregated by accommodation type and local authority at September 2025

Table showing breakdown of people living in different temporary accommodation types by local authority area

Accommodation type	Number of people
Bed and breakfast and hotels	**989**
Isle of Anglesey	58
Gwynedd	205
Conwy	281
Denbighshire	120
Flintshire	224
Wrexham	101
Caravan parks or similar holiday accommodation	**102**
Isle of Anglesey	0
Gwynedd	15
Conwy	58
Denbighshire	0
Flintshire	29
Wrexham	0
Hostels (including reception centres and emergency units)	**86**
Isle of Anglesey	0
Gwynedd	19
Conwy	31
Denbighshire	0
Flintshire	36
Wrexham	0
Other	**0**
Isle of Anglesey	0
Gwynedd	0
Conwy	0
Denbighshire	0
Flintshire	0
Wrexham	0
Private sector accommodation	**712**
Isle of Anglesey	14
Gwynedd	129
Conwy	212
Denbighshire	208
Flintshire	108
Wrexham	41

Registered Social Landlord (RSL) stock	**52**
Conwy	0
Denbighshire	0
Flintshire	24
Gwynedd	7
Isle of Anglesey	21
Wrexham	0
Within your own stock	**528**
Conwy	0
Denbighshire	99
Flintshire	87
Gwynedd	0
Isle of Anglesey	2
Wrexham	340
Womens refuge	**70**
Isle of Anglesey	0
Gwynedd	0
Conwy	21
Denbighshire	0
Flintshire	49
Wrexham	0

Source: stats.housing@gov.wales

Appendix 2: Local authority engagement survey

Support for Health and Wellbeing:

4. What are the most common health and wellbeing challenges you see when supporting people at risk of or experie
all that apply) *

- [ ] Mental health
- [ ] Substance misuse
- [ ] Gambling harms
- [ ] Weight management
- [ ] Dentistry and oral health
- [ ] Diabetes management and prevention
- [ ] Respiratory health
- [ ] Cardiovascular disease
- [ ] Sexual health
- [ ] Eye health
- [ ] Musculoskeletal (MSK)
- [ ] Cancer
- [ ] Other

5. How do you currently record the health and wellbeing needs of people you support? (Select all that apply) *

- [ ] Not recorded
- [ ] Paper assessment form
- [ ] Electronic assessment form
- [ ] Other

Support for Health and Wellbeing:

4. What are the most common health and wellbeing challenges you see when supporting people at risk of or experie all that apply) *

- [ ] Mental health
- [ ] Substance misuse
- [ ] Gambling harms
- [ ] Weight management
- [ ] Dentistry and oral health
- [ ] Diabetes management and prevention
- [ ] Respiratory health
- [ ] Cardiovascular disease
- [ ] Sexual health
- [ ] Eye health
- [ ] Musculoskeletal (MSK)
- [ ] Cancer
- [ ] Other

5. How do you currently record the health and wellbeing needs of people you support? (Select all that apply) *

- [ ] Not recorded
- [ ] Paper assessment form
- [ ] Electronic assessment form
- [ ] Other

6. How do you share any identified health and wellbeing needs with partners (including health partners)? *

Enter your answer

7. Have you ever received training on how to identify the health and wellbeing needs of people and how to support these? *

- ◯ Yes
- ◯ No

8. If no, how can this be improved? *

Enter your answer

9. Are you aware of all health and wellbeing services that exist in order to refer people to the appropriate services? Yes/No

If no, how can this be improved? *

Enter your answer

10. How can pathways into healthcare be improved for people with unmet health and wellbeing needs? Please state: *

Enter your answer

11. On a scale of 1 (very easy) to 5 (very difficult), how do you find contacting people regarding housing support when they are receiving hosp care? (this may include a named contact on a ward). *

- 1 - Very easy
- 2 - Easy
- 3 - Moderate
- 4 - Challenging
- 5 - Very difficult

12. Please explain the reason for this: *

Enter your answer

13. What additional support would help you to better address the health and wellbeing needs of people you support? *

Enter your answer

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Strengthening referrals into Homelessness Support Teams:

14. Do you routinely record the number of referrals you receive from health care into Homelessness Support Teams? *

- Yes
- No

15. Which healthcare providers do you often receive referrals from? *

- Mental health
- Emergency Department
- Acute Hospital Wards
- GP's
- Substance misuse
- Other

16. How do you receive referrals from healthcare into Homelessness Support Teams? *

- Electronic referral form
- Telephone call
- Email
- Other

17. Do you understand the pathways into and out of acute/hospital care?
*

- Yes
- No
- Unsure

18. If not, how can this be improved? *

Enter your answer

19. How much notice are you usually given for patients requiring homelessness support when being discharged from hospital?
Please give some anonymised examples if possible (free text) *

Enter your answer

20. What barriers do patients and homelessness support teams face when transitioning from health care settings into homelessness support?
Please describe: *

Enter your answer

21. What would improve the discharge process from hospital into Homelessness Support Teams? *

Enter your answer

Back Submit

Appendix 3: Engagement with people with lived experience – questions

Questions used for engagement:

1. Please can you tell me about yourself, and only what you are comfortable to share?
2. Please can you tell me about your experience of any hospital admissions and hospital discharges?
3. What do you feel was good or bad about your experience?
4. What do you think would have made your experience better?
5. What do you think we should be asking people as healthcare professionals when they access the health services and when they are discharged from hospital, thinking about those who are at risk of homelessness or are already homeless?
6. Please can I feed back the findings our work and share the report with you?

Bilingual version was made available.

Appendix 4: BCUHB Homelessness Staff Survey October 2025

This report was presented to Homelessness Reduction Implementation Group.

Please note that at the time this engagement report was written, the wording of the proposed duty was referred to as ‘ask and act’. Subsequent change has taken place since which now refers to ‘ask, act and cooperate’.

BCUHB Homelessness Staff Survey Report

October 2025

Authors:

Nia Thomas – Public Health Practitioner

Public Health Directorate

Staff Survey Report

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1. Introduction

On the 8th September 2025, the BCUHB staff Homelessness Survey went live. The aim of the survey was to gain insight from BCUHB staff about their current knowledge, practice, and confidence in having conversations with patients if they are at risk of or, experiencing homelessness. The survey remained live up until 11:45pm on 30th September 2025, and 133 responses were received.

The survey was devised to support the preparation for the Health Board and its staff for proposed new legislation by the Welsh Government called 'Ending Homelessness', and the duty that will be put upon all health boards throughout Wales to **'Ask**' and **'Act'** to prevent homelessness. The legislation is due to be implemented imminently by Welsh Government.

The objectives of the survey, were as follows:

- Gain insight into current understanding of what we mean by "homelessness".
- Understand current practice when someone is identified as being at risk of, or experiencing homelessness, when accessing our services across BCUHB.
- Identify training and resource needs to help prepare staff across BCUHB for the new Ending Homelessness legislation in Wales.
- Gather examples of good practice to support an integrated approach between health and housing.

This report outlines the key findings and recommendations from the survey results. These will be used to inform an overarching paper that will be presented to the BCUHB Informal Executive Committee, including recommendations on how the Health Board can meet the duty to prevent homelessness.

2. Background

Information on the health and wellbeing of people experiencing homelessness highlights that this vulnerable group face significantly poorer outcomes compared to the general population. This is supported by evidence from the Office for National Statistics (2021) which suggests the average age at death for someone who is homeless in England and Wales is **45.4** years of age for men, and **43.2** years of age for women, compared to **82.3** years for men and **85.8** years for women in the general population. Health and homelessness are deeply interconnected. Homelessness can be a cause of ill health, and ill heath can contribute to homelessness. Addressing homelessness requires an integrated and collaborative approach across NHS services and other partner organisations.

The Welsh Government white paper 'Ending Homelessness in Wales' was published in 2024 with proposed reforms to existing policy and legislation in Wales. The Homelessness and Social Housing Allocation (Wales) Bill is expected in winter 2025. The proposed changes will place a new duty on all Health Boards in Wales for services to '**Ask**' and '**Act**' to prevent homelessness. This means staff will be required

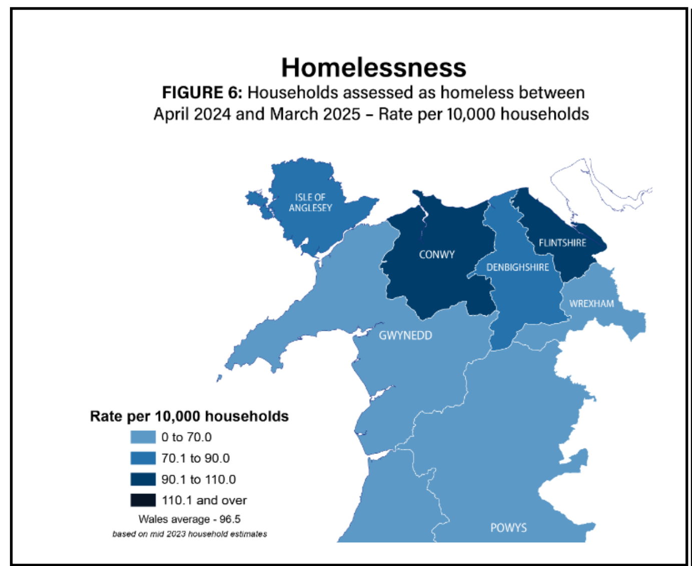
to **ask a person about their housing situation and act by referring them to support to avoid them becoming homeless wherever possible.**

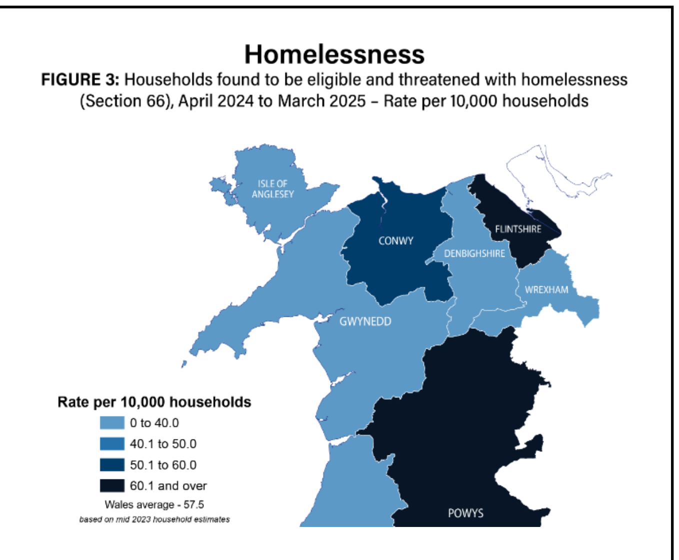
Historically most people associate homelessness with people sleeping rough on the streets. However, homelessness is complex and there are differing definitions and understanding of what is meant by homelessness. According to Shelter Cymru, a person can be classed as being homeless, or at risk of being homeless, if they are:

- 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 your 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 basic essentials
  Forced to live apart from your family, or someone you would normally live with, because your accommodation isn't suitable or a relationship breakdown.

The Health Board recognises that homelessness can affect anyone and preventing it is everyone's business.

The Welsh Government maps below illustrate households assessed as homeless, and households found to be eligible and threatened with homelessness, across North Wales





[Homelessness: April 2024 to March 2025 [HTML] | GOV.WALES]

These maps indicate that there are varying rates of homelessness across local authority areas in North Wales, with higher rates in Flintshire and Conwy, followed by Denbighshire. We know from our previous engagement work with Local Authorities that homelessness is increasing pressure on homelessness teams which is not always reported and reflected in official statistics.

3. Method

In order to support the homelessness work being undertaken in preparation for the new legislation impending new duty, the Public Health Directorate and the Equality Team developed an online staff survey in July 2025.

It was decided to utilise a behavioural science approach to forming the questions of the survey, specifically the COM-B model (Capability, Opportunity, and Motivation), to develop a more detailed understanding of what was influencing staff behaviour in relation to responding to homelessness. The survey was reviewed by members of the Preventing Homelessness Implementation Group. The purpose of the survey was to identify current practice amongst BCUHB staff for preventing homelessness, explore their understanding of homelessness, and to understand the organisation's readiness for the forthcoming Ending Homelessness Legislation in Wales.

The bilingual survey was created on Microsoft Forms to enable easy collection and analysis of the responses. The survey went live on 8th September and remained open until 30th September.

A communication plan for the survey was also devised with a step-by-step process of what needed to be achieved, by when and by who. Various avenues of promoting the survey were identified, including equality champions, wellbeing champions, culture change leaders, IHC People and Culture Groups, and the Implementation Group for Reducing Homelessness.

The survey with promotional posters were available in both Welsh and English with QR codes for easy access for busy staff. These were shared with the following:

- Wrexham Maelor wellbeing (staff) choir,
- BCUHB engagement officers for east, central and west, with the request they share them with their teams and other departments across BCUHB.
- During September we promoted the survey at information stalls at Wrexham Maelor hospital, Ysbyty Glan Clwyd and Ysbyty Gwynedd. This work was supported by the Public Health team and Equality Team.
- Raised awareness of the survey by visiting over 21 different hospital wards/departments providing posters and asking staff to promote the survey with their teams. This provided an opportunity to share what the survey was about and its importance to help prepare staff for the new duty to ASK and ACT.
- Posters displayed in the main canteens in the acute hospital sites.
- The equalities team uploaded information around the survey and links to the surveys on their Betsi net intranet pages.
- Survey shared with 94 Equality Champions with an request to share with their teams.
- BCUHB Weekly Bulletin contained links to the survey for 2 weeks. A request was placed for the survey to be included on the main landing page on Betsi Net. This was not approved due to other conflicting priority information.

