Bundle BCU Planning, Population Health and Partnerships Committee 10 December 2024

1 09:30 - PRELIMINARY MATTERS

1.1 09:30 - PP24/87 Welcome and Apologies - Verbal (Chair)

1.2 09:30 - PP24/88 Declarations of Interest - Verbal (Chair)

1.3 09:32 - PP24/89 Unconfirmed Minutes of Meeting held on 22.10.24 - Attached (Chair)
PP24.89 Minutes from PPHP Committee 22.10.24 V0.03 Unconfirmed (Public)

1.4 09:34 - PP24/90 Matters Arising & Action Log - Attached (Chair)
PP24.90 Summary Action Log PPHP Committee (Updated 03.12.24)

2 09:37 - STRATEGIC PRIORITIES

2.1 09:37 - PP24/91 Partnership Working - Discussion (Director of Partnerships, Engagement & Communications)
Gethin Morgan, Regional Partnership Board and Nicola Stubbins, Director of Social Services at Denbighshire Council to join for this item

2.2 10:07 - PP24/92 Primary Care Board Update - Paper (Executive Director of Transformation & Strategic Planning)
Rachael Page, Assistant Director of Primary Care to join for this item
PP24.92 Primary Care and Clusters Update - PPHP revised

3 10:17 - FOR ASSURANCE

3.1 10:17 - PP24/93 Outline Prevention Plan for 2025-58 - Paper (Acting Executive Director of Public Health)
PP24.93.1 Coversheet PPHP - Outline Prevention Plan 2425_2728 (002)
PP24.93.2 Overview Prevention Plan 25_28 Final V1.0

3.2 10:27 - PP24/94 Embedding Opportunities to be Active with the BCUHB Workplace - Paper (Acting Executive Director of Public Health)
PP24.94 ActiveWorkplace PPHP Committee FINAL
PP24.94.1 Active workplace toolkit 2024
PP24.94.2 Active Workplace Policy
PP24.94.3 Active Soles Insight Report
PP24.94.4 North Wales Healthy Travel Charter

3.3 10:37 - PP24/95 North Wales Gypsy, Roma, Traveller Health Needs Assessment - Paper (Acting Executive Director of Public Health)
PP24.95 GRT HNA PPHP Committee FINAL
PP24.95.1 GRT HNA

3.4 10:47 - PP24/96 BCU Diabetes Transformation Programme - Paper (Acting Executive Director of Public Health)
PP24.96 Transforming Diabetes Programme

4 10:52 - ROUTINE REPORTING

4.1 10:52 - PP24/97 Corporate Risk Register Report - Paper (Director of Corporate Governance)
PP24.97 Corporate Risk Register and BAF Report December 2024 PPHP (003)

5 10:57 - FOR INFORMATION

5.1 10:57 - PP24/98 Committee Forward Workplan - Paper (Director of Corporate Governance)
PP24.98 Workplan for PPHP Committee (Live Version as at 03.12.24)

6 10:58 - CLOSING BUSINESS

6.1 10:58 - PP24/99 Agree Items for Referral to Board / Other Committees - Verbal (Chair)

6.2 10:59 - PP24/100 Review of Meeting Effectiveness - Verbal (Chair)

6.3 11:00 - PP24/101 Date of Next Meeting - 18.02.25

6.4 11:00 - 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.'

Betsi Cadwaladr University Health Board (BCUHB)
UNCONFIRMED Minutes of the Planning, Population Health and Partnerships Committee held in Public on 22 October 2024 in the Boardroom, Carlton Court, St Asaph and via Teams

Committee Members Present	
Name	**Title**
Clare Budden	Independent Member (Chair of PPHP Committee)
Caroline Turner	Independent Member
In Attendance	
Chris Stockport	Executive Director of Transformation and Strategic Planning (Executive Lead)
Jane Moore	Acting Executive Director of Public Health
Helen Stevens-Jones	Director of Partnerships, Engagement and Communications
Dylan Roberts	Chief Digital and Information Officer
Mike Larvin	Independent Member
Pam Wenger	Director of Corporate Governance
Geoff Ryall-Harvey	Chief Officer, Llais North Wales
Dave Harries	Head of Internal Audit *(Observer)*
Fflur Jones	External Audit *(Observer)*
Lea Marsden	Programme Director, North Wales Medical School *(part meeting)*
Sharon Scott	EPRR Lead *(part meeting)*
Committee Support	
Laura Jones	Project Support Manager (Corporate Governance)
Philippa Peake-Jones	Head of Corporate Affairs

OPENING BUSINESS

PP24/70 Welcome and Apologies

The Chair of the Committee welcomed everyone to the meeting including Dave Harries on behalf of Internal Audit, Mike Larvin as an additional Independent Member and Geoff Ryall-Harvey representing Llais. Apologies were provided for Gareth Williams and Billy Nichols.

PP24/71 Declarations of Interest

Mike Larvin declared an interest in relation to the North Wales Medical School, no other declarations of interest were raised.

PP24/72 Unconfirmed Minutes of Meeting held on 20.08.24

It was agreed that the minutes of the meetings held on 20.08.24 were a true and accurate record subject to the following amendment: - item PP24/54.1 amend “A new National immunisation framework is being introduced” to “has been introduced”.

PP24/73 Matters Arising & Action Log

The Committee reviewed the action log and agreed to close the actions that were proposed for closure. It was confirmed that actions proposed for closure would remain on the action log in grey for an additional meeting before being removed to provide a line of oversight.

STRATEGIC PRIORITIES

PP24/74 Developing our Partnerships (Perspective from Llais North Wales)

The Chair welcomed the Chief Officer for Llais North Wales stating that part of the remit of the Committee relates to partnership working noting that the aim of the discussion was to better understand the role of Llais including any issues they may be facing and how we can work better together.

In presenting to the Committee, the Chief Officer for Llais North Wales highlighted:

- Llais is a statutory body funded by Welsh Government and was previously known as the Community Health Council.
- Llais is made up of a number of volunteers and the remit is based on a national programme.
- A framework is being established and the team are currently involved in areas of work which include site visits, complaints, staff, patient and public engagement.
- Llais work closely with the Health Board and share information they collate; some recent feedback was based around the discomfort of long waiting times in Emergency Departments (ED) and patients being open to travelling across North Wales to receive treatment more quickly.
- The team are working on several initiatives including linking in to Special Measures, the Royal College of Psychiatrists Review and the business case for the Llandudno Hospital Orthopaedic Hub.
- The team are also working on engagement opportunities and engage with approximately 1000-1200 people every month.
- There is a focus on links with Social Care and a Health & Social Care Summit is due to take place shortly.

As part of the discussion, the Committee:

- Recognised the need to develop links and create proposals in relation to the provision of Social Services
- Identified the need to consider feedback received via Llais in relation to service change and transformation such as patients willing to travel to access services in a more timely manner and addressing the issue of discomfort for patients waiting in ED.
- Reflected on the different aspects of the responsibilities of Llais and how this could be received by the Committee.
- Acknowledged the open and honest dialogue between Llais and the Health Board in terms of assurance and raising serious issues.
- Appreciated the request for stronger connection into the transformation programme.

Actions:

- PP24/74.1 Llais to provide a paper relating to the patient experience perspective to be included on the QSE/PPHP cycle of business on an annual basis (transfer log)

- PP24/74.2 Chief Officer for Llais North Wales to share the Llais monthly report on a regular basis.

PP24/75 Partnerships, Engagement and Communications Update

Members received the report and noted the progress. In presenting the report, the Director of Partnerships, Engagement and Communications highlighted:

- Work taking place is aligned to the three year plan and the annual objectives.
- A review of membership at the Regional Partnership Board (RPB) and Public Service Board (PSB) is currently taking place.
- The engagement of the team with partners and the positive impact this has on reporting.
- Improvements relating to the Stakeholder Reference Group (SRG) which has seen a renewed membership and growth in terms of forward looking and shaping the work of the Health Board.
- Progress in correspondence with politicians and a significant decrease in the time taken to respond.
- Development in the engagement space including support from Llais, pulse surveys across the organisation, staff workshops and bringing champions together.
- Progress from the Communications team in relation to a content plan approach to the website, stories and social media linked to the forward plan of the organisation.

As part of the discussion, the Committee:

- Recognised the work taking place in relation to the RPB and PSB with the aim of ensuring the right people attend and link back at a senior level to ensure we are engaging in an effective manner to gain value.
- Considered the need to start moving forward from an engagement stage into an influence stage in terms of connecting the feedback from the SRG and partners into the planning and priorities space.
- Discussed the use of pop-up health events and how these could link to assessing well-being within local areas and provide opportunities for people to discuss health issues.

Actions:

- PP24/75.1 Director of Corporate Governance to share the paper that went to the Executive Team on the Regional Partnership Board (RPB) and Public Service Board (PSB).
- PP24/75.2 Invite Nia Roberts, Vice Chair of the Joint Commissioning Committee (JCC) to attend a future meeting for a specific item and feedback.
- PP24/75.3 Director of Partnerships, Engagement and Communications to provide a reflection paper at the end of the year on the business that has been conducted by the Stakeholder Reference Group (SRG).

It was resolved that the Committee:

- Received **ASSURANCE**
- **DISCUSSED** and **NOTED** the paper

PP24/76 Review of Well-being Objectives

Members received the report and noted the progress in relation to the review of Well-being Objectives. In presenting the report, the Executive Director of Transformation and Strategic Planning highlighted:

- The work taking place focuses on the changes required to the well-being objectives in relation to fair working and sustainability by the end of quarter 3, a wider refresh is also required which aligns to the discussions around the ten-year plan.
- The paper focused on fair work and sustainable procurement and it was noted that the work of the Task & Finish Group is moving forward.
- A definition of fair work had been included in the paper following a previous action.
- Work continues in relation to the PSB, adult social care and modern slavery and this will develop through quarter 3.
- There has been good staff engagement across all fields within the Health Board.
- There is a need to understand the budget impact of some components and this is being discussed with Finance colleagues.

As part of the discussion, the Committee:

- Queried the work that is taking place in relation to deprived areas, health inequality and young people having apprenticeship opportunities.
- Highlighted the role of the Committee in relation to fair work is to receive assurance around the process and mechanism to align to the strategy. The People & Culture Committee need to be involved in discussions around what is being done within the organisation to address fair work.
- Considered the health and well-being profile of the future workforce and the need to establish young people within the workplace to protect the future of health services.
- Contemplated the timeframe for the work relating to the strategic plan and the opportunity to engage with the Committee to ensure the feedback links in to the longer-term strategy.

It was resolved that the Committee:

- **RECEIVED** the report and offered guidance on work underway to review the Health Board's well-being objectives.

Lea Marsden joined the meeting

PP24/77 North Wales Medical School

Members received the report and noted the progress in relation to the North Wales Medical School. In presenting the report, the Programme Director for the North Wales Medical School highlighted:

- This is the initial formal report that the Committee has received in relation to the North Wales Medical School.
- The timeline was established with Bangor University. The original plan was to launch in 2025 and the University subsequently launched the school a year earlier.

- There has been productive collaboration with the University and positive feedback from the first intake of students.
- The current curriculum provides students with early exposure to primary care and the flow through to secondary care, going forward the medical school seek to align the curriculum with the Health Board strategy.
- A business case based around the capital and revenue investment arising from the Medical School is in development and has considered estates across the organisation including general practices; recognised that current accommodation may be a barrier.
- The Medical School provides a catalyst for research and innovation in collaboration with Bangor University.
- There is a focus on pathways from education into employment including internships.
- A link with the careers fayre in Bangor University to promote a broad spectrum of career options within the Health Board including health and care professions as well as corporate careers.

As part of the discussion, the Committee:

- Agreed on the importance of getting the business case approved to support long term sustainability and address risks linked to the programme.
- Discussed the support provided by the Health Board, in partnership with Cardiff for students in Liverpool and Manchester as well as North Wales.
- Highlighted the need for students to understand the impact of population health and agreed that there is potential for innovation as the curriculum is revised to align with the annual plan.
- Agreed that the condition of facilities including GPs is poor and this needs to be address to ensure students can train and remain in North Wales.

Actions:

- PP24/77.1 Acting Executive Director of Public Health and Independent Member Mike Larvin to meet and discuss opportunities for Public Health research innovation within the curriculum.
- PP24/77.2 Have a wider discussion around the Medical School at a Board Development session ahead of this going to the Performance, Finance and Information Governance Committee in January 2025 and Board in March 2025.

It was resolved that the Committee:

- Were **ASSURED** on the progress to establish the North Wales Medical School and partnership working with Bangor University.

Lea Marsden left and Sharon Scott joined the meeting

FOR ASSURANCE

PP24/78 Civil Contingencies - Emergency Preparedness, Resilience and Response (EPRR) Progress Report

Members received the report and noted the progress in relation to Civil Contingencies. In presenting the report, the EPRR Lead highlighted:

- The paper provides a level of assurance that planning is taking place in relation to business continuity.
- Work has been taking place to review the current arrangements across the organisation and assess plans and policies in place within the IHCs and corporate services.
- A High Consequence Infectious Disease Strategic Planning Group has been established to work with the health protection team to ensure plans and pathways are in place to deal with issues including Mpox.
- Recruitment is taking place for senior posts to support winter planning, resilience and major incidents.
- Training is taking place to strengthen knowledge and support on call training needs.
- Winter planning is taking place and work continues with Integrated Health Communities (IHCs) to ensure robust plans are in place.