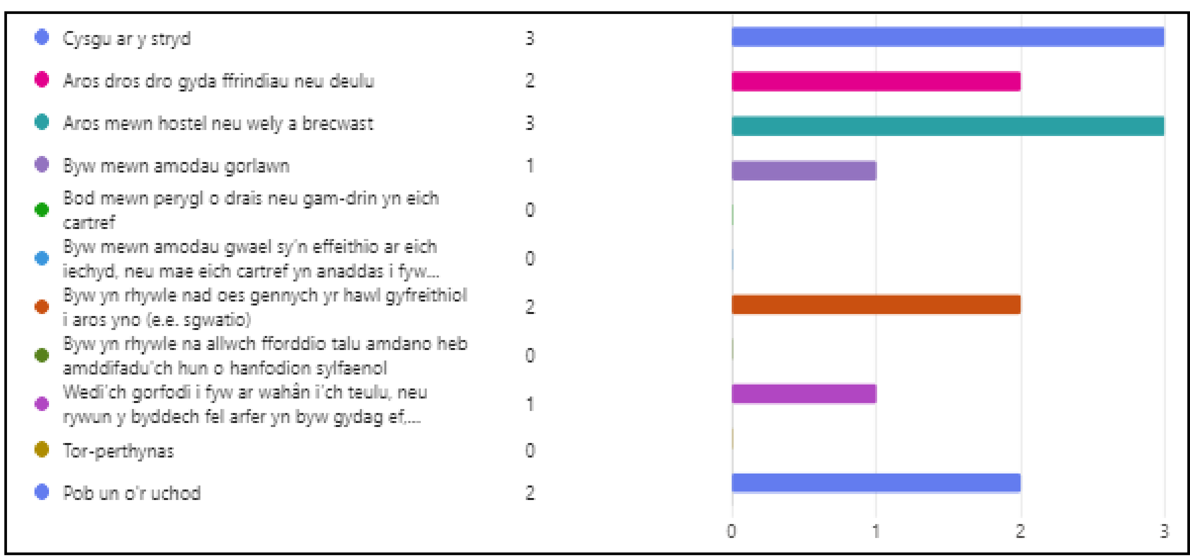
4. Results

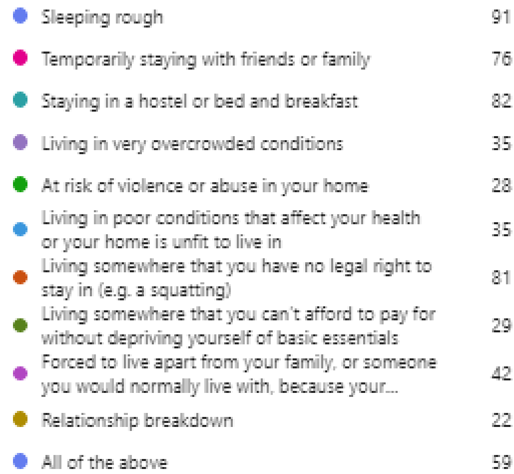
4.1 Survey responses

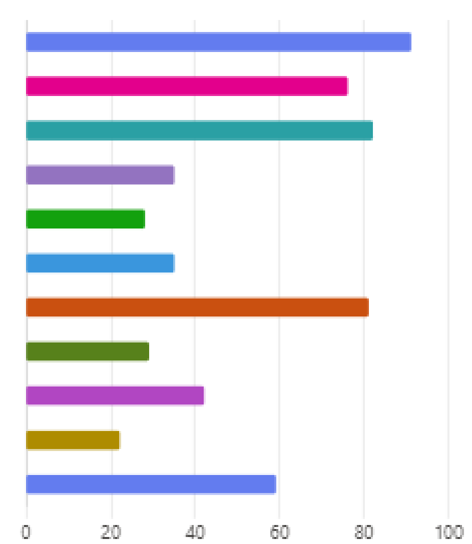
A total of 133 surveys responses were received (128 in English and 5 in Welsh). The results of the survey have provided invaluable insight into current practices, helping to highlight gaps in provision and knowledge, and what staff need to help support them to implement the new duty with confidence.

The findings will be combined for the free textbox responses; however, the diagrams will have both the English and Welsh graphs/charts included.

Q1. What is your understanding of what we mean by the term “Homelessness”? Please select all you feel are relevant.



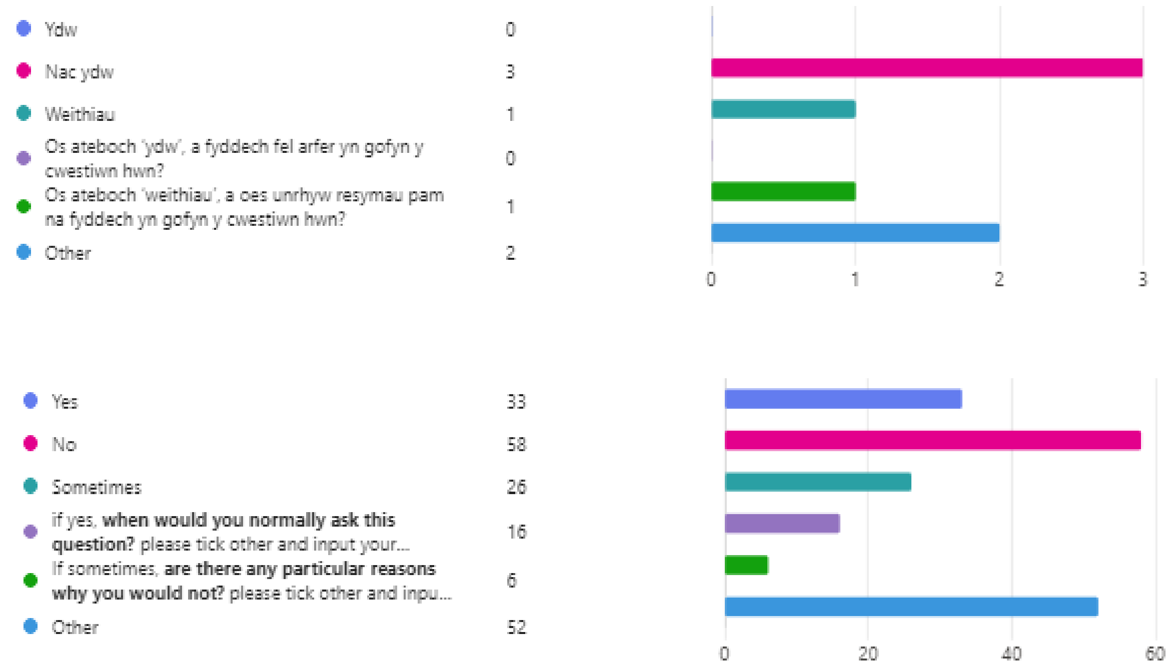




All 133 responded to the question.

The majority of staff had an understanding that ‘sleeping rough and ‘staying in a hostel or bed and breakfast’, or ‘living in somewhere where a person has no legal right to stay in’ were classed as homeless. Other less known categories had fewer responses such as ‘relationship breakdown’ and ‘at risk of violence or abuse in your home’, and ‘living somewhere that you can’t afford to pay for without depriving yourself of basic essentials’. The responses highlight that there is variation in the understanding of homelessness and who is at risk of homelessness.

Q2. Do you know if your service / department asks if an individual is experiencing homelessness or is at risk of experiencing homelessness e.g., on admission, during a consultation or during a pre-op appointment?



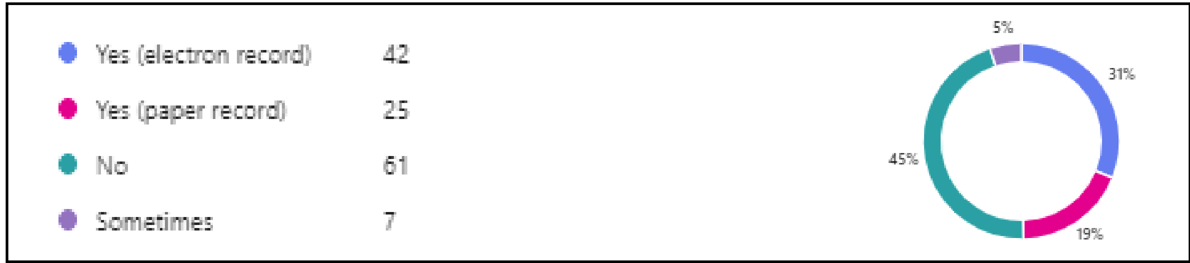
All 133 responded to the question. 61 (46%) told us that they didn’t know if their service asks an individual if they are experiencing homelessness. 60 (45%) told us that they ask or sometimes ask. The response highlights that there is variation across BCUHB on asking the question.

Staff were asked to provide further information in the free text ‘other’ box regarding when they would normally ask this question, or if there was a particular reason why they would not. Below is a summary of the answers provided:

- During conversations with the said person, and usually if they have indicated they are at risk?
- Patient reference states if person is of no fixed abode
- Home circumstances discussed on initial assessment and may be reviewed at annual reviews
- Fear of offending someone
- Yes, when it feels appropriate

- I tend to see regular patients. If there is anyone new the CTP will pick up issues around accommodation, as it is the first question
- Time limitation. Sometimes not aware
- We rely on information to be provided to us during a referral or when working with other professionals
- Don't explicitly ask unless someone alludes to this when we routinely ask about housing and financial difficulties

Q3. Do you record if an individual is experiencing or is at risk of homelessness on the system?



All 133 responded to the question. 69 people told us that they record if an individual is experiencing or is at risk of homelessness, 44 of which did so on electronic records, and 25 on paper. A significant number, 64 staff, said they do not record this information and a small number record it sometimes. This highlights that there is variation across BCUHB in the recording of individuals homelessness status.

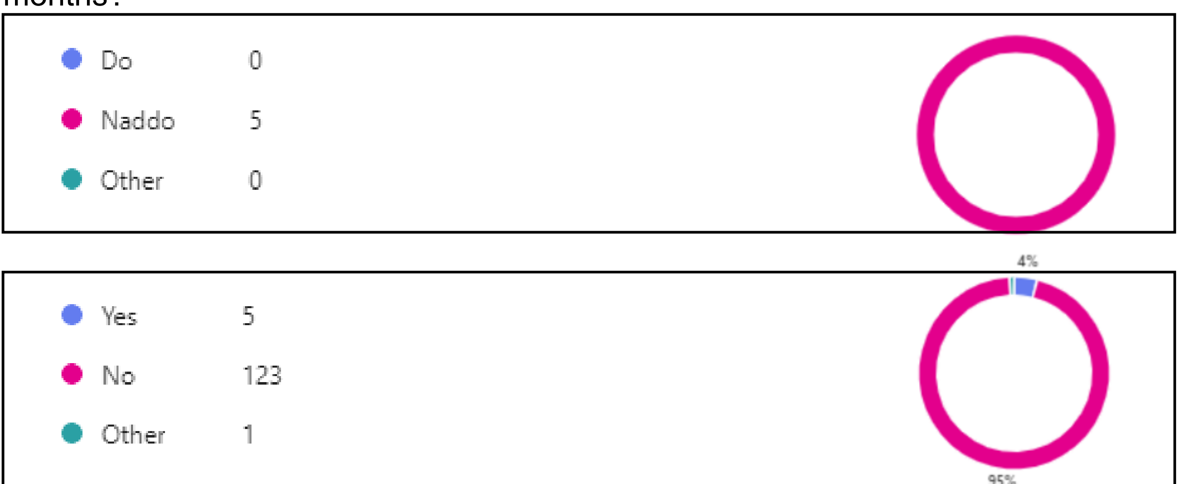
Q4. Who would you seek help from, both internally and external to the Health Board, in relation to supporting people at risk of or experiencing homelessness?

All 133 responded to the question. 24% (32) of respondents answered Local Authority/ Council/ Social services.16% (21) of respondents stated they didn't know or were unsure who to seek help from.

Ddim yn siwr Ddim yn siwr
Cyngor lleol, meddyg teulu, gweithiwr cymdeithasol, ymwelydd iechyd
Yr Awdurdod Lleol - er enghraifft Cyngor Gwynedd tîm opsiynau tai.
ask the health inequalities lead in our team who would be the best contact in the area

An analysis of the free text responses to this question highlights that there is a wide range of organisations and internal departments that staff seek advice from. However, a proportion of staff do not know where to go to seek advice and support.

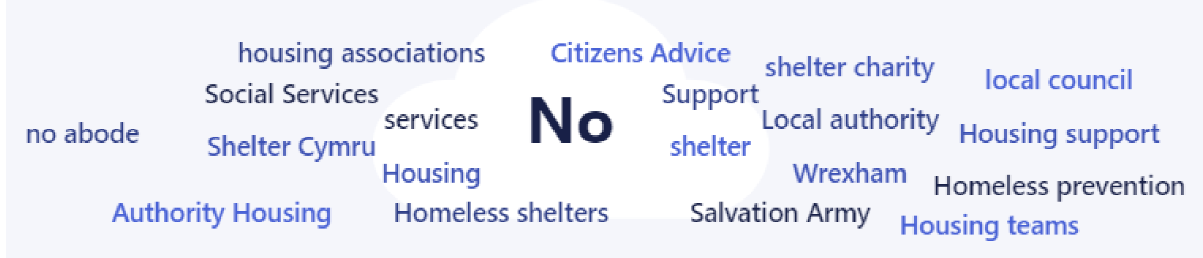
Q5. Have you received any training in relation to homelessness in the past 24 months?



All 133 responded to the question. 96% (128) respondents said that they had not received training on homelessness in the past 24 months. Only 4% said they had received training.

The responses to this question highlight a notable training need in relation to homelessness.

Q6. Do you know what existing services are available to support Homelessness in your area? Yes or No - please comment in text box below and list the services please.



ydw council, shelter cymru
Nac ydw
GISDA, Yr Orsaf Penygroes, ADRA
Hefyd Adra, Grŵp Cynefin, Shelter, Wallich, Digartref Ynys Mon, Gorwel.
Nac ydw
Mae geni syniad- tim opsiynau tai yn lleol.
Dibynnu beth yw oed ac amgylchiadau unigolion/ teuluoedd.

All 133 responded to the question. 69 respondents (52%) answered 'No' they did not know what existing services are available in their area. 48% of responses did have some knowledge of services in their area, which ranged from charitable organisations to statutory services such as the Local Authority. An analysis of the free text responses to this question highlights varying levels of knowledge of support available.

Q7. Are you aware of the services provided by Homelessness Teams within Local Authorities across North Wales? Yes or No - please comment in text box below and list the services please.

All 133 responded to the question. 61% (81) respondents said they did not know what the Local Authority Homelessness Teams provided across North Wales. An analysis of the free text responses to this question highlights that a few said they would contact Social Services, one said they would contact Shelter and another stated *"no as we refer to our Oncology Social Worker who was part of the homeless team".*

A further 31 (23%) selected yes, with 8 responding with Housing.

One staff member commented:

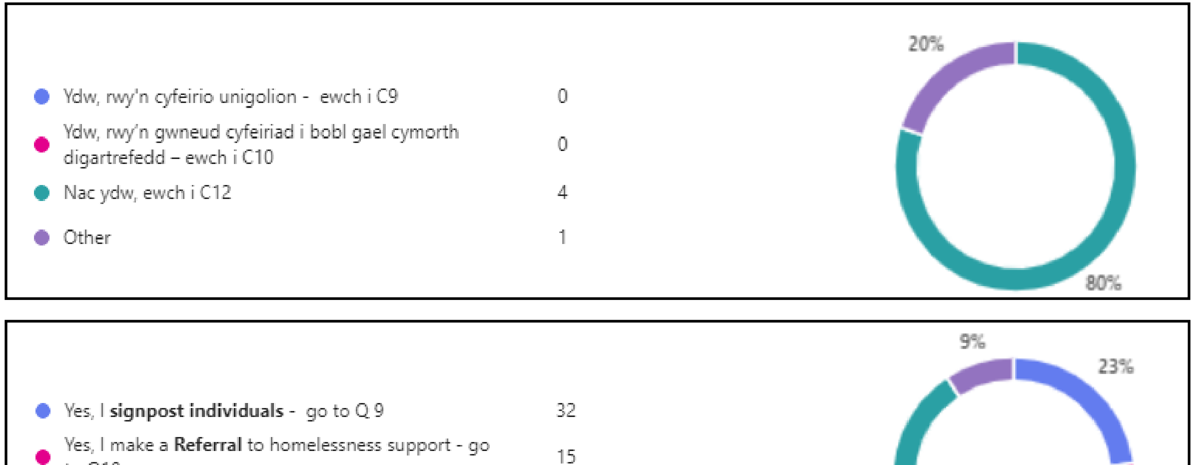
'Yn ymwybodol bod cefnogaeth ar gael. Ond diffyg tai addas ydi'r prif broblem. Yn aml mae unigolion neu teuluoedd yn cael ei rhoi mewn tai sydd ddim yn addas/ dros dro'. –

"The lack of suitable housing available is the main problem. Often individuals or families are put in unsuitable housing or only temporary housing".

Some respondents highlighted they were unsure or had little understanding of what Homelessness Teams do. Other responses shared they had some knowledge but a vague understanding, and some felt that these services were not well promoted.

The responses to this question highlight that there is variation in the understanding of the role of Local Authorities and their statutory duties.

Q8. Do you currently sign post or make a referral for individuals for homelessness support and advice if you have identified an individual is at risk of or experiencing homelessness?



132 responded to the question. 83 (62%) respondents said No, they do not currently signpost or refer individuals for support and advice around Homelessness if they have identified someone at risk of, or experiencing homelessness.

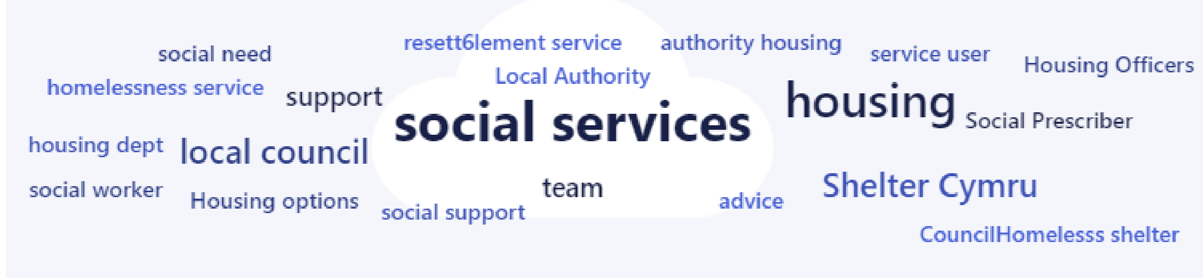
15 respondents said Yes, they signpost individuals and 16 said Yes, they make a referral to homelessness support. One response stated ‘not applicable’, and another did not respond to this question.

Within the responses for ‘other’ option, responses included:

- ‘I haven’t knowingly come across this’
- ‘Not a patient facing service’
- ‘No never had any training’
- ‘Refer to SW’ (Social Worker)
- ‘I haven’t experienced this in my role’
- ‘Have supported staff at risk of homelessness, do not have much patient contact’
- ‘I have never had to’
- ‘I signpost to community team in LD services to support, due to vulnerability’

The responses to this question highlight that over half the respondents do not signpost or refer individuals for homelessness advice and support. The reasons for this are highlighted in question 12.

Q9. Where do you currently signpost individuals for support and advice? please list below



Housing department Council Shelter Cymru

An analysis of the free text responses to this follow up to question 8 (yes, I **signpost**), where 44 people responded. Most commonly signpost individuals to **Local Authorities**, particularly **housing departments, social services,** and **homelessness support teams. Shelter Cymru** was the most frequently mentioned external organisation, followed by **Citizens Advice Bureau (CAB), NACRO (**are a social justice housing charity who provide supporting living accommodation)**, probation service**, and various **third sector charities**. Some also mentioned **youth-specific services** like the **Youth Homeless Team, INFO shop**, and **youngwrexham.co.uk**. A few respondents noted they would consult their **line manager** or had **not yet needed to signpost anyone.**

In addition to other services, respondents also identified a diverse range of other organisations and approaches for signposting individuals to support and advice. These include:

- **Specialist and Third Sector Services**:
  - ❖ *Tia Teg* and various rooms-to-let websites were mentioned as resources for housing options.
  - ❖ Food banks and the Red Cross were identified as sources of emergency support.
  - ❖ The SMS Support Team and Kaleidoscope were noted for providing targeted support, particularly in areas such as substance misuse and mental health.
  - ❖ Resettlement services were also referenced for individuals transitioning into stable housing.

- **Health and Wellbeing Support**:
  - ❖ The Wellbeing Hub and Social Prescribers were highlighted as key contacts for addressing broader social and health-related needs.
  - ❖ One respondent noted the importance of referring to a Wellbeing Team when housing issues intersect with wider social care needs.

- **Internal and Informal Support Pathways**:
  - ❖ Some staff indicated they would consult their line manager or the admin team for guidance when unsure about appropriate signposting.

- ❖ A few respondents acknowledged they had not yet needed to signpost anyone, indicating varying levels of direct involvement in support referrals.

The findings illustrate the breadth of services utilised across sectors and highlights the importance of both formal and informal networks in supporting individuals.
This range of responses highlights a strong reliance on statutory services and well-established third-sector organisations, with some variation based on individual roles and local service availability.

Q10. Where do you currently refer individuals to for support, both internally or externally for support? please list below

As a further follow up question to question 8 (yes, I make a **referral**) to homelessness support, a total of 42 responses were received. There were no responses to the Welsh survey. Respondents identified a wide range of internal and external services to which they currently refer individuals for support. The key themes and services mentioned include:

External referral Pathways:

- **Housing and Homelessness Support**:
  - ❖ Frequent referrals are made to **local authority housing departments**, **homeless prevention teams, housing options services**, and **Wrexham Council's Housing Options Team.**
  - ❖ **Shelter Cymru** and other **tenancy support agencies** were also commonly cited for housing-related support.

- **Specialist Support Services**:
  - ❖ **NACRO, probation services,** and **resettlement services** were mentioned for individuals with complex needs, including those involved with the criminal justice system.
  - ❖ **Welfare rights services, GPs,** and the **Discharge to Recover and Assess (D2RA)** team were also identified as key partners.

- **Safeguarding and Adult Social Care**:
  - ❖ Referrals to **POVA (Protection of Vulnerable Adults)** and **Adult Safeguarding** were noted for individuals at risk.
  - ❖ Several respondents highlighted occasional referrals to **Adult Social Care** for more complex or high-risk cases.

Internal Referral pathways:

- **Social Services**:

- The most frequently mentioned internal referral was to **Social Services,** including **SPOA (Single Point of Access)** and **social workers.**

- **Wellbeing and Support Services**:
  - Internal teams such as the **Wellbeing Hub, Social Prescribers,** and **Welfare LINK** were also identified as key sources of support.
  - Participation in **multi-agency meetings** was noted as a method of collaborative referral and case management.

Other Insights:
- A few respondents indicated they had **not yet needed to make a referral**, or that individuals were typically **self-sufficient** following signposting.
- One respondent noted that individuals of no fixed abode encountered in a pharmacy setting were often already under the care of **psychiatric services** or **police.**

Some respondents highlighted that they typically refer individuals to the local housing department, recognising their expertise and expecting individuals to manage independently unless additional needs arise. In more complex cases, referrals are made to the local authority through multi-agency meetings.

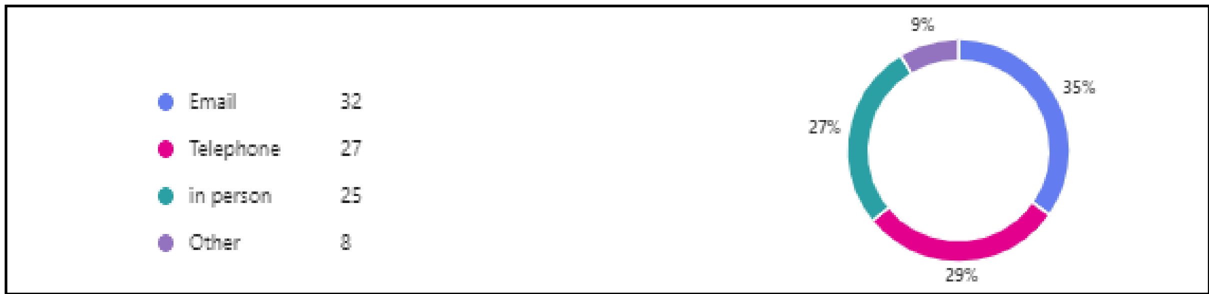
Other services mentioned include:

- Social Prescribers for holistic wellbeing support
- Resettlement services for housing transitions

These responses reflect a case-by-case approach, with referrals tailored to individual needs and circumstances.

This range of responses reflects a strong reliance on both statutory and third-sector services, with internal pathways often involving social care and wellbeing teams. The findings also highlight the importance of multi-agency collaboration in addressing homelessness.

Q11. How do you sign post / refer individuals?



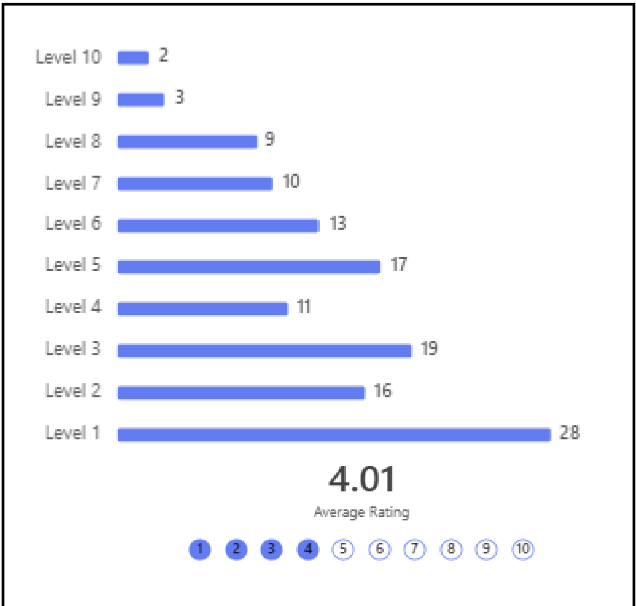
49 responded to the question in total, with no responses from the Welsh survey.

From the survey responses, within the details it is evident that most individuals use a mixture of methods to sign post/ refer individuals this includes email, telephone and in person. There were also different methods mentioned in the responses, namely:

- Email SPOA (single point of access)
- Find their social worker (not easy)
- Give directions to the local office and provide contact details

This highlights a mixed method approach is useful pathway to advice and support.

Q12. On a Scale of 1-10 how confident are you that you would know what to do if you identify someone at risk of homelessness or experiencing homelessness?

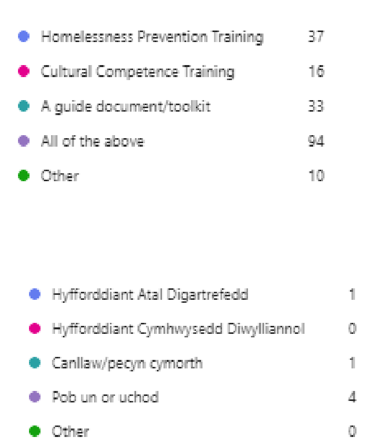


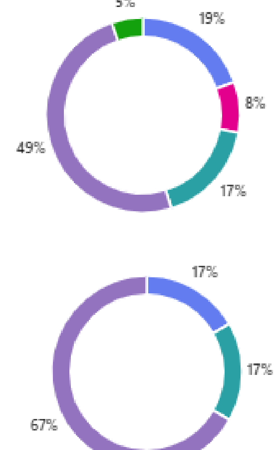
All 133 responded to this question. As illustrated in the scales above there is general low level of confidence in knowing what to do if an individual was identified to be at risk of or experiencing homelessness. 69% (92) responded with a level 5 or below. With an overall average confidence level of just above level 4.

This highlights that the majority of the respondents do not feel confident currently that they would know what to do if you identify someone at risk of homelessness or experiencing homelessness.

Q13. What would make you more confident to have a conversation (**ASK**) with a patient about their housing situation?

Homelessness Prevention Training	37
Cultural Competence Training	16
A guide document/toolkit	33
All of the above	94
Other	10





Hyfforddiant Atal Digartrefedd	1
Hyfforddiant Cymhwysedd Diwylliannol	0
Canllaw/pecyn cymorth	1
Pob un or uchod	4
Other	0

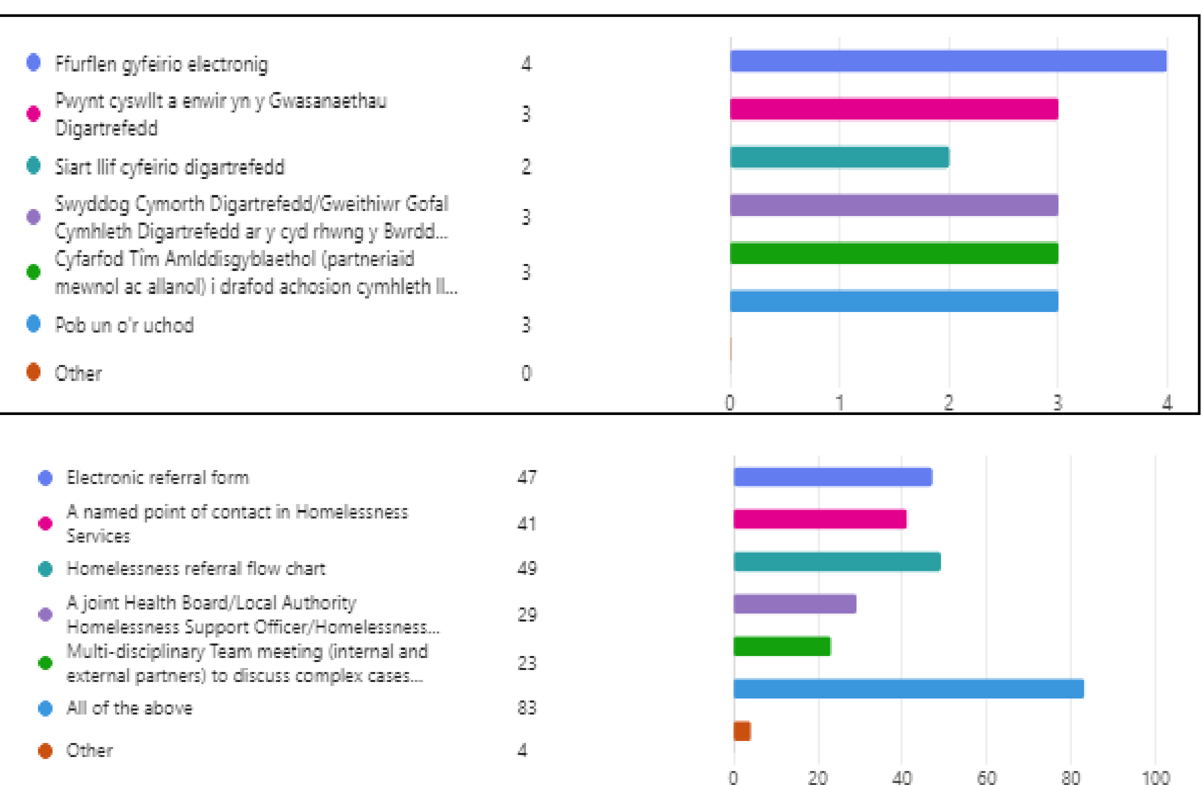
All 133 responded to this question. The majority of the respondents, both on the Welsh and English survey, selected their preference to be all of the suggested tools to increase their confidence.