As part of the discussion, the Committee:

- Discussed linking in with joint training events across North Wales to ensure good partnership working, it was confirmed that engagement is taking place in this space and there is a need to work closely with key partners agencies.
- Highlighted concern in relation to the deferment of the Civil Contingencies Internal Audit and suggested that the need for related risks to be reviewed.
- Agreed the need to re-establish good principles and practices in relation to EPRR by having key plans in place and recognising the big risks such as cyber security.
- Established that this is the start of the journey, robust arrangements need to be embedded to allow the team to move into a more strategic space.

Action:

- PP24/78.1 EPRR Lead to review the Corporate Risk Register with the Head of Risk Management

It was resolved that the Committee:

- **NOTED** the content of the report for assurance.

Sharon Scott left the meeting

PP24/79 Public Health Delivery Report

This item was covered in the discussion of item PP24/81.

PP24/80 Influenza (Flu) Vaccination Uptake Update Report

Members received the report and noted the progress in relation to the Flu Vaccination Uptake. In presenting the report, the Executive Director of Public Health highlighted:

- There has been a good start to the campaign and approximately 3000 members of staff have already received the vaccine.
- GPs and community pharmacists are involved in the process and these services will be included in the vaccination model for next year.

It was resolved that the Committee:

- **NOTED** the content of the report.
- **ENDORSED** the planned approach to improve flu vaccine uptake across the workforce and eligible North Wales population.

PP24/81 Health & Wellbeing Profile of the North Wales Population Update

Members received the report and noted the progress in relation to the Health & Wellbeing profile. In presenting the report, the Executive Director of Public Health highlighted:

- It was agreed at Board that there is a need to start assessing preventative measures and considering what health issues we should be addressing within the local communities.
- The need to link population data with clinical data to highlight disparities within care and emergency settings.
- Areas of health that may cause challenges in the future including long term chronic conditions, deprivation and the mental health and well-being of young people.

As part of the discussion, the Committee:

- Highlighted the demographic changes and how this may cause challenges in the future in terms of the workforce within the health service.
- Identified that health needs differ across areas and there is a need to link in with Local Authorities and services.
- Confirmed that the data needs to inform the strategic planning process and the public health plans need to be linked to this to allow the organisation to understand the impact of the work being completed.
- Agreed the need to understand all areas including resource, funding and investment into prevention and how the organisation can get to a place where new funding is being invested into areas that have an impact on population health.
- Concluded that a regular update on Public Health should be presented to the Committee for assurance which aligns to the annual plan and strategy to allow the Committee to focus on longer term actions.

Action:

- PP24/81.1 Acting Executive Director of Public Health to present a Public Health Delivery Report / Improvement Plan to the Committee at every other meeting, the cycle of business will be amended to reflect this.

It was resolved that the Committee:

- **NOTED** the updated summary; and
- **RECEIVED** the recommendation that further updates are provided to the Committee on a regular basis.

ROUTINE REPORTING

PP24/82 Corporate Risk Register Report

Members received the report and noted the progress in relation to the Corporate Risk Register. In presenting the report, the Director of Corporate Governance highlighted:

- A Risk Scrutiny Group has been established under the Executive Team to provide a more detailed review of risks and Nicola Jones will join the meetings to allow the Board Assurance Framework to be shaped with input from Internal Audit.
- Where the Board agreed that risks are within tolerance, the risks will be shared but not included as an agenda item at Committee meetings, this is being discussed at the Chairs Advisory Group on 30.10.24 and if agreed will be replicated for all Committees.

As part of the discussion, the Committee:

- Welcomed the approach and were assured by the work taking place and noted the earlier discussion of the need to review the risks related to EPRR

It was resolved that the Committee:

- **RECEIVED ASSURANCE** for the four (one private) corporate risks to which the Committee has overall accountability.

FOR INFORMATION

PP24/83 Committee Forward Workplan

The Chair highlighted that the Corporate planning update had been deferred to the December meeting. It was noted that there is a need for members to feel engaged and work collaboratively therefore it was suggested the private session of the December meeting could be scheduled to allow for the draft Annual Plan to be considered as a workshop style item.

CLOSING BUSINESS

PP24/84 Agree Items for Referral to Board / Other Committees

It was agreed that the following should be referred to the Board:

- Wider strategic discussions around the North Wales Medical School
- Reporting on the well-being objectives as part of the longer term strategic plan
- The work on Emergency Preparedness, Resilience and Response

PP24/85 Review of Meeting Effectiveness

It was agreed that there had been a good balance of items for discussion.

PP24/86 Date of next meeting

Tuesday 10th December 2024, 9.30-12.30pm

Planning, Population Health & Partnerships Committee Action Log

Updated 03.12.24

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	**PP24/78.1**	22.10.24	**Civil contingencies – Emergency Preparedness, Resilience and Response Progress Report** EPRR Lead to review the Corporate Risk Register with the Head of Risk Management.	Sharon Scott	~~Dec 2024~~ Revised timescale Feb 2025	**Remain Open** **21.11.24** An item focusing on the EPRR Risks will be included on the agenda for the meeting in February 2025. Civil Contingencies / EPRR will report to every other meeting of the Committee.
2	**PP24/11.3**	23.04.24	**Partnerships, Engagement and 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.	Helen Stevens-Jones	~~October 2024~~ ~~Dec 2024~~ Revised timescale June 2025	**Remain Open** **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.
3	**PP24/49.7**	20.08.24	**Developing our Partnerships** Director of Corporate Governance, Director	Pam Wenger Helen Stevens-	~~October 24~~	**Remain Open** **02.12.24** Further work is

			of Partnerships, Engagement and Communications to work together on a document to capture the key themes, next steps and strategic approach to working with the Third Sector with oversight from the Chair.	Jones Clare Budden	Revised timescale June 2025	required; an update will be presented to the Executive Team and will come back to the Committee in the next six months. **02.10.24** This action is in progress. A meeting has been arranged to take place and an update will be provided at the October meeting.
4	**PP24/56.2**	20.08.24	**Decarbonisation Action Plan** The Acting Executive Director of Public Health agreed to link in with the Interim Executive Director of Finance on the development of a transformation sub group to address options for active transport.	Jane Moore Russell Caldicott	~~October 2024~~ ~~Dec 2024~~ Revised timescale Feb 2025	**Remain Open** **03.12.24** This action will remain open and progress further once the new Director of Environment commences in post. **14.10.24** Further work is required to progress this action.
ACTIONS PROPOSED FOR CLOSURE						
1	**PP24/74.1**	22.10.24	**Developing our Partnerships** Ensure that a Llais experience paper is included on the QSE / PPHP CoB annually (transfer log)	Philippa Peake-Jones Geoff Ryall-Harvey	Within the year	**Action proposed for closure** **21.11.24** GR-H has confirmed that the Llais Annual Report / Experience Paper will go to QSE & PPHP in April / May 2025 and the CoB / forward workplan have been revised to reflect this.
2	**PP24/74.2**	22.10.24	**Developing our Partnerships** Chief Officer for Llais North Wales to share the Llais monthly report on a regular basis.	Geoff Ryall-Harvey	Dec 2024	**Action proposed for closure** **21.11.24** A copy of the October Llais Report has been circulated via email and going forward this monthly report will be shared as

						part of the weekly Corporate Governance update.
3	**PP24/75.1**	22.10.24	**Partnerships, Engagement and Communications Update** Share the Executive Team paper on the PSB and RPB.	Pam Wenger	Dec 2024	**Action proposed for closure** **21.11.24** The PSB and RPB papers that went to an Executive Team meeting have been circulated via email.
4	**PP24/75.2**	22.10.24	**Partnerships, Engagement and Communications Update** Invite Nia Roberts, Vice Chair of the Joint Commissioning Committee (JCC) to a future meeting for a specific item and feedback.	Helen Stevens-Jones Pam Wenger	Feb 2025	**Action proposed for closure** **21.11.24** The Chair, Dyfed Edwards attended the last meeting of the JCC to provide a verbal update and a future session is planned with the JCC in 2025. Suggest that we could extend an invite to Nia Roberts to observe a future meeting.
5	**PP24/75.3**	22.10.24	**Partnerships, Engagement and Communications Update** Director of Partnerships, Engagement and Communications to provide a reflection paper at the end of the year on the business that has been conducted by the SRG.	Helen Stevens-Jones	Feb 2025	**Action proposed for closure** **Update 25.11.24** HSJ has contacted Mike Parry to confirm that a paper on the impact of the SRG from 2023/24 will be presented to the Committee in February and Mike Parry has agreed to join the meeting.
6	**PP24/77.1**	22.10.24	**North Wales Medical School Update** Jane Moore and Mike Larvin to meet to discuss opportunities for Public Health research innovation within the curriculum.	Jane Moore Mike Larvin	Dec 2024	**Action proposed for closure** **26.11.24** Contact his been made between Jane and Mike to arrange a Teams meeting to discuss this further.
7	**PP24/77.2**	22.10.24	**North Wales Medical School Update**	Pam Wenger	Dec 2024	**Action proposed for closure**

			Look at having a wider discussion around Medical School at a Board Development session ahead of this going to PFIG in January 2025 and Board in March 2025.			**21.11.24** This session is planned for the February Board Development session.
8	**PP24/81.1**	22.10.24	**Public Health Delivery Report** Public Health Delivery Report / Improvement Plan to be presented to every other Committee and the cycle of business to be amended to reflect this.	Jane Moore Philippa Peake-Jones	Feb 2025	**Action proposed for closure** **21.11.24** The PPHP Committee cycle of business has been revised to include this report.
Closed Actions (as agreed at meeting on 20.10.24)						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	PP24/12.2	23.04.24	Civil Contingencies The Committee discussed the Emergency Preparedness, Resilience and Response (EPRR) and it was agreed that an interim report would come back to the Committee in October highlighting the findings from the initial review, the testing that has been completed and the plans that have been put in place.	Jane Moore	October 2024	16.09.24 EPRR has been included as an item on the agenda for the October meeting.
2	PP24/33.8	18.06.24	Population Health – Focus on System Approaches to Weight Management In terms of progress against the Weight Management programme it was suggested that a delivery plan comes back to the committee to provide assurance. In terms of risk, it was suggested work is completed to review risks that relate to this programme and how the committee have oversight of	Jane Moore	October / December 2024	14.10.24 The Public Health Delivery Report is included on the agenda for the October meeting and covers weight management and the current risks. 20.08.24 This will come back to the Committee in October / December 24.

			the risks. The committee agreed to receive a delivery and risk plan as part of the Public Health report.			
3	PP24/49.1	20.08.24	Developing our Partnerships Circulate the Bevan Commission report on the values and value of the third sector outside of the meeting.	Laura Jones	October 24	21.08.24 This link was circulated on 20.08.24 with the PPHP Committee actions.
4	PP24/49.4	20.08.24	Developing our Partnerships The Executive Director of Transformation and Strategic Planning to make contact with Tom Barham, Chief Officer, Denbighshire Voluntary Services Council to discuss the work relating to the Royal Alexandra Hospital outside of the meeting.	Chris Stockport	October 24	10.09.24 A meeting has been arranged to take place on 01.10.24
5	PP24/50.2	20.08.24	Becoming an Intelligence Led Organisation Ensure the report template being developed includes reference to the supporting data as a standard requirement and challenge that where required.	Philippa Peake-Jones Laura Jones	October 24	14.10.24 A Board and Committee template has been drafted and will be shared for comment in due course. This has been developed with other NHS Wales organisations and includes the ability to include supporting data within the template.
6	PP24/50.3	20.08.24	Becoming an Intelligence Led Organisation Circulate the Becoming an intelligence led organisation presentation outside of the meeting.	Laura Jones	October 24	21.08.24 The presentation was circulated on 20.08.24 with the PPHP Committee actions.
7	PP24/50.3	20.08.24	Becoming an Intelligence Led Organisation The Chief Digital & Information Officer and the team to provide an update to the Committee on Becoming an intelligence led	Dylan Roberts / Kathryn Lang	February 25	07.10.24 This has been included on the Committee forward workplan for February 2025 and the team are aware of this

			organisation on a bi-annual basis making reference to progress in relation to the spider diagram and progress on the link to the cultural change programme.			action.
8	PP24/50.3	20.08.24	Becoming an Intelligence Led Organisation The Assistant Director of Data, Intelligence & Insight to link the Intelligence Led programme into the Cultural Change programme via Jason Brannan / Nia Thomas.	Kathryn Lang	October 24	08.10.24 Kathryn Lang has made contact with Nia Thomas to join the discussion on the culture and leadership programme and provide a link in to the intelligence led elements.
9	PP24/51.3	20.08.24	Digital, Data and Technology Strategic Workstreams Update Chief Digital & Information Officer to link in with the Head of Risk Management to include reference to DHCW in a future risk update.	Dylan Roberts / Nesta Collingridge	October 24	07.10.24 The risk team are working with DR to ensure this is actioned ahead of the next risk update.
10	PP24/52.1	20.08.24	Review of Well Being Objectives The Executive Director of Transformation & Strategic Planning agreed to circulate the definition of “fair work” from Welsh Government outside of the meeting.	Chris Stockport	October 24	10.09.24 This will feature as part of the revised paper on the Well Being Objectives which has been included on the agenda for the October meeting.
11	PP24/52.2	20.08.24	Review of Well Being Objectives The Executive Director of Transformation & Strategic Planning agreed to bring a revised paper (Review of Well Being Objectives) to the October meeting once work has progressed further including a timetable for the implementation plan.	Chris Stockport	October 24	10.09.24 A paper on Well Being Objectives has been included on the agenda for the October meeting.
12	PP24/54.2	20.08.24	Immunisation: Performance Update The Acting Executive Director of Public Health to include an update in the report to	Jane Moore	October 24	14.10.24 The Influenza Vaccination Update Report is included on the agenda for the

			next meeting in October in relation to the low level of uptake from staff for the flu vaccine and how to maximise the use of GPs to encourage flu vaccine uptake.			October meeting.
13	PP24/55.1	20.08.24	Health Protection Service Circulate the Health Protection Service Overview presentation outside of the meeting.	Laura Jones	October 24	21.08.24 The presentation was circulated on 20.08.24 with the PPHP Committee actions.
14	PP24/55.1	20.08.24	Health Protection Service The Acting Executive Director of Public Health and the Assistant Director for Health Protection to provide an update to the Committee in 12 months time on the progress made within the Health Protection Service.	Jane Moore Sam Lauder	August 25	08.10.24 An update on the progress made within the Health Protection Service has been included on the forward workplan for August 2025.
15	PP24/56.2	20.08.24	Decarbonisation Action Plan The Interim Executive Director of Finance agreed to share the governance structure for the Decarbonisation work programme outside of the meeting.	Russell Caldicott	October 24	02.10.24 The governance structure has been shared and comments have been provided to update in terms of lines of responsibility.
16	PP24/64.1	20.08.24	Review of Meeting Effectiveness Establish a mechanism for agenda planning to ensure there is clarity in terms of items, presentations and attendance to allow meetings to flow more effectively.	Pam Wenger	October 24	02.10.24 Executive Team members informed of the process in terms of presentations and reminders sent out to members to confirm with Governance Officer in advance of the meeting.

Teitl adroddiad: ***Report title:***	Primary Care Board Update			
Adrodd i: ***Report to:***	Planning, Population Health and Partnerships Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 10 December 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide an update on how strategic objectives in primary care are being driven forward from the recently convened Primary Care Board			
Argymhellion: ***Recommendations:***	The Committee is asked to RECEIVE ASSURANCE on the progress to date and next steps and provide any feedback to be taken forward			
Arweinydd Gweithredol: ***Executive Lead:***	Dr Chris Stockport, Executive Director of Transformation & Strategic Planning			
Awdur yr Adroddiad: ***Report Author:***	Ffion Johnstone			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	To deliver against the organisation's key strategic objectives			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Not applicable			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?	Not applicable			

In accordance with WP7 has an EqIA been identified as necessary and undertaken?	Not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Not applicable
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Not applicable
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: Dim ***List of Appendices:*** *None*	

PLANNING, POPULATION HEALTH AND PARTNERSHIPS COMMITTEE
DECEMBER 2024
PRIMARY CARE ASSURANCE

Introduction

The purpose of this paper is to inform the Planning, Population Health and Partnerships Committee (PPHP) on how strategic objectives in primary care are being driven forward. In order to provide a detailed update on progress it is suggested that a rotating approach is taken at PPHP which will allow focus on key areas of primary care each quarter. The paper seeks to offer the committee assurance on how the primary care team is applying a more strategic emphasis on programmes of work, looking the early impact of the Primary Care Board (PCB) and the establishment of its supporting sub-groups.

The paper also provides a detailed update on the Accelerated Cluster Development Programme (ACD). This is a key component of the Primary Care Model for Wales (PCMW) and will shape how primary and community care services are delivered by the Health Board in the future.

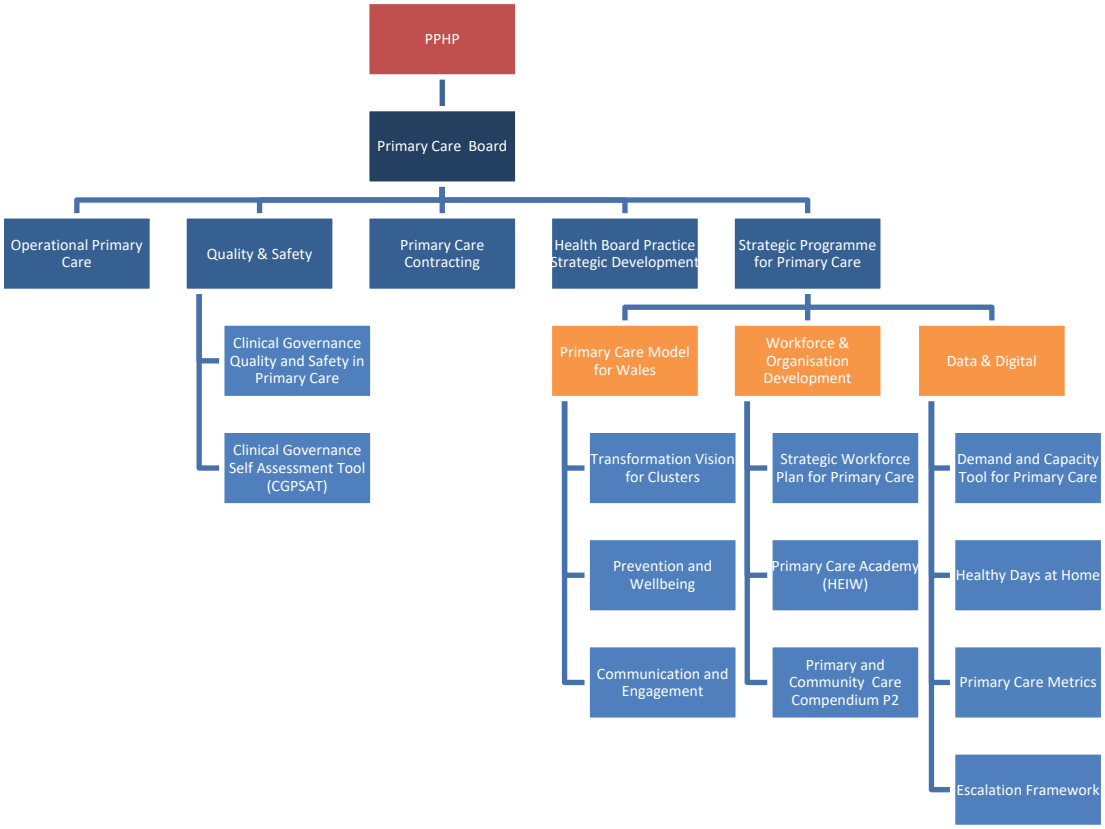
1. Primary Care Board Update

The Primary Care Board (PCB) has been established to provide senior oversight and decision making for all primary care services delivered by, or contracted by, the Health Board. The PCB will provide assurance to the Executive Team and Board, as well as all relevant committees, that primary care services are correctly configured, operationally delivering, and progressing priorities. It is recognised that some services and groups will need to work in a matrix way to maintain local accountability within the Integrated Health Community (IHC) whilst also ensuring a pan-BCU consistency in approach. In doing so, groups should operate to ensure a pan-BCU approach has primacy at all times except where variance from this position can be legitimately justified at an IHC level.

Membership of the group includes Executive Directors and IHC Directors as well as key members of the primary care teams including senior representation for General Medical Services (GMS), Dentistry, Optometry and Pharmacy. The seniority of the membership emphasises the importance of primary care services within the Health Board. The PCB was newly established in May 2024 and efforts have been made to embed the board over the last six months. In December 2024 a workshop is planned to finalise the PCB governance structure and to review the progress of the board's subgroups.

Primary Care Board Subgroups

There are five subgroups that report into the PCB, with each having bespoke workstreams that feed into them as required. The subgroups are strategic or operational in their scope, and are currently at different stages of establishment. The PCB's subgroup draft structure is set out on the diagram below:



Directly Managed Practices Strategic Development Group

This group is strategic and is responsible for scoping the development of Directly Managed Practices within the Health Board. The group has been established with an agreed chair and Terms of Reference. Initial scoping will include, but is not limited to:

- An assessment of viable options to inform whether practices should remain directly managed,
- An assessment of opportunities to improve back-office efficiency across directly managed practices,
- An assessment of opportunities to improve clinical cross-cover and skill-mix innovation across directly managed practices, and
- An assessment of opportunities to maximise the contribution of any directly managed practice that the Health Board has at any point in time, in supporting innovation and sustainability of Primary Care within the Health Board.

The Health Board currently manages twelve general practices across North Wales (with one out to tender), after they were handed back by GP partners. The vast majority of the practices are in the East IHC (6), with fewer based in the Central IHC (2) and the West (4). Although hand backs can occur for a number of reasons, it is a common occurrence that when practices are taken over by the Health Board that they are in a state of operational and financial failure. As such the management of these contracts tend to require a significant amount of input from the local team and they are usually adopted with severe reputational legacy issues.

The subgroup has will review the practices though a refreshed strategic lens in order to agree how services should be taken forward. It will consider both the short and long term strategy for the practices, ultimately deciding whether the services should be retained within BCU or put out to tender for other providers to manage them. The key areas of short term service development are:

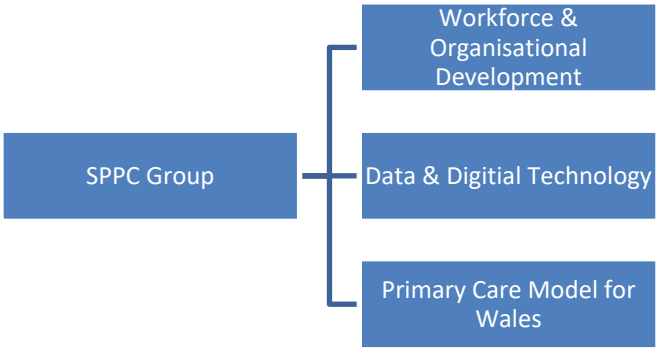
- Reviewing the patient journey to understand how access can be improved

- Communication and Engagement – looking at how comms and engagement with key stakeholders can be improved
- Recruitment and Retention – looking at how requirements are met within the budgetary constraints. Exploring how permanent staff can be both recruited and retained.
- Looking at ways of working together - scoping a managed practice hub

Delivery of the Strategic Programme for Primary Care Group

This group is strategic and looks to advance the national Strategic Programme for Primary Care (SPPC) in North Wales, including Accelerated Cluster Development, Pan-Cluster Planning Groups, Primary Care Professional collaboratives and the Primary Care Academies. The group will also provide coordinated contribution and oversight for BCUHB Primary Care strategic planning. The group will provide robust support to national programmes, reflecting the strategic direction that has been decided by the Board.

The SPPC subgroup has not yet been fully established but the first meeting is scheduled to take place in the near future. The membership of the group will include colleagues outside of primary care including Community Services, Public Health and Therapies. The national SPPC Board has recently agreed to revise its operational structure and the proposal is therefore that the BCUHB follows the same structure. This will bring together three key work programmes reporting into the SPPC group as follows:



Each workstream will cover the following programmes:

1. Workforce & Organisational Development

- ACD Expert Leadership Programme
- Strategic Workforce Plan for Primary Care
- Primary Care Academy
- Primary and Community Care Compendium

2. Data and Digital Technology

- Primary and Community Escalation Framework
- Healthy Days at Home Wales (HDAHW)
- Primary Community Care Metrics
- Demand & Capacity Tool for Primary Care:

3. Primary Care Model for Wales

- Accelerated Cluster Development
- Community Infrastructure:
    - Multi-Professional Framework for Integrated Working (MPF)
    - Enhanced Community Care (ECC)
    - Care Homes
    - Development of District Nurse Dashboard
    - Primary and Community Impact, Values and Measures
    - Demand and Capacity Modelling Tool

- National Community Nursing Specification
- AHP Lead Work
- AHP Planning and Oversight Group
- Primary Care & Community Nursing Framework
- VOED – Verification of Expected Death
- Staff Flu Peer to Peer vaccination Model in Nursing Homes

Primary Care Quality and Safety Group
This group is fully established and has been in place for a number of years, and will now report into the PCB. The operational group ensures that a pan-Health Board understanding of Quality and Safety across Primary Care is visible, understood and where necessary acted upon, bridging across IHC Quality and Safety structures.

Primary Care Contracting Group
This group is fully established and has been in place for a number of years, and will now report into the PCB. This group is operational and provides an oversight to all areas of contracting in primary care. It considers contract related issues with contractor providers, including sustainability assessments. The Primary Care Panel reports into this subgroup.

Primary Care Operational Performance Group
In the previous primary care structure the SLT acted as a programme board that monitored quarterly and annual primary care reporting requirements against the Annual Plan, Ministerial Priorities and other deliverables. This remit will move under the new operational performance group who will oversee the monitoring and management of primary care deliverables on a monthly basis.

The Primary Care Operational Performance group's scope will include the operational delivery of primary care (contractor and directly managed) across all domains. Primary care initiatives or projects which are not captured in any of the other sub-groups will also be covered by this group. The group has not yet been fully established but the first meeting is scheduled to take place in the near future where a chair and Terms of Reference will be agreed.