An analysis of the free text responses to this question notes the following responses within the other section on the English survey:

- A known responsible person to speak with
- I don’t have much patient contact in my role
- I'm fine asking as are all my colleagues. It is part of our job to gather this information, then signpost as needed
- Not patient facing therefore don’t need the training. Not relevant. Time could be better spent doing my job

The responses to this question therefore highlight the need for a suite of tools to be available to support staff to increase their level of confidence.

Q14. What would make you feel more confident to share (**ACT**) this information with other services if an individual identified they were at risk of, or experiences homelessness?

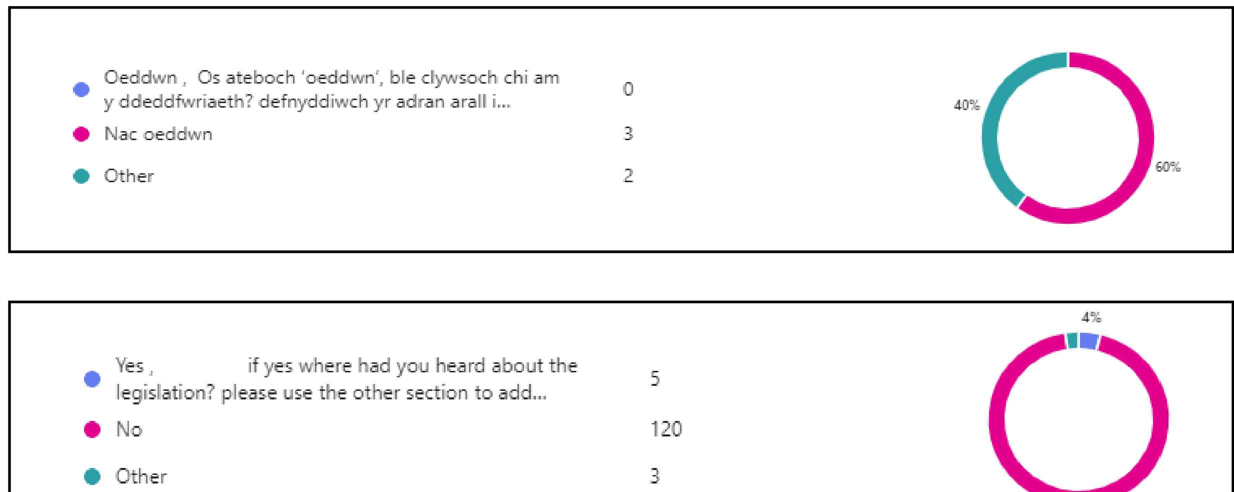


132 responded to this question. The majority of the respondent’s both on the Welsh and English survey selected their preference to be all of the methods suggested. These would help them feel confident to share information with other services. Within the other section on the English survey there were blank responses apart from this statement:

- All of the above; Very useful. I like an official paper trail. The electronic referral form sounds good.

The responses highlight a need from the respondents to have a mixture of methods available to them in order to feel confident in sharing this information with other services.

Q15. Were you aware of the new legislation (Ending Homelessness), and the requirement of health boards to Ask and Act before taking part in this survey?

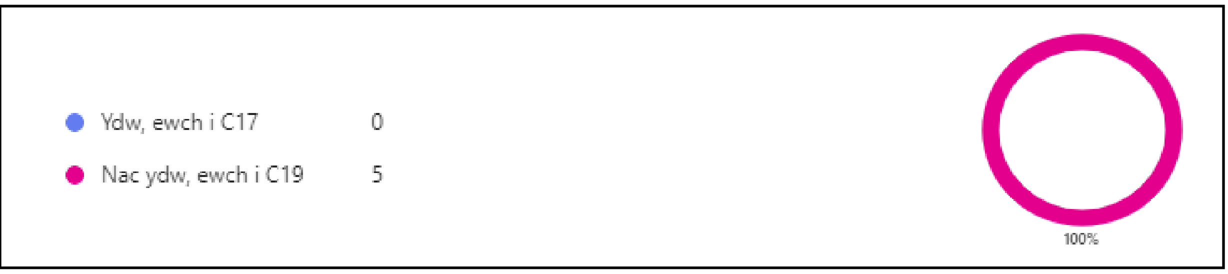


All 133 responded to this question. Over 92% (123) respondent stated they were not aware of the new proposed legalisation and the new requirement on the health board to Ask and Act coming in. Only 5 respondents said they were aware. From both other sections in the Welsh and English surveys comments in relation include:

- This Yn ymwybodol ddim yn cofio lle nes i glywed ond ddim yn siwr or manylion *(aware, can't remember where I heard but not sure of the details)*
- Through work
- From APB
- Only from the email sharing this survey

highlights that staff had a current low level of awareness of the proposed legislation and the requirement, which will become a statutory requirement on the health board. By completing the survey, and accompanying communications for it, we hoped to raise awareness of the proposed legislation.

Q16. Within your service/department, do you experience delays in discharge due to homelessness?



124 responded to this question. Majority answered that they did not experience a delay in patient discharge due to them being homeless. 26% (32) responded that they did experience discharge delays.

The responses to this question highlight that the majority of services and departments do not feel they are impacted by delays in discharge due to homelessness. However, 26% did, and the issue of homelessness poses a problem for discharge for certain patients.

Q17. If yes, how often? frequency e.g., for each patient, often, rarely and what causes the delay?

37 responded to this question. No responses from the Welsh survey responses. Here is a cross section of some of these responses:

- Often
- occasionally
- occasionally, as social circumstances may limit/prevent engagement with our service
- Rarely, lack of acceptable discharge location

The responses to this question highlights variation across the health board on the frequency of delays in discharge experienced which represents the diversity of cases being managed.

Q18. If yes, how does this impact your department / what do you do in these circumstances?

A total of 33 responded to this question. An analysis of the free text responses to this question highlights the following comments:

- This is usually a move from hospital to the community. Unsafe options are sometimes the only option, such as a HMO with known drug or alcohol misuse for recovering and vulnerable MH patients at risk of falling back into misuse or being financially exploited. Waiting for a vacancy I supported housing. Identifying a placement.
- From time to time. It is often felt that CAMHS should continue to support a young person who is at risk of or experiencing homelessness, due to associated emotional challenges.
- Can be weeks at times.
- I have come across homelessness perhaps 5 times in 5 year and the delay is rehousing and suitable accommodation for patients as it isn't always as simple as finding them a property but they have to meet their physical needs too and social needs such as close to family and services etc.

- Often - not seen as priority for local authorities.
- frequently - but all are under the age of 18 and therefore referral into the Local Authority is essential.
- Not directly with my service but those who use the service and are sitting on a ward and can't be discharged due to housing issues.
- Capacity for a property and the chaos the patients we support find themselves in, their life is already difficult.
  Communication issues, no postal addresses or regular phone access
- Finding funding or placement happens on a bi-weekly basis.
- LD services - difficult to discharge from hospital settings at times due to placement breakdown. Patient becomes homeless for reasons such as behavioural concerns or property damage. Few placements available so patient remains in hospital unnecessarily. I am unsure who to contact in these circumstances
- Capacity for a property and the chaos the patients we support find themselves in, their life is already difficult. Communication issues, no postal addresses or regular phone access

The responses to this question highlight that the services or departments who do experience delays in discharge, their experiences vary dramatically. The severity of delay also varies, with some patients experiencing significant delay in discharge e.g., waiting weeks in hospital due to factors pertaining to appropriate housing solutions to meet the patient's needs and the complex nature of their health condition.

Q19. What would improve the discharge process from hospital into Homelessness Support Teams?

Byddai system ar lein efallai yn helpu
Gweithio yn agosach efo asiantaethau/ rhannu gwybodaeth.
Fwy o wybodaeth am pathway/protocol a pwy i gysylltu hefo
N/A - gweithio yn y gymuned
flow chart/ information/ awareness of procedures both HB and Local authority
Diffyg amser i holi a gweithredu a diffyg amser i gyfeirio a gwneud follow ups
Mae sawl gwasanaeth yn bryderus wrth rannu gwybodaeth hefyd efallai
oes angen cytundeb rhannu gwybodaeth mewn lle?

All 133 responded to this question. The responses highlight a need for **improving the hospital discharge process into Homelessness Support Teams.** Respondents identified several key areas for improvement:

- **Clear Processes and Pathways**: Many called for a **well-documented referral procedure, clear protocols,** and a **named** single point of access to streamline communication and accountability.
- **Training and Awareness**: There was a strong need for **staff training, awareness of available services to signpost onto**, and **guidance on referral procedures,** especially for non-hospital-based staff.
- **Communication and Coordination**: Improved **multi-agency collaboration**, **early identification of needs**, and **shared care plans** were seen as essential for smoother transitions.
- **Accessibility and Resources**: Suggestions included **easy referral routes, electronic discharge forms**, **step-down housing options,** and **dedicated liaison roles** within hospitals.

Many respondents indicated limited direct involvement with hospital discharge processes due to their **community-based** or **non-clinical roles**, highlighting a gap in awareness and engagement across sectors.

Among those who provided suggestions, key themes included:

- **Improved Communication and Coordination**: Calls for **stronger links between hospital discharge teams and homelessness services**, including **clear points of contact, shared care plans,** and **early identification of housing needs.**
- **Clear Processes and Tools**: Suggestions included **electronic discharge forms, step-down housing options**, and a **clear referral pathway** with **defined timelines.**
- **Training and Awareness**: Respondents emphasised the need for **staff training, knowledge of available services,** and **guidance on referral procedures,** particularly for those outside acute settings.
- **Dedicated Support**: Proposals included **in-house homelessness liaison teams** within hospitals and **named workers** to coordinate patient journeys.
- **Systemic Challenges**: Concerns were raised about **patients being discharged without accommodation,** leading to repeat presentations, and the need for **safe, secure housing options** post-discharge.

These responses highlight the importance of **cross-sector collaboration**, **clear protocols**, and **accessible support pathways** to improve outcomes for individuals experiencing homelessness at the point of hospital discharge.

Q20. What barriers / issues do you foresee with implementing the Ask and Act duty from the new legislation?

accommodation for people
homelessness
available
multiple people
young people
people are on wards
Unsure
patients
ask and act
time
service
Lack
service users
housing
Staff
support
Lack of training
people
lack of knowledge
lack of understanding

Diffyg amser i holi a gweithredu a diffyg amser i gyfeirio a gwneud follow ups

Dwi ddim yn siwr

people being aware of the legislation and the new duty

what that means to them in their role

All 133 responded to this question. Respondents identified a wide range of potential barriers and challenges to implementing the 'Ask and Act' duty under the new legislation, with several key themes emerging, which include:

Lack of Training and Awareness

- Many respondents cited **insufficient training**, **lack of awareness,** and **limited understanding** of the legislation and referral processes as major barriers.
- Concerns were raised about **staff confidence** in asking sensitive questions and knowing how to respond appropriately.

Time and Resource Constraints

- A significant number of responses highlighted **time pressures**, **competing priorities,** and **limited staffing** as obstacles to effective implementation.
- Some feared the duty could become **tokenistic** if not properly supported.

Systemic and Structural Issues

- Respondents noted **insufficient housing availability**, **delays in support**, and **complex referral processes** as practical barriers to acting on disclosures.
- **Lack of clarity** around roles, responsibilities, and follow-up actions was also a concern.

Cultural and Interpersonal Challenges

- Barriers such as **stigma, sensitivity of the topic,** and **reluctance from individuals to disclose personal issues** were frequently mentioned.
- Some highlighted **cultural barriers** and **lack of rapport** with individuals as limiting factors.

Organisational Readiness

- Several responses questioned whether their **teams or departments were equipped** to implement the duty, particularly in **non-patient-facing** or **community-based roles.**
- There were calls for **clear protocols**, **embedded processes**, and **dedicated champions** to support implementation.

Concerns About Impact

- Some respondents expressed concern that **raising expectations** without the capacity to deliver meaningful support could lead to **frustration** or **disengagement** from individuals in need.

Overall, the respondents highlight the importance of a **whole-system approach** that combines **training, resources, clear protocols, and inter-agency coordination** to ensure the ***Ask** and **Act*** duty is implemented effectively and meaningfully.

Q21. Any other comments you may like to share on this area of work

44 responses received to this free text question. One response was received from the Welsh survey that simply stated 'dim' which means none.

Key themes from the respondents were:

1. **Barriers to Accessing Services**

- Staff highlighted **systemic obstacles** and inconsistent support:
  "Clients are often labelled as problematic, and hurdles put in their way to accessing accommodation in order to improve their outlook."
  "We have often felt completely at a loss as to what to do… we've actually purchased tents and sleeping bags from our own personal money."
- Concerns about **Local Authority protocols:**
  "In Wrexham, there is the belief that if you are rough sleeping you have to be 'seen' by the LA homeless outreach team on 3 separate occasions to be 'classed' as rough sleeping."

2. **Staff awareness and Training Needs**

- Strong call for **training across all staff groups:**
  "I don't work on the front line but I think it will be useful for all staff to do the training."
  "In my line of work, I have never been provided with any education, training or advice regarding patients who are facing homelessness."
- Concern about **irrelevant targeting:**
  "The form is mainly centred on clinical staff but I feel needs to be amended to include questions in relation to staff wellbeing."
  "I'm not patient facing. It would have been better targeted at staff who work with patients and/or members of the public."

3. **Impact on Staff**

- Recognition that **staff may also be affected:**
  "Please do not forget staff who are also facing homelessness (I was homeless with a small child 15 years ago)."
- Need for **managerial awareness and support:**
  "What a manager/supervisor should do for staff in this situation needs to be included."

5. Service Gaps and Suggestions

- Call for **dedicated roles and better integration:**
  "The health board would benefit from a homelessness warden/liaison officer to work with local services to ensure patients are discharged to a safe place."
  "Streamlined support is long overdue from housing and they most definitely need to be based at the hospitals and community mental health team offices."
- Highlighting **lack of appropriate youth provision:**
  "It seems that for teenagers currently there is only Hurst Newton, The Foyer or the place in Rhyl… certainly not for vulnerable 16-year-olds."

6. Motivation and Hope

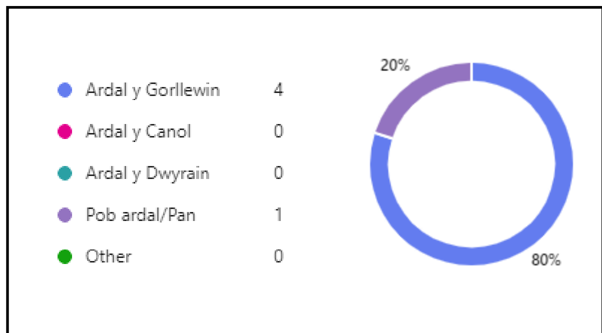
- Staff expressed a **desire to improve:**
  "This had made me stop and think, and realise the daily struggles of those experiencing the threat of homelessness. I feel that I/we need to do better in this area."
  "Thank you for raising my awareness- looking forward to some training and info regarding referrals where needed."
- Concern about **tokenistic approaches:**
  "Let's hope this is not another tick box exercise."

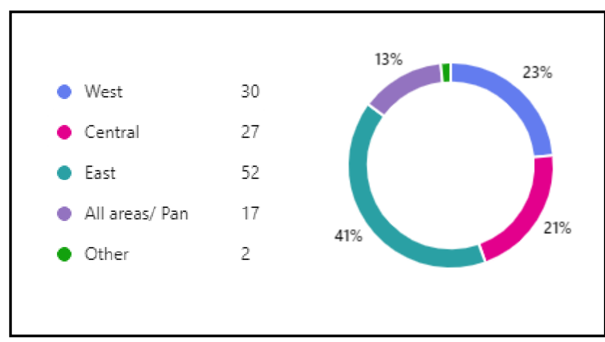
These additional comments are Insightful and helpful in identifying potential barriers and also highlighting additional ideas for consideration.
For a full breakdown of all these responses please refer to Appendix 8.

Monitoring section

The following questions provide monitoring information gathered from the survey responses.

Q22. Where do you work?





All 133 responded to this question. Fairly similar rate of responses from the Central area at 23% and West area at just over 25% (combined Welsh and English survey responses). Pan role, which covers all three areas, was just over 13% (combined Welsh and English survey responses). However, in the East area there is a significantly higher response rate at 41%. Two highlighted in the other section that their roles were corporate and north Wales.

The report highlights that there was a good split of responses between all areas apart from east which was much higher. This could be attributed to additional promotional work for the survey being undertaken in the east.

Q23. Which Department do you work in?

Gwasanaethau Deintyddol Cymunedol

public health directorate

Inpatients

Gorllewin

Anhwylderau Bwyta

All 133 responded to this question. As we can see from the work cloud above there were a variety of different departments who engaged with the survey. This shows good representation, with different departments sharing their insights. For a breakdown of departments that participated in the survey, please refer to Appendix 9.

This highlights an interest from these different departments in relation to this work.

Q24. What is your job title?

Ymarferydd Anhwylderau Bwyta

Public Health Practitioner

Ymarferydd

SLT

Swyddog Deintyddol Cymunedol

All 133 responded to the question. As we can see from the work cloud above there were a variety of different roles and levels who engaged with the survey. This shows good representation across different roles.

7. Insights and Themes

From the survey responses the following insights and themes have been identified:

1. **Awareness and Understanding of Homelessness**
   - While most staff understood traditional definitions of homelessness (e.g., rough sleeping), there was **less awareness of hidden forms** such as sofa surfing, overcrowding, or housing-related abuse.
   - **Over 90% of respondents were unaware** of the upcoming *Ask and Act* legislation, indicating a significant **gap in awareness** of policy changes.

2. **Inconsistent Practice Across Services**
   - There is **variation in whether and how staff ask about homelessness,** with many unsure if their service routinely asks or records this information.
   - **Recording practices** are inconsistent, with some using electronic systems, others using paper, and many not recording at all.

3. Low confidence due to Lack of Training and resources
   - **69% of staff rated their confidence at 5 or below** (on a scale of 1–10) in knowing what to do if someone is at risk of homelessness.
   - **96% had not received any homelessness-related training** in the past 24 months, highlighting a clear **training need.**
   - A strong desire for a suite of tools and training to increase their knowledge and confidence.

4**. Limited Knowledge of Support Services**
   - Over half of respondents were **unaware of local homelessness services** or the role of Local Authority homelessness teams.
   - This lack of knowledge contributes to **low levels of signposting and referrals,** with 62% stating they had never referred or signposted someone for homelessness support.
   - A desire for information on services providing homelessness support and what they provide.

5. **Barriers to Implementing 'Ask and Act'**
   - Key barriers identified include:
     - **Lack of training and awareness**
     - **Time and resource constraints**
     - **Systemic issues** (e.g., housing shortages, complex referral processes)
     - **Cultural and interpersonal challenges** (e.g., stigma, sensitivity)
     - **Unclear roles and responsibilities**
     - **Concerns about raising expectations without adequate support**

6. Discharge Challenges

- **26% of respondents reported delays in hospital discharge** due to homelessness, with some patients waiting weeks for suitable accommodation.
- Staff highlighted the need for **clearer discharge pathways, early identification**, and **better coordination with homelessness support teams.**

7. **Need for Clear Pathways and Signal Point of Access**

- Staff expressed a strong desire for:
  - **Clear referral protocols**
  - **Named contacts or Single Points of Access (SPOA)**
  - **Electronic referral systems**
  - **Multi-agency collaboration**

8. **Support for Staff at Risk of or experiencing Homelessness**

- Several comments highlighted the importance of recognising that **staff themselves may be at risk of homelessness**, and called for **internal support mechanisms.**

9. **Desire for Systemic Change and better Communication**

- Respondents emphasised the need for **stronger partnerships with Local Authorities, standardised processes**, and **equity across regions.**
- There was concern about **tokenism** and a call for the *Ask and Act* duty to be **meaningfully embedded** into practice.
- Communication across the health board regarding the new duty and what this means for its staff.

8. Conclusions

The survey was conducted over a relatively short period of time and was fairly representative of different departments and geographical areas of the Health Board. The survey was completed by 133 Health Board staff members and has helped us gain valuable insights into current practice, potential gaps and what staff would like to receive in order to help them feel confident in readiness for the new duty of **Ask** and **Act** under the new Welsh Government legislation.

The respondents demonstrated a general understanding of traditional meaning of homelessness, but indicated limited understanding of the current meaning of homelessness and lack awareness of hidden homelessness.

The survey results have highlighted that staff have not accessed homelessness training. The findings highlight significant gaps in training, confidence, and knowledge of referral pathways, with most staff unaware of local services and over 90% unaware of the new legislation, which may impact them and their roles. This may be linked to their reporting of lower confidence in knowing who to reach out to for support, advice and signposting.

The survey highlights inconsistent practices in asking and recording homelessness status, combined with low confidence levels, indicate the need for a structured and standardised approach. The survey indicated that there was variation in discharge

process and in asking patients about their homelessness status, and that in some cases homelessness is a reason for delayed discharge.
Barriers such as time pressures, resource constraints, and systemic challenges (including housing shortages) were identified as major obstacles to effective implementation. Additionally, cultural and interpersonal factors, such as stigma and sensitivity, present further challenges.

To successfully embed the **Ask** and **Act** duty, a whole-system approach is required, one that includes comprehensive training, clear referral pathways, improved inter-agency collaboration, and robust support mechanisms for both patients and staff. Addressing these areas will be critical to ensuring that BCUHB can meet its statutory obligations and contribute meaningfully to preventing homelessness across north Wales. In conclusion, without these measures, the duty risks being inconsistently applied and the health board being uncompliant and ineffective.

9. Recommendations

The following recommendations have been identified directly from the survey results.

1. Increase the level of staff understanding of homelessness through:
    - Further communications and engagement work across the health board
    - Review and enhance current homeless training module on ESR
    - Assess the need to make homelessness training mandatory for front line staff, to increase the knowledge, understanding and confidence of staff around homelessness
    - Embed Cultural Competence within the health board to reduce stigma and discrimination

2. Identify ways to increase local knowledge for signposting across all 3 IHCs for homelessness support and key contacts in partnership with Local Authorities and other partners who support the homelessness agenda.

3. Identify ways the Health Board can develop a single point of access/ homelessness lead within different departments, in order to support staff in their day-to-day work in relation to any homelessness queries.

4. Build stronger relationships with organisations which support people experiencing homelessness and also provide preventative services for people at risk of becoming homeless including:
    - Local Authorities
    - Third sector organisations

5. To increase awareness of the advice, guidance and support available for BCUHB staff who experience or who are at risk of homelessness.

6. To gather good practice where pathways are in place to embed the Ask and Act duty to aid timely discharge and prevent discharge delay due to homelessness. This may also include BCUHB in addition to other Health Boards.

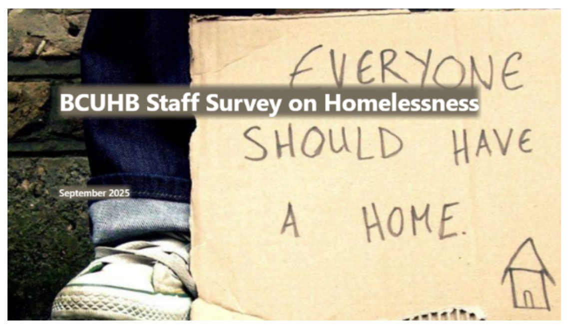
7. To review current systems across BCUHB that can be used to capture homelessness status and to develop a robust pathway for referrals, that can be

consistently applied across the Health Board. While also looking at the possibility of introducing a recording homelessness status for all patients.

The survey results will be shared with the Preventing Homelessness Implementation group to inform further actions in preparation for the Ask and Act duty and seek agreement of these recommendations.

For further information about this work please contact:
BCU.equality@wales.nhs.uk quoting homelessness.

Appendix 1: The Survey



1. **What is your understanding of what we mean by the term "Homelessness"?** Please select all you feel are relevant: *

- ☐ Sleeping rough
- ☐ Temporarily staying with friends or family
- ☐ Staying in a hostel or bed and breakfast
- ☐ Living in very overcrowded conditions
- ☐ At risk of violence or abuse in your 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 (e.g. a squatting)
- ☐ Living somewhere that you can't afford to pay for without depriving yourself of basic essentials
- ☐ Forced to live apart from your family, or someone you would normally live with, because your accommodation isn't suitable
- ☐ Relationship breakdown
- ☐ All of the above

2. **Do you know if your service / department asks (e.g., on admission, during a consultation or during a pre op appointment) if an individual is experiencing homelessness or is at risk of experiencing homelessness?** *

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ If yes, **when would you normally ask this question?** please tick other and input your comment in the other section
- ☐ If sometimes, **are there any particular reasons why you would not?** please tick other and input your comment in the other section
- ☐ Other

3. **Do you record if an individual is experiencing or is at risk of homelessness on the system?** *

- ☐ Yes (electron record)
- ☐ Yes (paper record)
- ☐ No
- ☐ Sometimes

4. **Who would you seek help from both internally and external to the health board in relation to supporting people at risk of or experiencing homelessness?** *

Enter your answer

5. **Have you received any training in relation to homelessness in the past 24 months?** *

- [ ] Yes
- [ ] No
- [ ] Other

6. **Do you know what existing services are available to support Homelessness in your area? Yes or No** - please comment in text box below and list the services please *

Enter your answer

7. **Are you aware of the services provided by Homelessness Teams within Local Authorities across North Wales? Yes or No** - please comment in text box below and list the services please *

Enter your answer

8. **Do you currently sign post or make a referral for individuals for homelessness support and advice if you have identified an individual is at risk of or experiencing homelessness?**

- [ ] Yes, I **signpost individuals** - go to Q 9
- [ ] Yes, I make a **Referral** to homelessness support - go to Q10
- [ ] No, go to Q12
- [ ] Other

9. **Where do you currently signpost individuals to for support and advice?** please list below

Enter your answer

10. **Where do you currently refer individuals to for support, both internally or externally for support?** please list below

Enter your answer

11. **How do you sign post / refer individuals?**

- [ ] Email
- [ ] Telephone
- [ ] in person
- [ ] Other

12. On a Scale of 1-5 how confident are you that you would know what to do if you identify someone at risk of homelessness or experiencing homelessness? *

1	2	3	4	5	6	7	8	9	10

13. **What would make you more confident to have a conversation (ASK) with a patient about their housing situation?** *

- [ ] Homelessness Prevention Training
- [ ] Cultural Competence Training
- [ ] A guide document/toolkit
- [ ] All of the above
- [ ] Other

14. **What would make you feel more confident to share (ACT) this information with other services if an individual identified they were at risk of, or experiences homelessness?**

- [ ] Electronic referral form
- [ ] A named point of contact in Homelessness Services
- [ ] Homelessness referral flow chart
- [ ] A joint Health Board/Local Authority Homelessness Support Officer/Homelessness Complex Care Worker
- [ ] Multi-disciplinary Team meeting (internal and external partners) to discuss complex cases where homelessness is discussed
- [ ] All of the above
- [ ] Other

15. **Were you aware of the new legislation (Ending Homelessness), and the requirement of health boards to Ask and Act before taking part in this survey?** *

- ( ) Yes , if yes where had you heard about the legislation? please use the other section to add comment
- ( ) No
- ( ) Other

16. Within your service/department, do you experience delays in discharge due to homelessness?

- Yes, go to Q17
- No, go to Q19

17. If yes, how often? frequency e.g. for each patient, often, rarely and what causes the delay?

Enter your answer

18. if yes, How does this impact your department / what do you do in these circumstances?

Enter your answer

19. What would improve the discharge process from hospital into Homelessness Support Teams? *

Enter your answer

20. What barriers / issues do you foresee with implementing the Ask and Act duty from the new legislation? *

Enter your answer

21. Any other comments you may like to share on this area of work

Enter your answer

About You

Thank you for your time in completing this survey. If you would like to know more about this work or have any questions, please contact BCU.equality@wales.nhs.uk

22. Where do you work? *

- ◯ West
- ◯ Central
- ◯ East
- ◯ All areas/ Pan
- ◯ Other

23. Which Department do you work in? *

Enter your answer

24. What is your job title? *

Enter your answer

Appendix 2: Survey Promotional Posters

Arolwg Staff ar Ddigartrefedd

Gall digartrefedd effeithio ar unrhyw un ar unrhyw adeg

Mae atal Digartrefedd yn fusnes i bawb

Bydd dyletswydd newydd, sy'n gofyn i'r Bwrdd Iechyd "Ofyn a Gweithredu" ynghylch unigolion sydd mewn perygl o fod yn ddigartref neu sy'n profi digartrefedd, yn cael ei rhoi ar waith yn ddiweddarach eleni.

Mae'r ddyletswydd hon yn golygu y bydd angen i Staff Betsi Ofyn (ceisio cydsyniad) a Gweithredu (cyfeirio) unigolion a allai fod mewn perygl o fod yn ddigartref, neu sy'n ddigartref, at yr Awdurdodau Lleol am gymorth.

Wrth baratoi ar gyfer y ddyletswydd newydd hon, rydym yn awyddus i ymgysylltu â staff ar draws Betsi drwy'r arolwg hwn, er mwyn deall y canlynol:

·Beth mae digartrefedd yn ei olygu i chi
·Beth yw'r arfer cyfredol ar draws Betsi
·Dynodi anghenion hyfforddi neu adnoddau

Mae'r arolwg yn cau ar Medi 30 Diolch

Dolen i'r arowlg: https://forms.office.com/e/65QS6N7rdP

Staff Survey on Homelessness

Homelessness can affect anyone at any time

Prevention of Homelessness is everyone's business

A new duty on the Health Board to "Ask and Act" regarding individuals at risk of or experiencing homelessness will be put in place later this year.