2. Accelerated Cluster Development Programme

The Accelerated Cluster Development Programme (ACD) is delivered as a workstream of the PCB's 'Delivery of the Strategic Programme for Primary Care' subgroup. It is the primary care component of Place Based Care, delivered through Collaboratives and Clusters. There are fourteen Clusters across the three Integrated Health Communities (IHCs) in North Wales. Collaboratives are the mechanisms by which profession specific groups from an area come together to help design local solutions, and include GPs, Dentists, Pharmacists, Optometrists, Allied Health Professions and others. The Health Board employs a Cluster Lead in each area, who will have oversight of the professional Collaboratives in their locality, each of which will also have a nominated lead.

The ACD programme builds upon the existing cluster structure which was first introduced in 2009 following the Welsh Government's 'Setting the Direction' delivery programme. It seeks to move Cluster working to a wider and more holistic setting, looking at place-based health and well-being considerations. The progress of the programme is monitored by the national Strategic Programme for Primary Care (SPPC) team, who gave BCU a positive end of year review in June 2024 noting that of the 20 mandated project milestones:

- Twelve have been fully delivered
- Five are 'amber' and progressing well. They include the development of public and patient engagement strategies, and plans for further development of the cluster and collaborative work force

- Three milestones are 'red' with more work needed to progress actions. They relate to developing relationships with the Regional Partnership Board (RPB).

Cluster Progress and Membership

During 2024 there has been significant progress made to develop cluster working with the primary care team and Cluster Leads working together to start looking at a more holistic agenda. Some of the areas of development include:

- **Progress in appointing Collaborative Leads in all professions** – Positive discussions amongst professional groups continue around how they will form their own Collaboratives with many now set up.
- **Dynamic approach and joined up working to ensure Collaborative membership** – Clusters and Collaboratives have been working together to ensure there are Leads for each geographical area, and attendance for all meetings. This sometimes involves 'cross-cover' and allowing some professional groups to work at a 'pan-Cluster' level to ensure appropriate coverage.
- **Coming together and networking –** In each IHC there are collective monthly meetings with the local Cluster Leads and the Primary Care team to ensure that the group can come together as a team. There is also a monthly pan-BCU Cluster Lead meeting which allows all of the leads the opportunity to network and gives the senior Primary Care team an opportunity to share communication and listen to feedback.
- **Sharing ideas and learnings** – Having an effective communication network between Clusters allows areas to share feedback and learning from their local projects. It has been noted in several localities that new Cluster pilots have been modelled on existing projects from other areas. There are also examples of Clusters pooling some of their funding with neighbouring areas to deliver projects at a larger scale.
- **Working with Third Sector Organisations** – There are several examples across North Wales of Clusters investing in projects hosted by local charities and organisations. This has led to positive feedback and evidences that the Health Board can work effectively with local organisations at a Cluster and Collaborative level.
- **Working towards splitting the role of Cluster Lead and GP Collaborative Lead** – historically Clusters were heavily focused on GMS rather than the wider health and social setting. Due to this in most localities across Wales the GP Collaborative Lead also took up the position of Cluster Lead. With reflection it is acknowledged that the same person holding two roles is not ideal, and there are concerns about the sustainability of this in the long term. Discussions are on-going to look at how the two roles can be separated with a dedicated person allocated to each.
- **The Primary Care Academy has developed a leadership programme for Cluster and Collaborative Leads** - This programme has been designed with the aim of giving current and future leads the skills to take forward the primary care agenda**.**

Looking Forward - Cluster Reshaping

Pan Cluster Planning Groups (PCPGs) are now in place across each IHC in the Health Board, and are supported by the Local Authorities and Public Health. In the East and West, the groups mirror the IHC footprint, whilst in the centre they are based on county footprints. The lack of a consistent approach across the three IHC is reflective of national feedback that many Health Boards are now questioning the numbers of clusters in each area and how they align effectively with local PCPGs. As such the senior Primary Care team are currently reviewing the Cluster structure with a view to prepare recommendations by the end of the financial year which will consider the pros and cons of having fewer, larger, collaboratives including:

- Could having fewer, larger collaboratives/clusters lead to better synergies? Examples may include a more unified structure, financial optimisation, reporting consistency, staffing flexibility and so on.

- Could having fewer, larger collaboratives/clusters lead to issues including a reduced local strategic focus, workforce challenges, diluted senior oversight and so on.

Recommendations

The Committee is asked to receive assurance on the progress of the new Primary Care Board and the strategic focus on primary care. The Committee is also asked to consider the progress to date in the ACD programme and to provide any feedback which can be taken forward.

Teitl adroddiad: ***Report title:***	Overview – Prevention Plan 2025-28			
Adrodd i: ***Report to:***	Planning, Population Health and Partnership Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 10 December 2024			
Crynodeb Gweithredol: ***Executive Summary:***	This paper provides a high level overview of focus and delivery 2025-2028 supporting the Health Board 3 year plan development, with a particular focus on the sub priority 4.B – Prevention.			
Argymhellion: ***Recommendations:***	The Committee is requested to note the content of the report.			
Arweinydd Gweithredol: ***Executive Lead:***	Dr Jane Moore, Acting Executive Director of Public Health			
Awdur yr Adroddiad: ***Report Author:***	Gwyneth Page, Head of Public Health Assurance and Development			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	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. Whilst this paper is largely focussed on the proposed programmes of work delivered and supported by the BCUHB Public Health Team, it demonstrates how it will operate differently to deliver support to the Health Board in achieving the commitment and responsibility to improve the health and wellbeing of the North Wales population. The paper provides an opportunity to review the high-level plan supporting the Health Board to start to describe the delivery of prevention across our services and functions, and strengthen information and evidence needs as the whole organisation 'shifts to prevention'.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	• Equality Act 2010 • Public Sector Equality Duty • Socio-economic Duty • Human Rights Act 1998 • Quality and Health and Care Quality Standards 2023 • Wellbeing of Future Generations Act 2015
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	This paper is for information to update the PPHP Committee in regards to proposed prevention and early intervention activity supporting the Health Board 3 Year Plan. Specific projects and programmes of work and the Health Board 3 Year Plan are subject to EQIA in accordance with health board policy.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	This paper is for information to update the PPHP Committee in regards to proposed prevention and early intervention activity supporting the Health Board 3 Year Plan.

	Specific projects and programmes of work and the Health Board 3 Year Plan are subject to SEIA in accordance with health board policy.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	**CRR24-08** There is a risk that the Health Board fails to consider and implement prevention and early intervention models in order to reduce health inequalities and improve long term population health and wellbeing. This may be caused by a lack of prioritisation, planning and delivery in relation to the prevention of ill health and early intervention. **CRR24-18** There is a risk that the Health Board does not plan adequately for outbreaks of transmittable diseases such as (but not solely) Measles, M-Pox, Covid. This may be caused by the unpredictability of when the disease may first occur, the availability and cost of associated resources (e.g. pharmaceutical products, workforce, estate), the scale of potential outbreaks, the difficulties in protecting specific and vulnerable groups in a timely way. This could lead to exposure of the public to preventable illness, increased cases and spread of disease and in some cases death. BAF 24-06, Population Health and Prevention Focus.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	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 risks and also within specific tier 1-2 risks managed via the Public Health Performance and Risk Management Group. An indicative funding allocation has been discussed with the EDoF to further support the shift to prevention to be confirmed in line with budget allocations and Financial plans for 25/26.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	There are some changes in terms of operational delivery within the Public Health Team however these within the context of current job descriptions. There are some recommendations for additional support via new posts which would be funded through grant or Health Board allocation.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Prevention as a priority for the Health Board has formed part of all key planning discussions and ensuring it is adequately represented in the Health Board narrative has been part of the Oversight Integrated Planning Group. The proposed approach has been discussed at Executive Team, Board and recently the Public Health Directorate Performance Review where it has been supported. The work of the Public Health team forms a regular part of the Population Health Executive

	Delivery Group. The prevention plan is part of the integrated Health Board plan and associated monitoring and reporting governance and assurance.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	CRR24-08 CRR24-18 BAF 24-06
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
The PPHP are asked to support the planned approach and accept feedback on progress as part of the Population Health Progress report to PPHP.	
Rhestr o Atodiadau: Dim ***List of Appendices:*** *None*	

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Planning, Population Health & Partnerships Committee
Overview – Prevention Plan 2025-2028

1.0 Situation

Keeping the population of North Wales healthy requires a shift to prevention and early intervention across all organisations in North Wales. In order to do this BCUHB must:

- Follow the Board recognition of the need for the shift to prevention through commitment to implement
- Understand our population and its needs, and the needs of different parts of that population or we will get poor outcomes
- Provide the right care that allows people to live fulfilled lives
- Expand focus on early intervention treatment and efficiency models . If we do not, we will fail to recognise the need to change the demand that is driving services
- Recognise that health is becoming the biggest barrier to economic growth in the UK resulting in loss of people to the workforce
- Acknowledge health and wellbeing of communities and individuals is key to improving health outcomes and boosting the economy
- Understand that people do not value health as an abstract concept. People describe health as enabling them to live their lives to the maximum - or as a barrier in doing so

This Overview Prevention Plan 25-28 paper provides PPHP Committee with an outline of the planned programmes of work in keeping with the development of the Health Board Plan for 25-28. It will indicate the main areas of focus led via the BCUHB Public Health Team and the required links to health board and partner involvement in delivering the shift to prevention.

2.0 Background

The health board is currently undertaking the annual refresh of the three year plan, to review and build on what has been achieved during 24/25 and to look ahead up to 27/28. Whilst the overall direction and focus of the plan should not change significantly (agreed and supported via the Board approved Integrated Planning Process 24/25), there should be recognition that what has been delivered within the Prevention element of the plan in 24/25 has resulted in a shift of key activities over the forthcoming period to support the next steps in delivering the shift to prevention.

Reflecting the health board strategic priorities, during 24/25 the focus for activity has been laying foundations through:

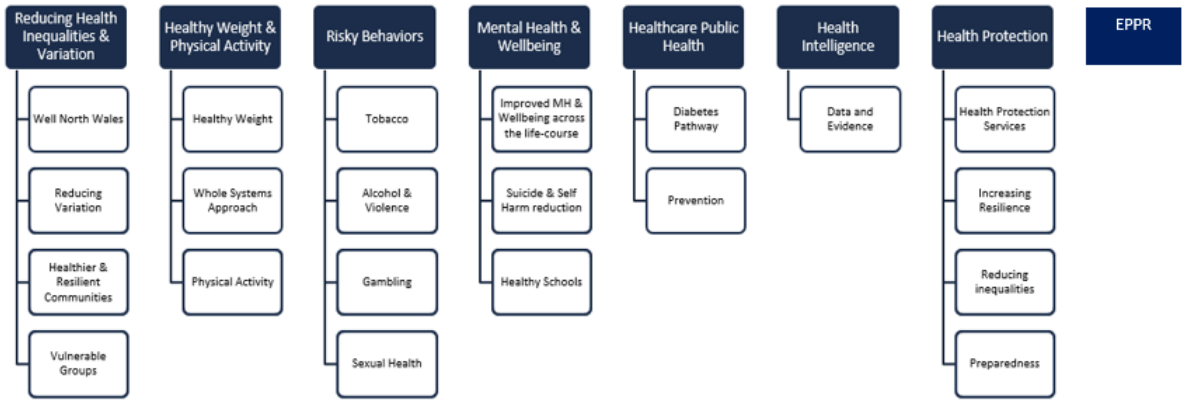
- Starting to understand the impact of the preventive services we deliver (e.g. pre-habilitation services)

- Working with IHCs and Corporate services to identify and deliver the prevention actions within their plans
- Starting to improve the linkage between population data and clinical data to enable the Health Board to understand the impact on different communities/groups of our service delivery
- Developing a case for change for new models of care for Diabetes

This has been strengthened further as part of Well North Wales through our work with partners where we have been:

- Continuing to build the Inverse Care Law activity through collaborative approaches with communities, the third sector and primary care to reduce health inequalities
- Developing a partnership approach to delivering equitable, effective social prescribing and social interventions
- Tackling the wider determinants of health – starting from the First thousand days – Developing systems approaches and children's right approaches that recognise the anchor organisation role of statutory organisations

The model of support via the Public Health Directorate has been through programme areas with specific topics.



3.0 Assessment

Alongside programmes of work supported by grant funding, supporting Corporate Services and IHCs, partner plans and PSB activity, significant progress has also been achieved during 24/25 to establish the prevention focus and begin to embed throughout health board programmes and plans. This has included:

- **Papers supported at Board** –
  - Well North Wales – proposed approach for North Wales
  - DPH Annual Report (Nov)
  - Children's Charter
- **Papers to PPHP**
  - Health Protection Delivery/Assurance Report
  - Population Health Delivery Report, as a regular item

- **Funding awards**
    - Arts Council Wales/Baring Foundation year 3 support to fund Arts in Health Strategic Lead post (to Sept 2025)
    - Diabetes additional funding support
    - Indication of future funding allocation from the Executive Director of Finance to support the shift to prevention
- **Research**
    - Successful Bevan Exemplar application – "How to put communities truly at the heart of improving outcomes"
    - Securing Public Health Wales research and intelligence support for the Diabetes programme
- **Planning**
    - Development of IHC population health data packs and Headline reports to support plan development
    - Population Health Executive Delivery Group Workshop – "Prevention – prioritisation, planning and delivery"
    - Regional Leadership Group session
    - Board development session
    - Key membership at Oversight Integrated Planning Group

During the course of 24/25 the role and function of the Public Health Directorate in supporting the health board to achieve its core responsiblity *'To improve the health and Wellbeing of the population'* has been explored. The Public Health Directorate has worked with the Board, Corporate functions, IHCs and services to determine how best to deploy its expertise and resource to achieve the best possible impact for the health board, its partners and the population.