This duty means Betsi Staff will need to Ask (seek consent) and Act (refer) individuals who may be at risk of or are homeless to Local Authorities for support

In preparation for this new duty, we are eager to engage with staff across Betsi through this survey, to understand:

- what homelessness means to you
- current practice across Betsi
- identify training or resource needs

Survey closes on the September 30 Thank you

Link to survey: https://forms.office.com/e/4CLmrDxtK5?origin=lprLink

Appendix 3: Communication Plan

Communication Plan – Engagement work across BCUHB: preparation for Homelessness Ask and Act duty

These form the main actions for engagement work with BCUHB staff

Description	Stakeholders / audience	Time line	Who is responsible	Complete Yes
1. Develop a form for gathering feedback from staff	PH/ EDI	12//7/2025 to 12/8/2025	NT/JDM/HL/FS	
2. Send form for translation to WL team		18/9/2025	NT	
3. Do on line form		25/9/2025	NT/HL	
4. Online form to be shared via BCUHB Weekly Bulletin – deadline for completion 30/9/2025	Staff	7/9/2025	NT/HL	
5. Share survey with Equality Champions and Equality staff networks	Equality Champions	7/9/2025	JDM	
6. Share survey with Wellbeing Champions	Wellbeing Champions	7/9/2025	CW	
7. Share survey with IHC people and culture group			HCL/JDM	
8. Share survey with Culture Change Leaders	Culture Change Leaders	7/9/2025	NH via NT	
9. Share survey with members of the Implementation Group for reducing homelessness	Implementation group – internal BCUHB members	7/9/2025	JDM	
10. QR posters for displaying in staff areas via champions	Staff	7/9/2025	NT/JDM	
11. Pop up stand at Wrexham Maelor with paper copies – (share stand with hate crime week)	Staff	23/9/2025	NT/JDM	
12. Pop up stand at YG with paper copies – share stand with hate crime week)	Staff	29/9/2025	NT/JDM	
13. Pop up stand at YGC with paper copies (share stand with hate crime week)	Staff	30/9/2025	NT/JDM	

Internal

Appendix 4: Comms messaging for Betsi Comms Team

Supporting info:

Comms for Betsi

Everyone should have a home… give your views to help improve health services for people at risk of or experiencing homelessness

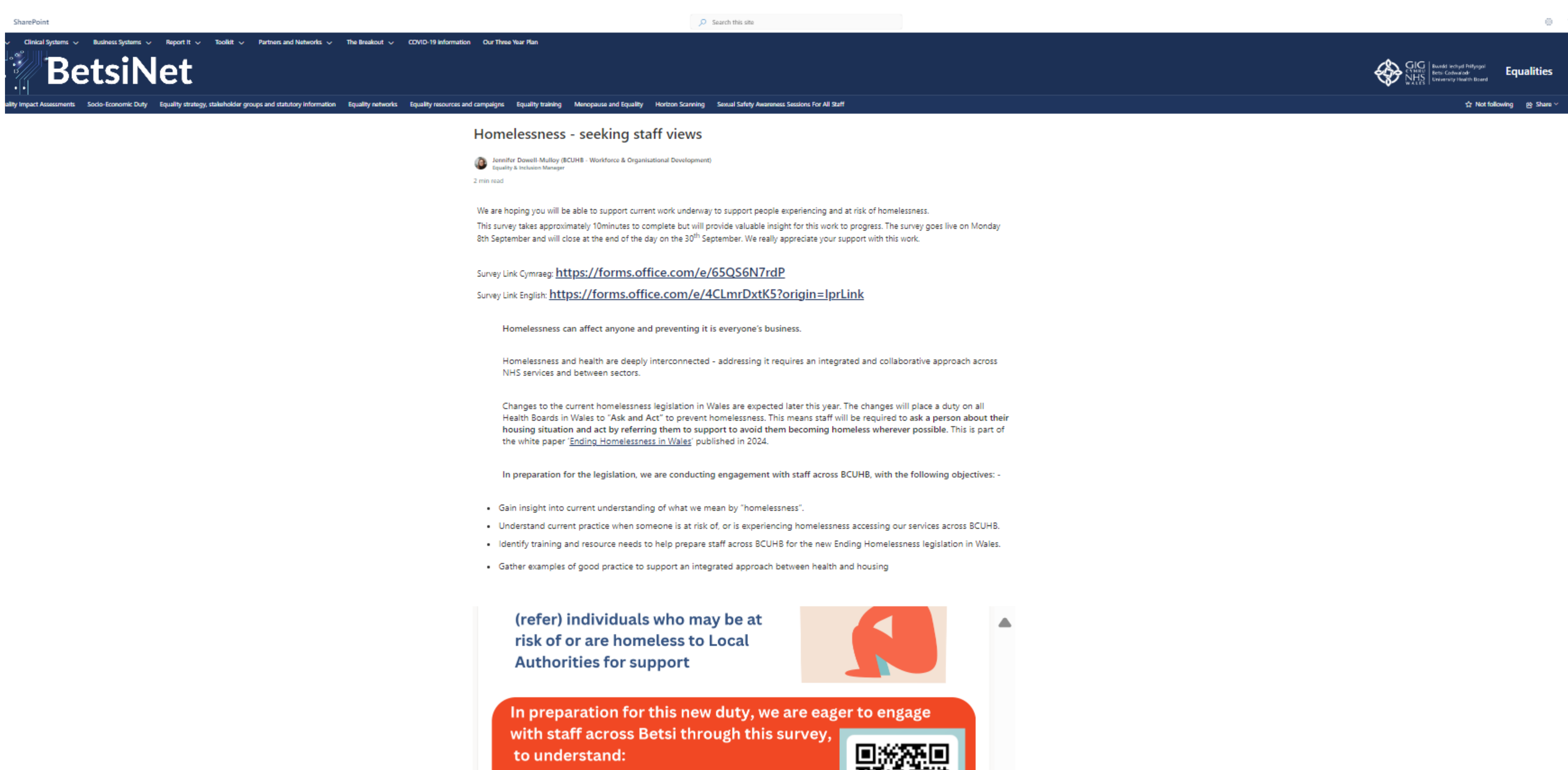
Homelessness and health are deeply interconnected. Homelessness can affect anyone, and the prevention of it is everyone's business. Changes to the current homelessness legislation in Wales are expected later this year. The changes will place a duty on all Health Boards to '**Ask** and **Act'** as a key intervention to end homelessness by requiring health board staff to **ask about a person's housing situation as early as they can and act to avoid them becoming homeless wherever possible**.. This is part of the white paper proposals to end homelessness in Wales.

In preparation for the legislation, we are carrying out engagement work with you to ask your views on your understanding, current practice, and confidence in supporting patients with homelessness. We want to use this feedback to improve our current support to people (both patients and staff) who face homelessness or are at risk of homelessness. Please see the survey link below. The form is anonymous but if you wish to be involved in this work, please contact **BCU.equality@wales.nhs.uk**

For further information about the changes to the Homelessness Legislation in Wales please see Written Statement: The Homelessness and Social Housing Allocation (Wales) Bill (19 May 2025) | GOV.WALES

NT/JMD 12/8/2025

Appendix 5: Promotion on Betsi Net (the Equality page)



Appendix 6: Promotion on BCUHB Staff Weekly Bulletin (x2 consecutive weeks)

Weekly Bulletin - 22nd September, 2025

17 min read

Weekly Bulletin

Notices, Events and Training

Vacancies and Secondments

Staff benefits and Discounts

WEEKLY BULLETIN - News and Updates

New this week:

- Preventing Tailgating: Protecting Our Workplace
- Reminder: Check patient email address before use
- Staff guidance for managing filming and photography on BCU sites
- Use of meeting recordings in MS Teams

Preventing Tailgating: Protecting Our Workplace

Reminder: Check patient email address before use

Staff guidance for managing filming and photography on BCU sites

Use of meeting recordings in MS Teams

Coming Soon – the 2025 NHS Wales Staff Survey

Printing cost efficiency

Launch of new protocol and revised template (NU51)

All Ages Mental Health and Learning Disabilities Electronic Healthcare Record Project – Children Services' workshops

Intermediate level Course at Nant Gwrtheyrn for the Health and Care Sector

Supporting Un-Paid Carers - Feedback Survey

Culture Roadshows – September/October 2025

Lunchtime Webinar: Supporting Discharge Planning and Optimising Hospital Patient Flow

Your menopause matters - join our October Roadshow (13- 15 October)

An Introduction to Eating Disorders - Foundation Level 1

Macmillan coffee morning (more cake than coffee!)

Wrexham glaucoma peer support group meetings

Fit Testing- Optrel PAPR Kits

Health & Safety Self-Assessment Tool Box Talk via Teams

The Conversations WE Need to Have: Neurodivergence Awareness

Now Recruiting - Culture Change Leaders

Everyone should have a home... give your views to help improve health services for people at risk of or experiencing homelessness

Homelessness and health are deeply interconnected and can affect anyone. Prevention of this is everyone's business. Changes to the current homelessness legislation in Wales are expected later this year. The changes will place a duty on Health Boards to 'Ask and Act' as a key intervention to end homelessness. This is part of government proposals to end homelessness in Wales.

In preparation for the legislation, we are carrying out engagement to ask your views about homelessness. We want to use this feedback to improve our current support to people (both patients and staff) who face homelessness or are at risk of homelessness. Please see the survey link below.

Survey Link Cymraeg: https://forms.office.com/e/65QS6N7rdP
Survey Link English: https://forms.office.com/e/4CLmrDxtK5?origin=lprLink

Appendix 7: Images of promotional materials at BCUHB establishments

Appendix 8: Q21 in the survey – Any Other Comments full responses

Would be helpful to look at this from supporting staff in this situation rather than just a patient view.
As above, distinct barriers to accessing homeless services for our clients. Clients are often labelled as problematic, and hurdles put in their way to accessing accommodation in order to improve their outlook
Training required
I do think the health board would benefit from a homelessness warden/liaison officer to work with the local services to ensure patients are discharged to a safe place.
I think as we are a service providing shorter courses of treatment for patients, the new patients entering the service may not divulge such information. In the past we have known families, and siblings, situations at home to a far greater degree. This had made me stop and think, and realise the daily struggles of those experiencing the threat of homelessness. I feel that I/we need to do better in this area.
thank you for raising my awareness - looking forward to some training and info re referrals where needed
interested as homelessness is becoming more common
Staff who do not require training required to complete training because of where they sit e.g., nursing, not likely for the foreseeable future be patient facing
Contact with our service is a good opportunity to ensure anyone at risk of or experiencing homelessness is getting the support they need.
Please do not forget staff who are also facing homelessness (I was homeless with a small child 15 years ago)
How horrified I frequently am that nothing appears to be done to help highly vulnerable young people- hopefully this is due to a gap in my knowledge of what is available? It seems that for teenagers currently there is only Hurst Newton, The Foyer or the place in Rhyl - these are usually housing adults who are dealing substances, predators, and certainly not for vulnerable 16-year-olds but apparently there is nothing else available- and I don't have a spare room!
I don't work on the front line but I think it will be useful for all staff to do the training
The form is mainly centred on clinical staff but I feel needs to be amended to include questions in relation to staff wellbeing and what a manager/supervisor should do for staff in this situation
I think this is really important as the most deprived are those with the highest proportion of chronic conditions. If we can get the systems in line - it will ease burden on NHS in long run and be economically important, as well as the obvious benefits to all individuals affected.
No, I look forward to learning more about it and how to ask the appropriate questions
I'm not patient facing. It would have been better targeted at staff who work with patients and/or members of the public rather than a general roll-out to all.
Streamline support is long overdue from housing and they most definitely need to be based at the hospitals and Main community mental health team offices
I do think there are a lot of people getting lost to the system and not being able to get the help that may be out there due to communication breakdowns
let's hope this is not another tick box exercise

I have a patient who is living in overcrowded conditions with his family and is having very poor support from the local housing department. They are in desperate need of a larger property. I have a patient whose partner is pregnant and they would like to move from their one-bedroomed first floor housing association flat, but have been told there are families in more crowded situations that can't be moved. There is no housing available. Everything takes too long to sort out.
A gap we notice is that where a person in known or reports to be homeless, and there is either no duty to accommodate or no accommodation available, it can be a very difficult conversation to have with the person that is there with you, as a non-housing service. Across north Wales there appears to be differing provision of things like 'rough sleeper packs', so we have often felt completely at a loss as to what to do. As a team, we have at times actually purchased tents and sleeping bags from our own personal money in order to be able to provide people with 'shelter'. We hear various feedback from people who are rough sleeping, for example in Wrexham, there is the belief that if you are rough sleeping you have to be 'seen' by the LA homeless outreach team on 3 separate occasions to be 'classed' as rough sleeping. We also hear reports that where people have had tents in order to gain shelter, that these tents are removed if found by the homelessness outreach team. We as a service have also made referrals for people who are rough sleeping in Wrexham to be told that they have to be 'seen' rough sleeping by the homelessness outreach team, they will not accept the report from us, a BCUHB service, which I guess would be an issue/barrier to 'Ask and Act'.
where can we get posters to display in waiting rooms that could guide someone who needs help?
None, other than this survey has highlighted how much I don't know
In my line of work, I have never been provided with any education, training or advice regarding patients who are facing homelessness or are currently homeless.
This survey seems more geared to secondary and community care rather than primary care. Some questions are not relevant to primary care.
Please let me know if I can help outside of work as a volunteer

Appendix 9: Summary of departments who undertook the survey

Audiology	IHC
Pathology (Blood Sciences, Immunology) x3	Living Well Service x2
CAMHS x3	LDS x2
Cancer	Medicine
Cardiology	Mental Health x2
Children's	MH and LD
Children's LD Service	Morris Ward
Children's Services	Neuro Outpatients
Community Mental Health Team (CMHT) x3	Neurophysiology
Community	PALS
Community Dental x2	Occupational Health x4
Community Hospital	Pharmacy x17
Community Mental Health and Substance Misuse Services	PAMS/Prosthetics
Corporate Services	Patient Flow
DDAT x2	Patient Records
Dental	Physio Outpatient
Diabetes	Posture and Mobility Service x3
Dietetics x3	Physio
Emergency Care	Podiatry
Enhanced Care Service Community Resource Team	Primary Care BCU managed practice
Enhancing Lives	Public Health x2
EQ	Pre-op clinic
Equalities	Rehabilitation
Eye Department	Same day Emergency Care
Finance	SBSS
GP/ Primary care (GP, Practice Nurse, GP surgery) x8	Speech and Language Therapy x5
Health Improvement – Stop Smoking Advisor	Stroke
Harm Reduction Service	Substance Misuse x4
Health liaison for Learning Disability	Therapies
Help Me Quit x3	Surgical
Health Psychology	Workforce and OD x3
HMP Berwyn	Unison TU lead rep
Hostel Services	Youth Justice
Hospital- HCA	

Planning, Population Health & Partnerships Committee

CORPORATE RISK REGISTER

Dyddiad y Cyfarfod **Date of Meeting**	05 March 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 Committee is asked to **receive assurance** of the two updated Corporate Risks and will fall under the remit and oversight of the Planning, Population Health and Partnership Committee (see appendix 3):

- CRR25-03 'Population Needs'
- CRR25-05 'Strategic Change – Impacting Care and Staff Delivery'

CRR25-03 'Population Needs' risk has a current risk score which sits outside the risk tolerance level set within the risk appetite. No proposed changes in risk scoring.