4.0 Recommendation

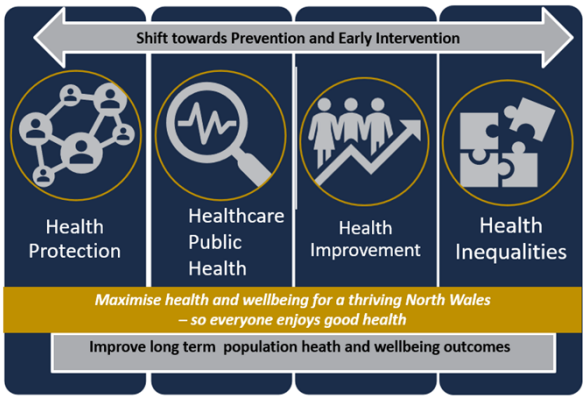
Key messages established within the Health Board three year plan 2025-2028 are based on the following to strengthen the position in relation to prevention:

- Embed population health and the Public Health Team as a core function of the Health Board - and drive delivery
- Enable the shift to prevention – establish the baseline, data and monitoring, and strengthen the ability to measure impact
- Create Health Board wide ownership of population health risk and delivery of changes – Clinical Services Plan, HB Strategy, embed in priority programmes
- Manage current local and national level investment challenges – grow evidence base of impact to support Value based Health
- Create greater collaboration with partners and Universities – grow research around non-clinical/integrated models

During 25/26-27/28 the Public Health Directorate will continue to drive the shift to prevention through a simplified model focused on four major programme areas:

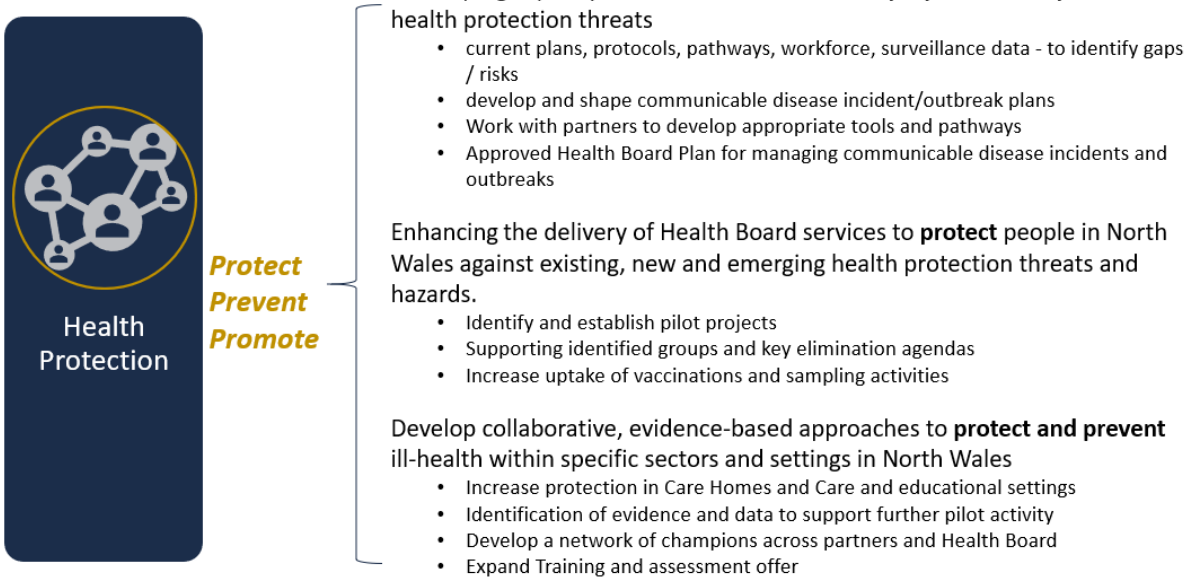
- Health Protection
- Healthcare Public Health
- Health Improvement
- Health Inequalities

Key priorities within each programme align to the strategic and priority objectives within the health board.



Health Protection

Health Protection continues to provide an essential operational service whilst developing capability to identify and respond to emerging and known threats.

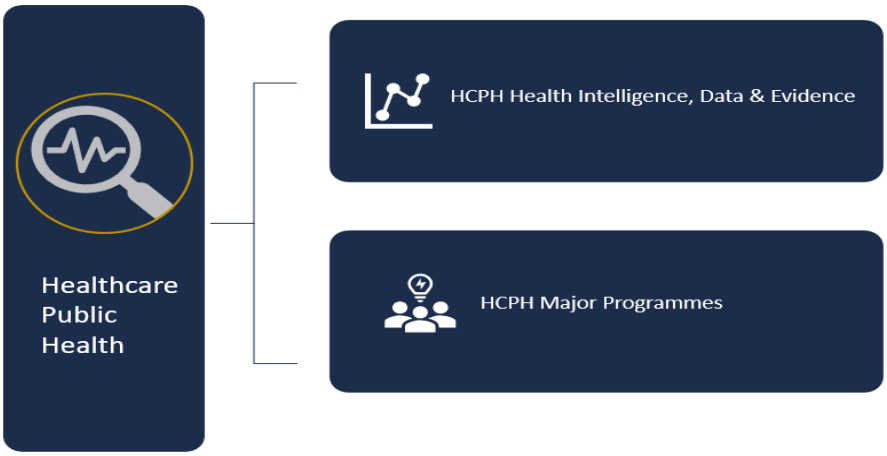


Linked to the work of the Health Protection Programme, the Emergency Preparedness, Resilience and Response (EPRR) work plan will also contribute:

- Support IHCs to identify priorities and rectify gaps in resilience at IHC level across all sites and services.
- Further develop the Health Boards EPRR Governance arrangements and re-establish the Health Board's Civil Contingencies Assurance Group and its sub-groups to strengthen governance arrangements across the Health Board, identifying risk, immediate priorities and longer term goals.
- Build on stakeholder relationships and multi-agency partnerships including local area teams, other health board and national teams.
- Work alongside operational and clinical teams to embed year-round surge and escalation resilience strategies across IHCs in support of operational flow and provision of safe services.

Health Care Public Health

Data and evidence are at the heart of Healthcare Public Health. They are two key strands of equal importance in delivering effective care and better outcomes. Without recognising the connection between population and clinical data and and its importance in becoming an intelligence led organisation and we will not deliver effective change in our major change programmes.



HCPH Health Intelligence, Data and Evidence key priorities will be focused on:

- Linking Population Health and Clinical data/intel.
- Supporting Priority Programmes in developing data and intelligence.
- Research and evaluation -understanding impact to inform change, including non-clinical/integrated models of health and wellbeing.

HCPH Major Programmes will focus on:

- Supporting the development of the Clinical Services Plan and Health Board Strategy to consider prevention.
- Embedding evidence and research through system wide thinking.
- Bring a population health perspective to the Priority / Major Programmes including Planned Care, Unscheduled Care, MH Adults and the continuing Diabetes programme.

Health Improvement

Recognising the need to support people, their families and communities to maintain and improve their health and wellbeing, this programme seeks to understand what delivery models look like to tackle the biggest issues in our population through examining the impact of existing offers and exploring holistic approaches to improve outcomes.

Review
Recognise
Respond

- **Maximise** delivery and **impact** of health Improvement Programmes
  - Review of activity to date
  - Establish impact of existing grant funded approaches / gaps
  - Develop MOU in relation to delivery against funds
- Develop **effective** health improvement **interventions** to address the needs of *vulnerable groups*
  - Identify current offer
  - Evaluate impact
  - Recommendations for improvement
- Develop an effective health improvement model / offer that improves **outcomes** for the population of North Wales

Health Inequalities

The Health Inequalities programme will seek to drive impactful change through not only the health board but the wider partner network. Through Well North Wales, the programme will operate a collaborative approach to tackling variation and addressing the wider determinants of population health, particularly in our vulnerable groups. The programme will harness the knowledge and experience of our communities and partners to develop sustainable models that truly address individual need.

Engage
Evaluate
Grow

Develop whole system approaches to addressing wider determinants of health & wellbeing

- Engaging HB stakeholders and partners to support early co-development of Anchor Organisation Framework for north Wales

Reducing variation in population health across the health & care systems

- Access, experience, outcomes
- Vulnerable groups
- Early development of plans to reduce variation through integration into organisational strategy & planning

Building effective partnerships to deliver sustainable community-based non-medical preventative models of health & care

- Develop understanding of what matters & how best to engage with communities where the identified needs are greatest - to co-design & co-produce services
- Embedding effective funding & joint commissioning models of social prescribing

The four key programmes also inform activity in other areas of the Health Board Plan through focusing on the need to:

- Embed population health and the Public Health Team as a core function of the Health Board - and drive delivery
- Enable the shift to prevention in operational services and pathways – establishing the baseline, data and monitoring, measuring impact of changes
- Create Health Board wide ownership of population health risk and delivery of changes – through establishing the overall strategic commitment in the Clinical Services Plan, health board Strategy, and embedding delivery in priority programmes which are regularly monitored and reviewed
- Manage/inform current local and national level investment challenges – growing the evidence base of impact to support Value Based Health
- Create greater collaboration with partners and Universities – to grow research around non-clinical/integrated models

In addition, we are developing plans for investment on prevention with agreement from the Executive Director of Finance.

Teitl adroddiad: ***Report title:***	Embedding opportunities to be active within the BCUHB workplace
Adrodd i: ***Report to:***	Betsi Cadwaladr University Health Board (BCUHB) PPHP Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 10 December 2024
Crynodeb Gweithredol: ***Executive Summary:***	A report to PPHP Committee outlining a number of public health developed approaches to increase opportunities for BCUHB employees to move more and improve health and wellbeing in the workplace. This report went to BCUHB Executive Team in October where it received support to proceed with the recommendations.
Argymhellion: ***Recommendations:***	The PPHP Committee are asked to: • Support to embedding the Active Workplace Toolkit and Active Workplace policy across BCUHB and the implementation of physical activity interventions. • Show support for the use of Active Soles as a movement within BCUHB to encourage staff to move more by wearing active footwear during the working day • Support BCUHB sign up to the North Wales Healthy Travel Charter
Arweinydd Gweithredol: ***Executive Lead:***	Dr Jane Moore – Interim Executive Director of Public Health
Awdur yr Adroddiad: ***Report Author:***	Hannah Lloyd – Principal Public Health Practitioner Dr Faye Sheldon – Consultant in Public Health

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐	Derbyniol *Acceptable* ☒	Rhannol *Partial* ☐	Dim Sicrwydd *No Assurance* ☐
	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	This programme of work will contribute to the following strategic objectives: Objective 1 – Building an effective organisation. Objective 3 - Creating compassionate culture, leadership and engagement. Objective 4 – Improving quality, outcomes and experience
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	There are no legal implications for this programme of work.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	An EQiA will be undertaken on the BCUHB Being Active Policy.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	An SEIA will be undertaken on the BCUHB Being Active Policy.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The following Datix risks are associated with physical activity: ID 4200 – Tier 1 - Residents in North Wales are unable to achieve a healthy weight due to multifactorial and complex system wide factors that promote obesity. ID 1638 – Tier 2 – Physical activity and sedentary behaviour. Alongside these explicit physical activity related risks there will be a number of business continuity risks relating to staff ill health. This work will significantly contribute to reducing these risk scores.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Implementation of the Active Workplace Toolkit may require some initial investment to support infrastructure costs such as – • Standing desks • Cycle racks • Improvements to showering facilities The initial investment costs however would be offset by a range of health and economic outcomes including, but not limited to: • Improved physical and mental health outcomes (reduction in MSK, stress and anxiety

	• Reduction in the incidence of chronic diseases such as CHD and Type 2 Diabetes • Reduced absenteeism • Increased productively • Employee retention and engagement
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Whilst there is a wider programme of work in BCUHB responsible for pay terms and conditions which may incorporate thinking and integration of access to physical activity and the physical environments, there are a number of recommendations that can be implemented that are not dependent on workforce policy that would support employees to move more - • Walking/wheeling or standing meetings • Incorporate short breaks in meetings longer that 1 hour • Set default on MST's to start meetings 5 minutes later and finish 5 minutes early to encourage movement between meetings • Staff stories/case studies • Internal communications for health campaigns • Promotion of corporate discounted leisure memberships Evidence of impact will be generated to inform future policy development and conditions for staff
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Staff consultation on this work has taken place through: BCUHB staff health and wellbeing survey where low levels of physical activity have been reported by staff, the workplace has been identified as a significant barrier to being active. Consultation across a range of staff forums on Active Soles, which include Trade Union Representation : • Anti-Racism Action Plan Implementation Group • People and Organisational Development Leadership Meeting • Staff Wellbeing Operational Group • BAME Unity Network • Workforce Partnership Group
Cysylltiadau â risgiau BAF:	See above Corporate Risk Register risk.