CRR25-05 'Strategic Change - Impacting Care and Staff Delivery' - As most actions are now complete (with one due for closure at the next review), the Lead Executive will reassess the risk score with a view to reducing it.

Action Progress
A total of 19 actions have been developed across the two corporate risks.

- 2 actions are complete
- 15 actions are progressing
- 2 actions are delayed, both relating to CRR25-03 'Population Needs', with commencement now planned for 2026/27 due to external dependencies.

A number of actions are due in March 2026 and require monitoring or assessing to ensure this is the correct action date.

Risk Scrutiny and Governance
All corporate risks have been reviewed and updated by Executive Leads. The following risks are scheduled to undergo deep dives review at the Executive Committee:

- April 2026: CRR25-03 'Population Needs'
- May 2026: CRR25-05 'Strategic Change - Impacting Care and Staff Delivery'

The Committee is asked to:

- Provide feedback on the adequacy of controls, gaps in control, and current action planning.
- Note ongoing oversight through Executive Leads, Senior Risk Owners, the Risk Scrutiny Group, and the Executive Committee, prior to escalation to the 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**
Head of Risk Management	16/01/2026	The Head of Risk Management conducted an assessment on all corporate risks, this has been presented to RSG and the risk leads. The risk action plans are both due to be updated and

		should be outcome focused and measurable (including metrics where possible).

Acronymau / Rhestr Termau Acronyms / Glossary of Terms	
CRR	Corporate Risk Register
RSG	Risk Scrutiny Group
BAF	Board Assurance Framework

Corporate Risk Register

1. Y SEFYLLFA
SITUATION

The purpose of this report is to provide an update to the Committee on the most significant risks to which the committee has overall accountability and oversight of.

Two consolidated Corporate Risks will fall under the remit and oversight of the Planning, Population Health and Partnership Committee (see appendix 3):

- CRR25-03 ‘Population Needs’
- CRR25-05 ‘Strategic Change – Impacting - Care and Staff Delivery’

2. Y CEFNDIR
BACKGROUND

One risk remains above the Health Board’s risk tolerance, reflecting the scale of challenges associated with the services. Continued monitoring of associated actions will be required to ensure progress is maintained.

Both risks are now planned for further scrutiny scheduled at the April and May 2026 Executive Team Meetings.

3. MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

Overdue/Delayed Actions

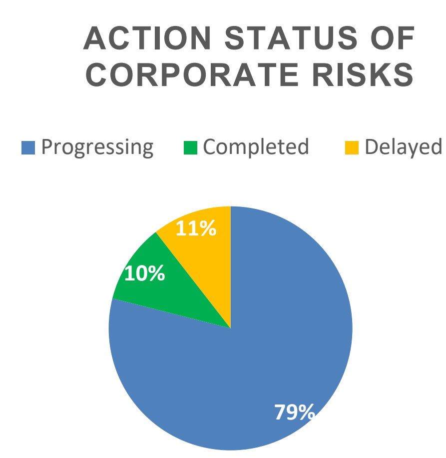
- **Note** the delay in two actions with commencement now planned for 2026/27 due to external dependencies on risk CRR25-03 'Population Needs'.

Risks above Health Board 25/26 appetite

One risk reported to Committee scores outside the tolerance range set in the appetite.

Risk Ref	Risks	Lead Exec Director	Current Risk Score	Risk Tolerance Range in Appetite Score
CRR25-03	Population Needs	Executive Director of Public Health	**16**	Quality <15

Action Plan status of Corporate Risks



Out of the 2 corporate risks, 19 actions have been developed to mitigate the risks, with all 15 open actions progressing and on track. 2 actions have been completed, with 2 delayed actions.

4. RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION

All risks have been reviewed and updated by the relevant service, with no proposed changes in risk scoring. One risk has a current risk score which sits outside the risk tolerance level set within the risk appetite.

Both consolidated Corporate Risks that fall under the remit and oversight of the Planning, Population Health and Partnership Committee are scheduled to be subject to deep dives at the Executive Committee, during the April and May 2026 meetings.

5. ARGYMHELLION
RECOMMENDATIONS

Gofynnir i'r Pwyllgor:
The Committee is asked to:

- **Note** the update on the two strategic risks **CRR25-03** and **CRR25-05** with one risk scoring **16** and remaining above the Health Board's risk tolerance**.**
- **Endorse** both risks for submission to the Board**,** noting no proposed scoring changes.

6. CAMAU NESAF
NEXT STEPS

1. Executive Committee deep dives, and to consider feedback from the group.
2. Approved Corporate Risks to be monitored, as business as usual, by Senior Risk Leads, Executives, the Risk Scrutiny Group and the Executive Committee.
3. Submission of Corporate Risks to Board.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	1. Building an effective organisation
	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**	Corporate Risks linked to Board Assurance Framework risks
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	Not Applicable 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** All Apply	**Meysydd Ansawdd** **Domains of Quality** All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:

	If more than one applies, please list below:	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:	
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?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

Counter Fraud Impact Assessment *Have you considered the counter fraud impacts*	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 - Corporate Risk Register Dashboard – Planning, Population Health and Partnership Committee (PPHP) (Public) – January 2026

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type / Appetite Level	Lead Board Committee	Action Progression			Risk Management Commentary
							Total	Completed	Delayed or Overdue	
EDoPH	CRR25-03	Population Needs	4x4 16	12	Quality (<15) Above Tolerance	Planning, Population Health and Partnerships Committee	13	0	2	13 actions with 11 progressing, 2 delayed actions due to external dependencies, to commence 26/27. Dental and community actions to be reviewed for impact and outcome.
EDoTSP	CRR25-05	Strategic Change – Impacting Care and Staff Delivery	4x3 12	8	Quality (<15) In Tolerance	Planning, Population Health and Partnerships Committee	6	2	0	Additional actions to be identified to reduce the risk to achieve the target risk score

Key:

Executive	
Executive Director of Public Health	EDoPH
Executive Director of Transformation and Strategic Planning	EDoTSP

Appendix 2 – Corporate Risk Register Heatmap

Corporate Risk Register Heat Map – Jan 26

Impact							
Catastrophic	**5**				Extreme • **Timely Patient Access to Safe and Effective Care** • **Modernising our Infrastructure** • **Value Delivery and Financial Sustainability** • **ICT Failure and Cyber**	Extreme
Major	**4**				• **Future Demand & Sustainable Workforce** • **Population Needs** • **Leadership and Operating Model** • **Non-Compliance with Regulatory and Legislative Requirements** • **Health and Safety**	Extreme • **Safe Environment**
Moderate	**3**				• **Strategic Change – Impacting Care and Staff Delivery**	
Minor	**2**					
Negligible	**1**					
		1	**2**	**3**	**4**	**5**
		Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain** 2

Possibility

Corporate Risks

Planning, Population Health and Partnership Committee (Public)

Appendix 3 - Corporate Risk Register PPHP Committee (Public) – January 2026

<table>
<tr><td rowspan="2">CRR 25-03</td><td colspan="2">Risk Title: Population Needs</td><td>Date Opened: 21/08/2025
(version 2 refined from 2023)</td></tr>
<tr><td colspan="2">Assuring Committee: Planning, Population Health & Partnership Committee</td><td>Date Last Committee Review: 06/11/2025</td></tr>
<tr><td>Date Last Reviewed:
24/12/2025</td><td>Director Lead: Executive Director of Public Health</td><td>Link to BAF: BAF24-06/07</td><td>Target Risk Date: 31/03/2028</td></tr>
<tr><td colspan="4">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.
This may be caused by a failure to take appropriate health prevention responses in areas such as immunisation, outbreak management and screening, failure to deliver interventions that improve people's health, increasing pressures in primary care, rising demand for chronic condition management, and insufficient capacity in children’s, dental, and mental health services.
This may lead to unmet health needs, preventable and communicable diseases, poorer health outcomes and widening inequalities for the North Wales population.</td></tr>
</table>

Mitigations/Controls in place	Additional Controls required
1. Recurrent funding secured for Healthy Weight / Healthy Wales programmes 2. Diabetes “Case for Change” a structured, evidence-based mechanism to identify service gaps 3. Healthcare Public Health programmes support the integration of population health approaches within patient pathways	a. Limited system-wide prevention leadership and prevention not consistently prioritised b. Inconsistent commissioning approach across community and primary care services. c. The plan in place for the management of communicable disease outbreaks (in and out-of-hours) within BCUHB

4. Approved Communicable Disease Plan in place with supporting procedures in place for some communicable diseases. 5. Primary Care Board and subgroups (dental, community pharmacy, optometry, GMS) provide cluster-level governance. 6. CHC (Community Health Council) teams and community escalation frameworks in place 7. Welsh Government ND transformation programme funding to support longest waiters 8. National referral pathways in orthodontics and Dentist with Enhanced Skills / Tier 2 provision. 9. Prevention, Population Health & Early Intervention Executive Delivery Group provides oversight of delivery.	requires testing / simulation and socialising to ensure effectiveness d. Diabetes Programme support to establish cross cutting delivery plan e. Insufficient digital integration for community and Neurodevelopment services f. Fragility of Neurodevelopment workforce and reliance on temporary funding g. Lack of restorative dentistry service and workforce pipeline h. Evidence to support the Health Inclusion offer.

Actions	**Action Owner**	**Due Date**	**Progression Analysis**
Complete Population Needs Assessment which informs the development and focus of Health Board Strategy. Data to support the Strategic Intent has been provided	Head Of Public Health Assurance & Development, Public Health	31/03/2026	Progressing
Identify population health focused priorities for Health Board delivery Data to support the Strategic Intent has been provided alongside a number of evidence reviews. Programme plans within the Public Health Directorate include identification of need across a range of services, programmes and within the population.	Head Of Public Health Assurance & Development, Public Health	31/03/2026	Progressing

Development of Population Health Management data and intelligence to ensure that Health Board is intelligence-led Delayed due to financial approval for spend against new posts. Recent agreement for posts to commence in 26/27.	Head Of Public Health Assurance & Development, Public Health	31/03/2026	Delay
Develop a plan which addresses recommendations from the BCUHB Weight Management Service review Report received outlining recommendations, which will inform 26/27-28/29 IMTP plans.	Head Of Public Health Assurance & Development, Public Health	31/03/2027	Progressing
Communicable disease outbreak management plan is embedded within services with an agreed schedule of simulation events and schedule of review by the Board The plan is available however it is recognised that the risk now lies within preparedness for communicable disease likelihood and severity. The associated risk descriptor has been updated to reflect this. The gaps around preparedness lie with communications, knowledge and application of existing plans and procedures.	Assistant Director Of Health Protection, Public Health	31/03/2026	Progressing
Contribute to co-design Wellbeing, Prevention & Anchor Framework for North Wales as part of the Regional Partnership Board The Regional Partnership Board and BCUHB have develop a set of 7 key mission statements as the basis of the Framework.	Head Of Public Health Assurance & Development, Public Health	31/03/2026	Progressing

Achieve the ministerial priority BCUHB Integrated Vaccination & Immunisation Service – Increase vaccination rates against targets	Head Of Public Health Assurance & Development, Public Health	31/03/2026	Progressing
Implement plan to target resources for the most vulnerable groups (e.g. – those experiencing homelessness, Gypsy, Roma and Traveller communities) which will contribute to reducing inequalities in healthy life expectancy This work supports the development of the Health Board Health Inclusion Offer which will support access to health in key groups.	Head Of Public Health Assurance & Development, Public Health	31/03/2026	Progressing
Establish Diabetes Change Programme providing programme management, milestones and delivery plan – in order to meet the Ministerial priorities (increasing the % receiving all 8 NICE Care processes) There is a risk to delivery of the Q3 and Q4 Diabetes objectives, related to system resources available. This is being mitigated through alignment with other Health Board key programmes of work to support efficient use of resources, but may result in changes to timelines for delivery. There are plans currently being implemented to progress the programme and these will extend into 26/27.	Head Of Public Health Assurance & Development, Public Health	31/03/2026	Delay

Develop a Community and CHC Strategic Plan with Local Authorities.	Acting Assistant Director Care Homes Support & CHC Commissioning	31/03/2026	Progressing
Implement surge and escalation plans with Local Authority partners for community flow	Acting Assistant Director Care Homes Support & CHC Commissioning	31/03/2026	Progressing
Management of CYP (Children and Young People) needs, ND workforce business case submitted to the Executive Team, decision on the case deferred pending a broader review of funding priorities No approval received in relation to business case submitted, focus for this financial year is on utilising additional non-recurrent funding received from WG to reduce longest waiters	CAMHS Programme Management Business Lead, Child & Adolescent Health	31/03/2026	Progressing (revised date from 31/12/2025)

Undertake a dental diagnostic deep dive to inform strategy In 2025 a review of the primary care dental service was undertaken to look at the current challenges in both General Dental Services (GDS) and the Community Dental Service (CDS). Key issues were identified in areas including leadership, performance, process, finance and people management. Progress within the service is now being monitored at a senior level via the IPEDG group, and a senior clinical review of the service is being planned for earlier 2026.	Assistant Director Of Primary Care	31/03/2026	Progressing

25
20
15
10
5
0
01/11/2023. 08/02/2024. 18/03/2024. 15/05/2024 12/08/2024 08/10/2024 12/12/2024. 24/02/2025. 02/04/2025. 21/08/2025. 25/08/2025. 28/11/2025. 24/12/2025.
Inherent: 20 20 20 20 20 20 20 20 20 20 20 20 20
Current: 20 20 20 20 16 16 16 16 16 16 16 16 16
Target: 12 12 12 12 12 12 12 12 12 12 12 12 12
Inherent Current Target

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality <15		Not in Tolerance

	Position & Intended Outcome for Risk
	Life expectancy / healthy life expectancy is declining, and there are worsening health inequalities. This has significant impact on demand for services and potentially on the wider community due to the loss of people from the workforce, and through the subsequent economic impacts on our communities. Worsening health outcomes, increasing ill health and widening inequalities directly affects the Health Board's ability and capacity to deliver excellent healthcare services, meaning the Health Board's purpose must retain clear focus on prevention and early intervention to improve the health and wellbeing of the population

<table>
<tr><td rowspan="2">CRR 25-05</td><td colspan="2">Risk Title: Strategic Change – Impacting Care and Staff Delivery</td><td>Date Opened: 21/08/2025
(version 2 refined from 2023)</td></tr>
<tr><td colspan="2">Assuring Committee: Planning, Population Health & Partnership Committee</td><td>Date Last Committee Review: 06/11/2025</td></tr>
<tr><td>Date Last Reviewed:
31/12/2025</td><td>Director Lead: Executive Director of Transformation and Strategic Planning</td><td>Link to BAF: BAF24-02</td><td>Target Risk Date: 31/03/2026</td></tr>
<tr><td colspan="4">There is a risk that patients may not benefit from planned improvements in care, access, and outcomes if the HB does not effectively implement or develop its strategic change programmes.