(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable

Next Steps:

- Identification of a Senior Responsible Officer for the implementation of the Active Workplace Toolkit and development the Active Workplace BCUHB policy
- Implementation of the Active Soles movement in BCUHB led by the BCUHB Public Health team in partnership with the BCUHB Staff Health and Wellbeing Team, Trade Union and Communication Team.
- Identification of a lead for the implementation of the North Wales Healthy Travel Charter across BCUHB. Undertake a baseline assessment of the organisation's delivery against the charter recommendations and secure board approval for BCUHB to formally sign-up to the Healthy Travel Charter.

List of Appendices:

- ***Appendix A – Active Workplace Toolkit***
- ***Appendix B – Being Active Policy Template***
- ***Appendix C – BCUHB Active Soles Insight Report***
- ***Appendix D – North Wales Healthy Travel Charter***

PPHP Committee:

1. Introduction

Being active is in the top three modifiable risk factors for ill health and premature death in the UK (behind tobacco and unhealthy weight). As well as preventing ill health and premature death, being active also has a profound impact on community cohesion, educational attainment, the economy and climate change. The priority to increase physical activity levels is recognised in a number of national and regional strategies including:

- Healthy Weight Strategy: Healthy Weight, Healthy Wales (2019)
- Actif North Wales: 10 year strategy (2023)
- BCUHB Healthy Weight, Healthy Wales Whole System Approach Strategic Delivery Plan (2023)

In North Wales the proportion of people who are physically inactive is rising. The latest evidence from the National Survey of Wales indicate that over a third of the population in North Wales do less than 30 minutes of activity per week. Low socio-economic status, women, older adults, disabled people and people from ethnically diverse backgrounds are among the most inactive groups. The inequalities gap is also increasing for activity levels across these groups.

The environments that we live in and work in strongly influence our ability to be active. Increased reliance on car use, sedentary office jobs, online meetings and workplace culture influence our ability to move more throughout the working day. With up to 50 percent of our waking hours spent

in work, it is important that opportunities for movement are supported and embedded across the whole workplace.

2. Current Situation

Findings from the recent BCUHB Staff Health and Wellbeing survey found that 38 percent of employees surveyed did not meet the recommended guidelines for physical activity. Lack of time (due to home and work commitments), fatigue and physical pain were cited as the top three reasons for inactivity amongst the BCUHB workforce.

Embedding opportunities for movement in the workplace is a sub-system priority within the BCUHB Whole System Approach to Healthy Weight delivery plan. As part of this work the BCUHB Public Health Team have been working with partners from across the system to change system beliefs, goals and structures to increase the opportunities for being active when in the workplace (including when travelling to and from work).

Embedding opportunities to be active within BCUHB requires a 'whole-workplace approach'. This paper proposes a programme of work which seeks to increase physical activity levels and improve health and wellbeing outcomes of the workforce identified through the recent staff Health Needs Assessment.

The main approaches that have been developed to enable this work are:

- Active Workplace Toolkit
- Active Workplace Policy Template
- Active Soles
- North Wales Healthy Travel Charter

Support and buy-in for the implementation of the Active Workplace Bundle was sought from BCUHB Executive Team on the 23rd October 2024. Members were highly supportive of the recommendations, although queries were raised in relation to Active Soles and the acceptability amongst clinical staff in terms of infection control and upholding a professional image. The Public Health Team will work through the concerns raised to ensure infection control and organisational reputation are upheld.

2.1 Active Workplace Toolkit

Developed with support from experts in areas such as physical literacy and occupational wellbeing including Bangor University, BCUHB Occupational Health and Healthy Working Wales, the toolkit adopts whole system approaches to increasing physical activity in the workplace from individual behaviour change through to policy development and culture change (see appendix A). The toolkit outlines:

- why movement in the workplace is important,
- the need to secure senior leader buy-in,
- how to engage with staff,
- how to assess current workforce physical activity levels,
- recommendations such as developing active workplace champions, and action plans to enable more opportunities for movement in the workplace,

This document will be used with partners from across the system in North Wales to support them to increase opportunities for being active in the workplace but as the organisational lead for this work. BCUHB Public Health Team will work collaboratively with Actif North Wales, 2025 Movement and PSB's to increase system wide awareness and buy-in for this programme of work. It is crucial that BCUHB lead by example and embed the guidance within this document into the BCUHB approach to staff health and wellbeing. BCUHB Public Health Team will work collaboratively with BCUHB Occupational Health Team to embed actions from the Active Workplace Toolkit into the refresh of the 25/26 Occupational Health and Wellbeing Plan. BCUHB Public Health will seek buy-

in from the Strategic Occupational Health and Wellbeing Group and Integrated Health Community SLT's. One of the key priorities will be to consult with BCUHB employees regarding the implementation at an Active Workplace Policy.

2.2 Active Workplace Policy Template

To support the implementation of the toolkit the team developing the guidance have also developed a template policy for workplaces to use. The policy formalises an organisation's commitment to achieving change by outlining how they plan to commit to the approaches required to ensure the workplace enables employees to move more. As BCUHB currently does not have a policy to support being active in the workplace and staff health and wellbeing remains a key priority, it is proposed that the being active policy template is used as a basis to develop a BCUHB Active Workplace policy. As part of the EQIA and Impact Assessment process, BCUHB Public Health Team will work in partnership with BCUHB Equalities Team, Trade Union, and Occupational Health to understand and mitigate against any negative impacts on staff, particularly those who share protected characteristics.

2.3 Active Soles

Research suggests that office workers spend an average 65 percent of their working time sitting, walk between 3000 – 5000 steps a day and are more prone to undertake sedentary behaviour outside of working hours (Clemes et al, 2014). Active Soles is an intervention identified within the active workplace toolkit. It is a movement that originated from "Greater Manchester Moving". The campaign encourages staff to move comfortably in the workplace by allowing staff to wear active footwear throughout the day instead of formal footwear. Increasing opportunities for staff to reduce sedentary behaviour through opportunities to move more, can support healthy weight loss, improve mood and reduces the risk of heart disease, cancer and type 2 diabetes.

Work has already taken place to consult with key stakeholders on the approach, with the purpose of ensuring that the approach does not contradict existing organisational policies, and to understand staff acceptance. The conclusions of this work are that the existing All Wales and BCUHB policies would be supportive of Active Soles as an approach. Staff engagement suggests that the approach would be welcomed. For example, even staff groups considered to hold "active roles" are finding that they are increasingly inactive and would welcome opportunities to be more active in the workplace. BCUHB Public Health Team will work collaboratively with internal stakeholders including BCUHB Communications Team, Trade Union, Equalities Team, Occupational Health and the IHC's to plan and coordinate the roll out of Active Soles and evaluate its effectiveness across BCUHB.

2.4 North Wales Healthy Travel Charter

Developed by the BCUHB Public Health Team in partnership with Local Authority Active Travel Officers, Natural Resources Wales and Sustrans, the charter is designed to be used by a range of organisations across North Wales. It provides organisations with a range of areas to take action. The charter includes:

- leadership and communication,
- public transport,
- walking and cycling,
- agile working,
- and ultra-low emission vehicles.

The charter offers an opportunity to encourage a shift away from car use to walking and cycling for staff, patients and visitors. Such an approach offers a range of benefits across physical and mental health, income, productivity, congestion and air quality.

The Healthy Travel Charter has been endorsed by the North Wales Regional Leadership Board and all three Public Service Boards across North Wales. The members of these groups have now committed to taking the charter back to their own organisations and securing commitment through their internal governance procedures. Organisations including North Wales Fire and Rescue Service, Natural Resource Wales and Wrexham County Council have signed up to the Healthy Travel Charter , As BCUHB led the development of this work, it is crucial that we show our commitment by securing board approval to sign-up to the charter.

The Public Health Team will work with the Director of Environment to agree on an approach to formally sign-up to and work through the actions within the Healthy Travel Charter and to co-develop a communications plan to increase awareness of healthy travel options across the region.

3. Budgetary / Financial Implications

The work associated with the implementation of this specific programme promoting increased activity in the workplace should be able to be delivered through existing resource within the health board including:

- BCUHB Senior Leaders
- BCUHB Staff Health and Wellbeing Team
- Integrated Health Community People and Culture groups
- BCUHB Sustainability Programme Board and Team
- BCUHB Line Managers

Implementation of the Active Workplace Toolkit may require some initial investment to support infrastructure costs such as –

- Standing desks
- Cycle racks
- Improvements to showering facilities
- Information and resources to support walking and activity at sites
- There are also a number of links to free or discounted items to help people become more active that will be widely publicised.

The initial investment costs however would be offset by a range of health and economic outcomes including, but not limited to:

- Improved physical and mental health outcomes (reduction in MSK, stress and anxiety
- Reduction in the incidence of chronic diseases such a CHD and Type 2 Diabetes
- Reduced absenteeism
- Increased productively
- Employee retention and engagement

4. Risk Management

The implementation of this programme of work to increase physical activity levels will contribute to actions identified within two current BCUHB Datix Risks:

ID 4200 – Tier 1 - Residents in North Wales are unable to achieve a healthy weight due to multifactorial and complex system wide factors that promote obesity.

ID 1638 – Tier 2 – Physical activity and sedentary behaviour.

5. Equality and Diversity Implications

An EqIA and SEIA will be completed on the Being Active policy for BCUHB as part of the policy development process.

Appendix A – Active Workplace Toolkit

Appendix B – Being Active Policy Template

Appendix C – BCUHB Active Soles Insight Report

Appendix D – North Wales Healthy Travel Charter

Pecyn Cymorth Gweithle Actif

Active Workplace Toolkit

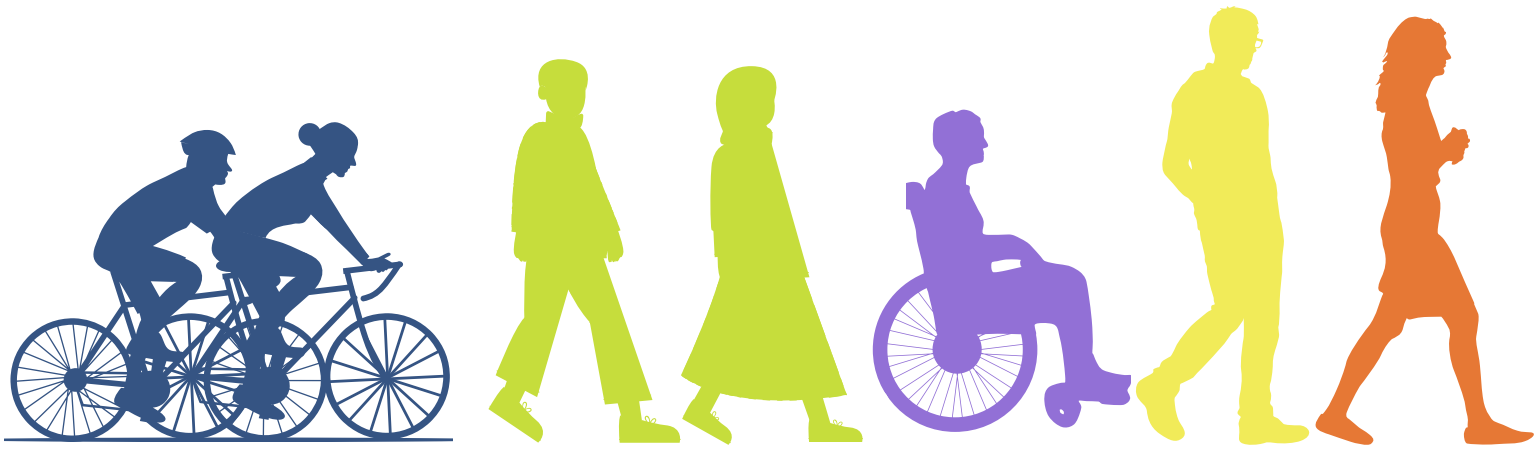
2024

GOGLEDD CYMRU
ACTIF
NORTH WALES

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

CONTENTS



Introduction

The environments that we work in can significantly impact on our health and wellbeing. Factors such as job demands, the physical environment and workplace culture can all influence the health and wellbeing of employees.

Being active encompasses all the ways in which people move their bodies. It's important to remember that every movement counts. For some people, this could mean stretching or moving regularly at their desk, walking or wheeling to work, going for a lunchtime walk or trying a new sport.

Positive work environments that provide opportunities for employees to be active and move more throughout the working day, will result in a happy, healthy, more engaged and productive workforce.

We all have a role to play in designing movement back into the workplace

The aim of this toolkit is to provide employers with helpful tools and ideas about how to create a healthy and active workplace culture. You can choose to follow all the stages in this toolkit, or focus on just one or two key actions.

Remember, small changes can make a big difference

This toolkit is aimed at **anyone** in the workplace who has responsibility for, or an interest in improving the health and wellbeing of their employees.

This toolkit has been developed by Betsi Cadwaladr University Health Board (BCUHB) Public Health Team in partnership with Actif North Wales.

We would like to thank Bangor University, Gethin Thomas, Healthy Working Wales and colleagues from BCUHB Occupational Health Team for their contribution towards the development of the toolkit.

For further information about Active Workplaces, contact BCU.PHAdmin@wales.nhs.uk

The case for change 01

Evidence shows that healthy and happy workplaces can improve employee productivity, increase morale and reduce the amount of days lost to ill health.[1]

It is estimated that sickness absence results in **8.82 million of lost working days** each year in Wales[2], and costs Welsh businesses annually between **£855 million**[3] **and £1.3billion.**[4]

Keeping our population healthy not only benefits individuals, it also has significant positive impacts on the economy.

The top cause of workplace sickness in the UK are:[5]

Minor illnesses, including common coughs and colds

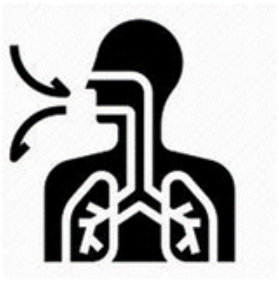
29.3%

Others' including infectious diseases, COVID-19 & Accidents

23.8%

Musculoskeletal conditions

10.5%



Respiratory conditions

8.3%

Mental Health conditions

7.9%

Being active is one of the most effective ways to prevent and protect against a range of health conditions

[1] Oxford University Oxford University's Saïd Business School, 2015
[2] ONS, 2017
[3] Murphy, 2018
[4] ERS Research and Consultancy, 2016
[5] ONS, 2022

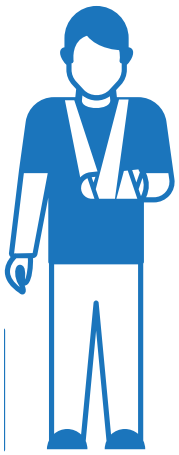
Being active has positive benefits for mental health and wellbeing, and can also reduce the risk of a range of chronic conditions such as heart disease, some cancers, diabetes, musculoskeletal and respiratory conditions and supports a heathy weight.[6]

With up to 50 percent of our waking hours spent in work, it is essential that being active in the workplace is encouraged, and opportunities to move more are identified and promoted.

Physical inactivity results in sickness absence costing the Welsh economy £314m per year. Promoting physical activity in workplaces can increase physical activity participation at a cost of £4.11 per person.[7]

Employers play an important role in supporting and creating conditions for employees to move more, as **creating an active workforce can:**[8]

Reduce injuries in the workplace



Improve morale and working atmosphere

Help create a more positive corporate image

[6] GOV.UK, 2019
[7] Tudor, et al, 2019
[8] Puig-Ribera et al, 2015

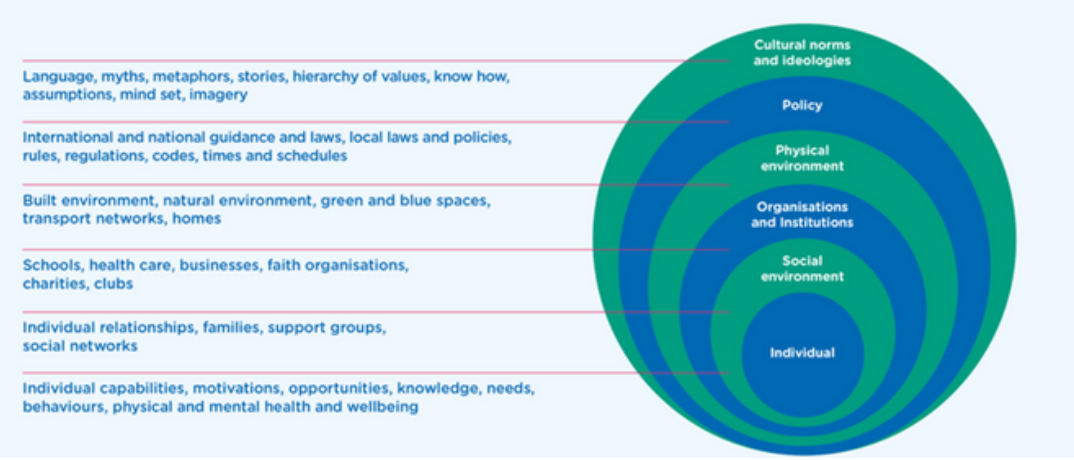
Why Take a Whole Workplace approach? 02

We know lots of factors influence how we are able to move during the workday, and **simply telling employees how active they need to be is not an effective way to increase activity levels.**

However, by taking a 'whole workplace approach' and looking at how changes can be made at different levels in the organisation, such as **policy, organisational, cultural, and social and to the physical environment,** interventions are more likely to be effective and sustainable over time.

The socio-ecological model (or onion model) below is one way to think about how changes can be made across a whole system within the workplace.
Throughout this toolkit, you will find helpful ideas and suggestions about how to influence and implement a range of active workplace interventions across the different levels within your organisation.

Figure 1: the 'whole workplace approach',



Source: https://www.gmmoving.co.uk/about/how-we-work

Whilst it is important to understand the wider factors that influence being active, it is also important to understand people's **individual relationships** with movement and how past experiences shape attitudes and behaviours towards being active – this is sometimes called **physical literacy**.

When encouraging employees to be active in the workplace, employers should consider how the organisation supports positive physical, social, and emotional experiences that develop employee's confidence and motivation to engage in, and contribute to, an active workplace culture.

Opportunities to be active in the workplace should therefore be **enjoyable, easy, and accessible for all.**

Throughout this toolkit, we will provide examples of how employers can work in collaboration with employees to create an active workplace culture, that considers the needs and experiences of the whole workforce.

03 Securing Senior Leader buy-in

For the purpose of this toolkit, a senior leader is anyone in the workplace who has overall responsibility for, or influence over the health and wellbeing of employees. This could be a CEO, an Executive Director or a Line Manager.

Securing senior leader buy-in is important as it provides a clear commitment to employees that their health and wellbeing is valued.

Senior leadership buy-in can -

- Validate the importance of an active workplace to the organisation
- Build trust and respect with employees by being role models and adopting new behaviours, such as wearing trainers to work, walking meetings, taking regular breaks or splitting up the day to balance sedentary behaviour with activity
- Increase employee motivation and buy-in for cultural change
- Give confidence to employees that behaviour change is possible within the organisation
- Demonstrate leadership support for employees to develop new ideas and introduce strategies or interventions to improve activity levels

How to secure senior-leader buy-in?

Identifying 'who' you need to influence, is the first stage of seeking senior buy-in. A stakeholder analysis is a good way to think about who the key movers and shakers are at senior level.

You can do this by plotting your senior leaders on a stakeholder analysis matrix. Senior leaders with the highest power and influence (top right quadrant) are the key people you will need to influence the most.

Figure 2: Stakeholder analysis matrix

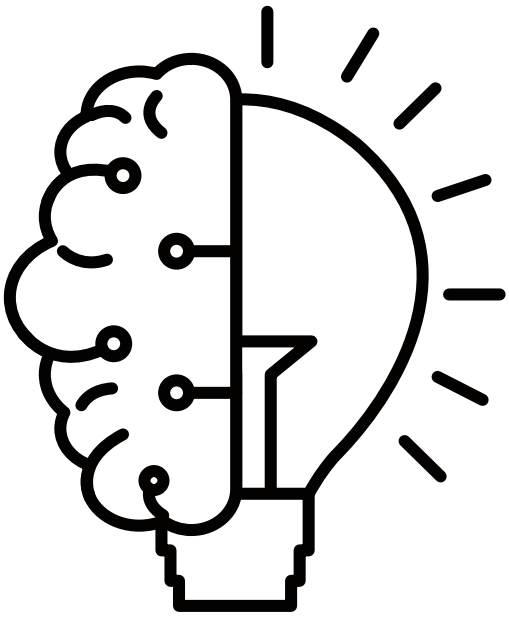
Once you have identified who the key players are, you will now need to make the case for change.

A **heart, head, and hands** approach is one technique that could be used to increase buy-in from senior leaders.

Storytelling is a powerful tool to engage and build rapport with audiences. Begin by sharing case studies or videos of employees who have benefited from being active, and how moving more has supported them in the workplace.

Make the case for change by presenting data and evidence about the short and long term benefits of an active workforce. You could share sickness absence data or describe how an active workplace aligns to your organisational values or strategy.

Now that you have set the scene, it's time to take action. Describe what resources and support you need from senior leaders for action to take place. Defining roles, timescales and resource will give senior leaders confidence that you have considered a range of different factors to creating an active workplace.



04 Staff Engagement

Employees are the target and beneficiaries of a healthy and active workplace, and without their proactive involvement and buy-in, policies and interventions which aim to increase activity levels may not succeed.

Engagement with employees should be a continuous and cyclical process and should include continuous feedback loops to provide assurance, and demonstrate how their input has been considered and has influenced decisions within the organisation.

How to increase staff engagement?

- Consider using a person-centred approach. Ask employees about their views and involve them in discussions. Most importantly, listen to them. People's attitudes to being active may be influenced by previous experiences. Communicating positive stories can change perspectives and help break down barriers to being active.
- Develop advocates or Active Workplace Champions to encourage an active workplace culture. Champions can tailor strategies to influence staff, such as the awareness of physical activity campaigns, peer to peer support, work-place challenges or establish social groups.
- Establish a staff Active Workplace Forum to provide ongoing opportunities for communication, engagement and learning opportunities for staff interested in improving activity levels in the workplace.

Knowing your workforce 05

When creating an active workplace culture, it is important to understand how active the workforce currently are, and how employees would like to be supported and encouraged to move more throughout the working day – we sometimes call this 'creating a baseline'.

Understanding how active your workforce currently are is important as it can help demonstrate how effective interventions and policies are at improving workforce physical activity levels once they are implemented.

You might want to find out -

- How active your employees are during and outside of work.
- What opportunities and support are currently available for employees to be active in work?
- The barriers to being active during work time.
- What activities or opportunities employees would like to try, or do more of?

When creating a baseline, it is important to think about the 'whole workplace'' and how employees are currently supported, and encouraged to be active in the workplace at an **individual, organisational, social, physical environment, policy and cultural perspective.**

You may want to consider some of the following questions when developing your baseline:

- How active are employees during working hours, including when working from home?
- Do employees travel actively to and from work?
- Do employees take active breaks and lunch times?
- Are employees supported and encouraged to take part in fun social activities which include their families and community, such as Park Run or outdoor charity events?
- Do employees have access to facilities such as showers, changing rooms or cycle racks?
- What are the current barriers to moving more in the workplace?
- Does the workplace have an Active Workplace Policy and if so, how embedded is it across the organisation?

There are different ways you can understand how active your workforce are. You could try combining one or two of the methods shown in the table below to collect this information.

Approach	Description
Active Workplace Survey	An online or paper based survey with open and closed ended questions.
Focus Groups	A facilitator asks open-ended questions to a group of 5-10 people to understand the challenges and opportunities to being more active in the workplace.
Case Studies	Case Studies can be captured in written, audio or video format, to understand and document people's experiences of being active in the workplace and how it has benefited their health and wellbeing.
Sickness level data	Obtain sickness level data from HR or Occupational Health department to understand the number of people who were sick for the previous 12 months and the reason for their absence.

Once an active workplace assessment has been completed, a supporting action plan can then be developed.

Active Workplace Champions?

06

Evidence suggests that organisations with Active Workplace Champions have been successful in developing an active workplace culture.[9]

Active Workplace Champions are members of staff who advocate and promote physical activity interventions in the workplace. Their role includes supporting colleagues take part in interventions by understanding the barriers, and identifying opportunities to move more throughout the day.

Active Workplace Champions require support to complete their role. Time should be allocated in their work plans to allow them space to complete their role effectively. Their role should be actively advertised and promoted within the organisation.

Training should be offered to equip Champions with the necessary skills to advocate for colleagues within an active workplace. Peer support from other Champions both within and outside the organisation will allow setting up of learning sets and networking events to resolve challenges and share successful strategies.

Bangor University have developed an Active Workplace Champion training package. For further information visit www.bangor.ac.uk/short-courses-and-cpd

[9] NICE, 2019

07 Developing An Action Plan

Once you have created a baseline, and engaged with staff at all levels, an **action plan** can be developed.

The purpose of the action plan is to provide details of key activities and goals over the short, medium and long term. The actions should reflect the insights and baseline information gathered from staff engagement. If you have Active Workplace Champions, you may want to involve them in the development of your action plan.

Once the action plan has been created, it is important to feedback and seek approval from employees or the Active Workplace Forum on the proposed ideas.

How to create an action plan?

When creating an action plan, it is important to remember the following:

Activity	Description
Are the goals SMART?	**Specific**: Be clear about what you want to achieve and how you want to achieve it. **Measurable:** What data or information will you gather to demonstrate you've achieved your aim or goals? **Achievable**: Do you have the right skills or resources available to undertake the proposed activities? Do you have buy-in and permission from senior leaders and employees to implement your ideas? **Relevant:** Is what you're planning relevant to organisational values and long term objectives? Are your ideas based on feedback from employees? **Time-relevant:** Be realistic about what you can achieve and by when. Set specific but realistic time-scales, even if these are longer than you would prefer. So that they are realistic.
Have roles and responsibilities been allocated to people who can support the delivery of the plan?	When embracing a **'whole workplace approach'** to increasing workforce activity levels, a range of stakeholders including HR, Occupational Health, Senior Managers, staff representatives and Union Representatives should be included. For small or medium workplaces, the project lead should consider who in the workplace is best suited to support the work.
Have resources been identified?	The action plan should highlight if there is funding and if funding is required to implement actions.