This may be caused by a lack of momentum in delivering change, unclear or underdeveloped clinical strategy, competing ministerial priorities, and inconsistent transformation efforts across clinical services.

This may lead to inefficiencies, missed opportunities to modernise care, continued misalignment between service delivery and patient needs, patient harm from long waiting times, delays, and backlog reviews, and increased frustration or disengagement among staff tasked with delivering change.</td></tr>
</table>

Mitigations/Controls in place	Additional Controls required
1. Scrutiny and oversight of strategy development work by the Strategic Planning and Service Change Group (SP&SC Group a sub-group of the Executive Committee), Planning Population Health and Partnerships (PPHP) Board Committee and the Health Board to ensure robust governance arrangements and timely escalation; which are important for enabling foundations for successful delivery of strategic change and co-production of the 1) Strategic Intent for North Wales with partners, 2) 10 Year Strategy for the Health Board, 3) Clinical Services Plan 2. Priority change programmes in place for the organisation 1) Major Change Programmes (Planned Care; Urgent and Emergency Care; Value and Sustainability; and Foundations For The Future), 2) Key Programmes (grouped into: Mental Health; Llandudno Planned Care hub; Improving safety, efficiency and effectiveness through digitisation; Diagnostics improvement; and Health and Well-being Hubs), 3) Challenged Services (Dermatology, Ophthalmology, Vascular, Urology, Oncology, Plastics, Orthopaedics, Orthodontics). 3. Change programmes controls in place and monitored by the Transformation and Improvement team to ensure they are run consistently and best practice project, programme and portfolio management is applied. As well as providing an objective and independent assessment of progress and areas of risk. 4. Oversight and scrutiny of the Major Change Programmes tracking progress, risks, and dependencies by the Executive Committee, relevant Board Committee and Health Board. The	a. Completion of the strategy development work, moving into the execution phase. b. Organisational approach to change management to be developed and implemented.

Key Programmes reports into SP&SC Group, PPHP and Health Board. 5. The Challenged Services report into SP&SC Group for review and oversight, Quality, Safety and Experience Committee (QSE) and Health Board. 6. External oversight and scrutiny is provided by Welsh Government via IQPD and JET as well as quarterly Challenged Services review meetings. 7. Terms of References for all groups with clear routes to escalation. 8. Legal and policy compliance including adherence to Welsh Government (WG) service change guidance. 9. Continued development of the portfolio management and reporting approach for all priority change programmes, including monthly monitoring of high risks across all priority programmes 10. Mobilisation of the Challenged Services oversight group that will report into the SP&SC Group.	

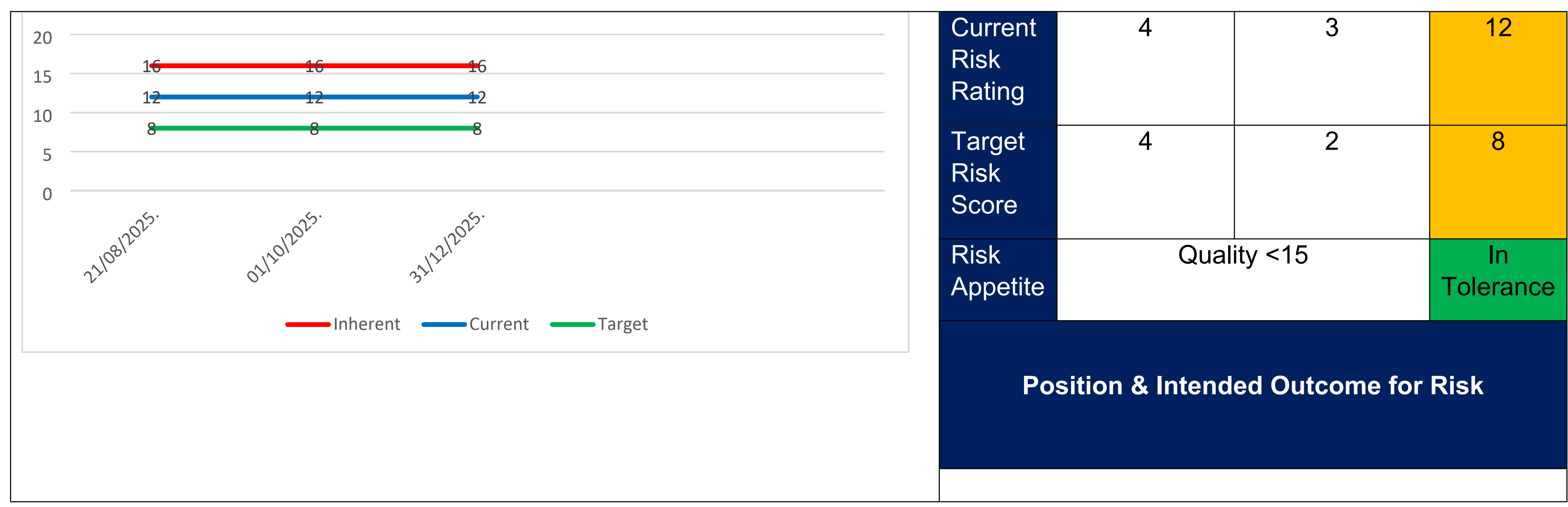
Actions	Action Owner	Due Date	Progression Analysis
Complete Strategic Intent for North Wales with partners, presenting to Health Board for approval	Head of Health Strategy and Planning, Transformation	31/01/2026	Progressing

Draft Strategic Intentions have been co-created, tested and refined with partners. The final draft strategic intentions will be presented to PPHP Committee on the 14th of January for review and comment and subject to any further amendments suggested by the Committee, the SIs will be submitted to the Board for approval on the 29th of January The lead Executive is reviewing the risk in light of the additional controls now in place and will be reported for the next cycle (This action is awaiting approval for closure and a review of the risk score with a view to reduce the score).	& Strategic Planning		
Complete the diagnosis phased of the Health Board's 10 Year Strategy, including an implementation plan for the remaining programme of work Now referred to as the discovery phase. A range of engagement activity has taken place to date including sessions with the Board, sub committees and partners as well as specific Strategy Development events. Further work is required to gather the more quantitative pieces of evidence which are required to develop the output of this work - a case for change document and to develop the implementation plan	Head of Health Strategy and Planning, Transformation & Strategic Planning	31/03/2026	Progressing
Complete preparations for phase 2 of the Clinical Services Planning (CSP) work, including an implementation plan	Head of Health Strategy and Planning, Transformation	31/03/2026	Progressing

Work has commenced and actions identified which will need to be developed into a work plan for the remainder of the financial year – actions include: - Establish initial Clinical Reference Group - Develop, test and finalise CSP methodology - Identify first tranche of CSP services - Raise awareness with staff, leveraging the opportunities presented by Foundations for the Future - Produce overarching case for change which will underpin the CSP Phase 2 work.	& Strategic Planning		
Implement changes to portfolio management and reporting based on feedback on early iterations of reporting across all the priority programme areas, including monthly monitoring of high risks across all priority programmes. Work is now complete and will continue to evolve as part of business as usual. Iterative changes have been made and the reporting has been very well received by Board Members for both Key Programmes and Challenged Services, with Board members stating that they feel more assured. Highlight reports in place for each programme/service in scope with summarised reporting through the Strategic Planning and Service Change Group and onwards to PPHP and Board. The lead Executive is reviewing the risk in light of the additional controls now in place and will be reported for the next cycle (This action is awaiting approval for closure and a review of the risk score with a view to reduce the score).	Assistant Director of Transformation and Improvement (Interim), Transformation & Strategic Planning	31/12/2025	Complete

Mobilise the Challenged Services oversight group that will report into the SP&SC Group This is complete. The first meeting was held on the 28th November with the next meeting scheduled for the 26th January, with the group developing plans for the regionalisation of services and transitioning into broader Clinical Services Plan work. The lead Executive is reviewing the risk in light of the additional controls now in place and will be reported for the next cycle (This action is awaiting approval for closure and a review of the risk score with a view to reduce the score).	Assistant Director of Transformation and Improvement (Interim), Transformation & Strategic Planning	31/12/2025	Complete
Organisational approach to change developed as one of the enabling products within Foundations for The Future programme Work is progressing and on track with a core group in place to drive forward the work. A paper outlining the approach was socialised at the Strategy Workstream in December followed a full presentation to the Informal Executive meeting on the 4th February, where the principles were met with support. Further work is being undertaken including a session with the Stakeholder Reference Group on the 2nd March.	Assistant Director of Transformation and Improvement (Interim), Transformation & Strategic Planning	31/03/2026	Progressing

	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16



Current Risk Rating	4	3	12
Target Risk Score	4	2	8
Risk Appetite	Quality <15		In Tolerance

Position & Intended Outcome for Risk

Planning, Population Health & Partnerships Committee

CORPORATE GOVERNANCE REPORT

Dyddiad y Cyfarfod **Date of Meeting**	05 March 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**
Members are asked to: • **NOTE** the summary of business considered in private session to be reported in public • **NOTE** the forward workplan

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**	

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 item were considered in private at the meeting held on 15 January 2026:

- Developing Sustainable Solutions for the Future of Penley Community Hospital
- Deep Dive on Cyber Risk

4.2 **Committee Forward Work Plan**

4.2.1 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.

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 15 January 2026.
- **NOTE** The Committee forward workplan.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	1. Building an effective organisation
	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

<table>
<tr><td rowspan="3">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</td><td>Do/Yes: ☐</td><td>Naddo/No: ☒</td></tr>
<tr><td>Canlyniad/Outcome:</td><td></td></tr>
<tr><td>Os naddo, dylech gynnwys y rheswm:
If no, please include rationale:</td><td>Not necessary for this report</td></tr>
<tr><td rowspan="3">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?</td><td>Galluogwyr Ansawdd
Enablers of Quality
All Apply</td><td>Meysydd Ansawdd
Domains of Quality All Apply</td></tr>
<tr><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant
Wellbeing of Future Generations Act – Wellbeing Goals</td><td colspan="2">Not Applicable</td></tr>
</table>

<table>
<tr><td rowspan="3">Effaith Amgylcheddol / Cynaliadwyedd (5Rs)
Environmental /Sustainability Impact (5Rs)</td><td colspan="2">Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td></tr>
<tr><td colspan="2">No - Not Applicable</td></tr>
<tr><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny:
If more than one applies, please list:</td><td></td></tr>
<tr><td rowspan="3">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</td><td>Do/Yes: ☐</td><td>Naddo/No: ☒</td></tr>
<tr><td>Canlyniad/Outcome:</td><td></td></tr>
<tr><td>Os naddo, dylech gynnwys y rheswm:
If no, please include rationale:</td><td>Not necessary for this report</td></tr>
</table>

<table>
<tr><td>Have you considered the Armed Forces Covenant Due Regard Duty?</td><td></td><td></td></tr>
<tr><td rowspan="3">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?</td><td>Do/Yes: ☐</td><td>Naddo/No: ☒</td></tr>
<tr><td>Canlyniad/Outcome:</td><td></td></tr>
<tr><td>Os naddo, dylech gynnwys y rheswm:
If no, please include rationale:</td><td>Not necessary for this report</td></tr>
<tr><td rowspan="3">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</td><td>Do/Yes: ☐</td><td>Naddo/No: ☒</td></tr>
<tr><td>Canlyniad/Outcome:</td><td></td></tr>
<tr><td>Os naddo, dylech gynnwys y rheswm:
If no, please include rationale:</td><td>Not necessary for this report</td></tr>
<tr><td rowspan="2">Cyfreithiol
Legal</td><td colspan="2">There are no specific legal implications related to the activity outlined in this report.</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td rowspan="2">Enw Da
Reputational</td><td colspan="2">There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td rowspan="2">Effaith ar Adnoddau
(Pobl / Ariannol)
Resource Impact
(People / Financial)</td><td colspan="2">There is no direct impact on resources as a result of the activity outlined in this report.</td></tr>
<tr><td colspan="2"></td></tr>
</table>

Planning, Population Health & Partnerships Committee – Non-Routine Committee Business Workplan

(1 April 2025 – 31 March 2026)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
27.11.25	Action 25.208.1 from Board	Board	Director of Public Health Annual Report	Update on progress to PPHP. Links to action 25.208.1 from Board: Director of Public Health Annual Report: Progress against the recommendations included in the Director of Public Health Annual Report to be taken forward by the Executive Committee and reported back to the Planning, Population Health and Partnerships Committee.	Jane Moore	Jane Moore	07.05.26	This update will form part of the Population Health Delivery Report
27.11.25	Action 25.209.1 from Board	Board and email from Philippa	Healthy Travel Charter	Update to PPHP Committee following sign up by the Board. Links to action 25.209.1 from the Board: Healthy Travel Charter: Progress against the Healthy Travel Charter to report back to the Board in May 2026.	Jane Moore	Jane Moore	07.05.26	This will be a separate report that will go to the Board after PPHP
15.04.25	Action from PPHP Committee PP24/11.3	PPHP Committee	Third Sector	Action states that a strategic approach to working with the Third Sector should be discussed further with the Executive Team and come back to the Committee. Steve Powell leading on Third Sector Commissioning Arrangements.	Helen Stevens-Jones Steve Powell	Helen Stevens-Jones Steve Powell	05.03.26	**CLOSED** A paper was included on the private agenda for the March 26 meeting.
12.03.25	Discussed with DR 12.03.25 See action PP25/21.2 on private action log	Dylan Roberts	Intelligence Led May be covered in a Board Development Session – PW to confirm	Progress on Intelligence Led Organisation	Dylan Roberts	Dylan Roberts	28.10.25	**CLOSED** This will be part of the Board Development Session in Feb 26
07.04.25	Email from Clare Budden 07.04.25	Clare Budden	Substance Misuse It was agreed at agenda setting on 28.07.25 to put this forward to Nov	Kirsty Brooke to present a item on substance misuse (Kirsty to join PPHP on 1st May)	Kirsty Brooke	Jane Moore	28.10.25	**CLOSED** This was included on the agenda for the Oct meeting
27.03.25	Action from Board 25/53.2	Board	IMTP Continuous Planning Committee to confirm whether any further action is required by PPHP	PPHP Committee to discuss how continuous planning in relation to the IMTP and focus for the next ten to fifteen years can be facilitated and monitored going forward.	Paolo Tardivel	Pam Wenger Clare Budden	TBC	**CLOSED** Continuous discussions are taking place with the Board & Committee