Examples of Active Workplace interventions:

The actions in your plan should reflect how the organisation is implementing change at all levels of the organisation (or system), from an individual, social, policy, culture level to the physical environment.

Active workplace interventions should focus on social enjoyment and self-satisfaction not just the health and wellbeing benefits.

Some suggestions for interventions are provided below:

Organisation level	Example intervention
Individual	• Create an active Workplace intranet page, e-bulletin or newsletter • Create an Active Workplace screen saver with chair-based or standing stretches or exercises • Arrange Workplace Activity sessions such as Walking, Wheeling, running, cycling or yoga groups. Before, during (active work) or after work • 'It's good to talk' - encourage staff to walk and talk, rather than email to increase activity • Arrange active meetings (walking or standing up meetings) • Promote workplace walking routes or maps • Targeted health promotion campaigns • Reduce or limit back-to-back 'online' meetings and periods of collaborative online working • Staff rewards to foster motivation • Promote activities outside of work such as local gardening projects, walking groups or sports activities • Capture and share employee case studies • Have Making Every Contact Counts conversations about being active during one-to-one or team meetings
Social	• Organise activity fun days involving employees' families (option to make this an annual event) • Arrange active workplace challenges (pedometer/swim challenges) • Active workplace challenges with other businesses or organisations • Promote active social events during and outside of work, such as the Park Run or charity events. • Introduce 'Active Buddies' or 'Active Groups' that connect via MS Teams to include homeworking colleagues

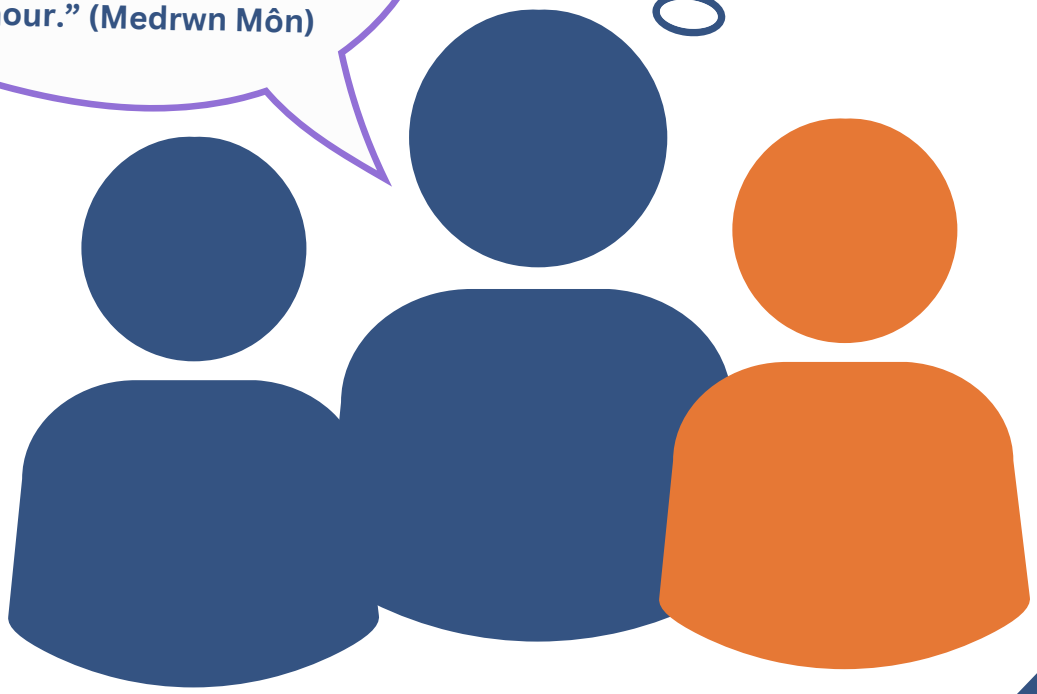
Organisation level	Example intervention
Organisational	• Create Active Workplace Champion roles. • Give permission for employees to wear trainers or flat comfortable shoes to work through the 'Active Soles' campaign. • Conduct annual staff surveys. • Encourage and promote active travel to work. • Discuss employees wellbeing during management meetings. • Agree corporate membership rates at Local Authority and private sector gyms. • Ring fenced time during working hours for employees to be active (1 hour per week). • Sign up to cycle to work schemes. • Provide protected time for staff to be active during their lunchbreak. • Consider active travel millage reimbursement for employees that use active travel during work time. • Liaise with external organisations to connect active workplace initiatives to wider health and wellbeing initiatives e.g 5 ways to wellbeing - https://bcuhb.nhs.wales/health-advice/five-ways-to-wellbeing-invisible-folder/five-ways-to-wellbeing/
Physical Environment	• Create onsite fitness facilities or exercise equipment. • Provide changing facilities • Provide secure cycle storage or racks • Standing desks • Dedicated active workplace notice boards
Policy	• Create an Active Workplace Policy • Provide flexible working hours • Restrict email access and meeting times during specific times of the day to ensure people have time in their day to eat well and be active • Require all staff to have a wellbeing plan which outlines how the organisation will support staff to achieve their wellbeing goals which incorporates moving more
Culture	• Seek senior leader buy-in • Engage senior leader role models who are leading by example • Adding health and wellbeing conversations into monthly/annual reviews • Flexible working hours • Start and finish on-line meeting a few minutes early/later to allow time for staff to move between meetings • Sign up to the Healthy Travel Charter - www.healthytravel.wales

"We established a WhatsApp group whereby 3 weekly challenges (fitness, social and photography) are set at the start of each week. Members then compete against each other / as part of a team to complete them. One such challenge included members of one team competing against members of another team to complete a certain amount of squats – a staff member in the control room decided to complete them whilst stood at her desk on a late / night shift (as time was of the essence) and managed to encourage others to do the same causing a Mexican wave (or should that be squat?!) effect."
(North Wales Police)

"The wellbeing questionnaire results evidenced some great feedback about the physical wellbeing sessions/ interventions that occurred over lockdown and included requests for more of this type of activity. As such we now walk as a team every lunchtime – weather permitting!"
(Medrwn Môn)

"We have an established monthly walking group and meet one Sunday a month outside of work times."
(North Wales Police)

"Staff have also been using an agile approach of 'daily scrums' for task and finish projects where they are encouraged to stand in the meetings for half an hour." (Medrwn Môn)



08 Active Workplace policy

Creating a healthy and active workforce also requires action at policy level. Workplace policies are important as they define the rules and expectations in the workplace, and align to the organisational values and beliefs.

An Active Workplace Policy is one way of embedding opportunities to be active across the organisation. It defines how opportunities to move more should be implemented across the working day, including how employees travel to and from work.

When developing an Active Workplace Policy, it is important to involve management teams, employee representatives, and relevant health and wellbeing and Trade Union representatives. Involving people will increase support and buy-in for an Active Workplace Policy.

An example Active Workplace Policy (appendix 1) template has been created to enable workplaces to develop their own policy in line with their organisational policy procedures.

The policy sets out opportunities to be active in the following areas:

- **travel**
- **when at work**
- **when working remotely**
- **breaks and lunch times**
- **Social activities which could include families and the local community**

You can choose to adopt our draft Active Workplace Policy template, or develop your own.

Measuring Success 09

Measuring success is important as it can:

- Demonstrate how the programme or intervention has made a difference to reducing inactivity levels and to who
- Inform senior management about how interventions or programmes have impacted on employee health and wellbeing
- Identify what is going well and what needs to be improved or changed
- Create new ideas for development

How to measure success?

There are a number of ways you can measure the success of your programme or intervention. A combined approach using data (head), and stories (heart) is a great way to demonstrate your success.

Here are a few examples of different ways you could measure impact:

- Record the number of new activities being created to support and encourage people to be active before, during and after work and participant numbers.
- Record physical activity levels of staff during one to one reviews to understand how active they currently are, and to set some achievable goals. Review activity levels during follow up review meetings to see how staff have increased their physical activity levels and the impact on their health and wellbeing over time.
- Review sickness absence data to see If there any improvements in sickness absence rates over time.
- Repeat Active Workplace Surveys to measure improvements in physical activity levels, staff health and wellbeing, engagement in local programmes and interventions or if active travel rates have increased.
- Capture case studies from employees to measure changes in behaviour and attitudes towards being active, and how programmes or interventions have improved their health and wellbeing.

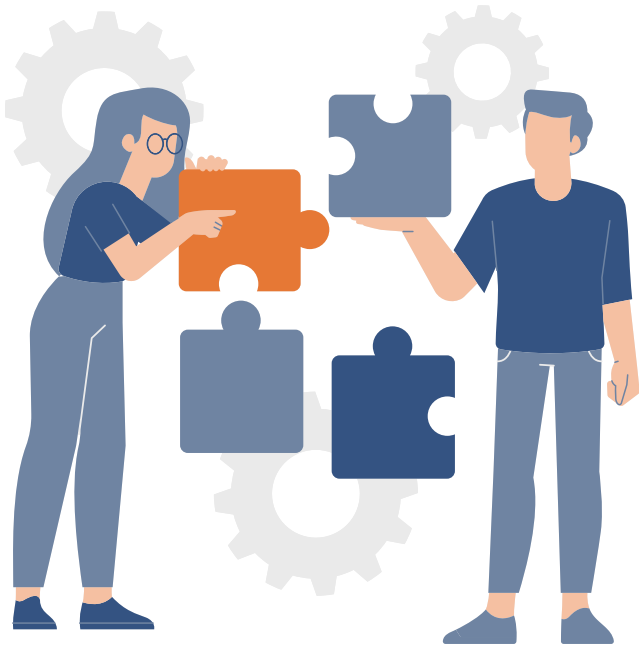
10 Conclusion

We hope you have found the Active Workplace Toolkit helpful in providing useful tools and ideas about how to create an active workplace culture.

It's important to remember that we **all** have a role to play in improving the health and wellbeing of our workforce. By working in partnership with employees, and adopting a 'whole workplace approach', active workplace interventions are more likely to be effective and sustainable.

Further information and support about improving employee health and wellbeing can be found here:

Healthy Working Wales - Public Health Wales (nhs.wales)



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GOGLEDD CYMRU

ACTIF

NORTH WALES

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Active Workplace Policy

Policy Title: Active Workplace Policy

Responsible Executive:

Responsible Office/Dept:

Endorsed by:

Contact: (nominated person responsible for implementing and monitoring)

Effective Date: (date policy was approved)

Review date: (policy should be reviewed annually)

Contents:

1. Introduction

Policy Statement:

The purpose of this policy is to support a whole-workplace approach to embedding and promoting opportunities for employees to be active and move more across the working day.

Why are we committed to an Active Workplace?

The environments that we work in can significantly impact our health and wellbeing. Factors such as job demands, the physical environment and workplace culture can all influence the health and wellbeing of employees. Positive work environments that provide opportunities for employees to be active and move more through the working day will result in a happy, healthy, more engaged and productive workforce.

Being active has positive benefits on mental health and wellbeing, and can also reduce the risk of a range of chronic conditions such as heart disease, some cancers, diabetes, musculoskeletal and respiratory conditions and supports a heathy weight. It has also been found to be an effective treatment for reducing the symptoms of mild to moderate depression.

With up to 50% of our waking hours are spent at work so it is important that opportunities to be active are supported and encouraged across all levels of the organisation.

Opportunities to remain active in work may lead to:

- fewer sick days taken by active staff
- a reduction in absenteeism
- reduced staff turnover
- improved productivity
- positive teamwork, communication, and team unity
- prevention of isolation
- improved sleep and cognitive ability

2. Definitions - Key concepts and terminology:

Whole-workplace approach

There are lots of factors that influence how people are able to move during the workday, and **simply telling employees how active they need to be is not an effective way to increase activity levels.**

By taking a 'whole workplace approach' and looking at how changes can be made at different levels in the organisation, such as **policy**, **organisational, cultural, social and the physical environment** are more likely to be effective and sustainable over time.

Person centred approach

Using a person-centered approach will increase the chance of employees engaging in an active workplace. Asking employees how the organisation can help them to stay active at work and what support they need to do this will build trust and lead to a gradual change in behaviour. **Imposing change will not work**.

Active Workplace Culture

Opportunities to be active are supported, encouraged and integrated across the whole organisation. An active workplace cultures involves initiatives and polices that support employees to be active throughout the work day, contributing to healthy and happy workplace environments.

3. Roles and Responsibilities

As an organisation we will: (delete as appropriate)

- Monitor and evaluate the health, wellbeing and physical activity levels of all employees
- Discuss the wellbeing of staff during meetings at all levels within the organisation
- Demonstrate a clear commitment to managing and reducing work-related stress
- Demonstrate a clear commitment to reducing and breaking down time spent engaged in sedentary behaviour
- Provide strategic guidance that supports a change in culture towards an active workplace
- Discuss the health and well-being and engagement in active workplace activities with employees during appraisals
- Promote a culture where an active workplace becomes the norm using a range of communication strategies
- Use a range of tools, such as surveys, to capture employee needs
- Identify and support active workplace champions and positive role models
- Educate senior managers about the importance of being active in the workplace
- Support employees to make changes that lead to a more active workplace
- Encourage active sustainable travel to work
- Encourage employees to wear active footwear to work by adopting and embedding Active Soles as a workplace intervention
- Re-design office space to encourage a more active workplace.
- Provide adequate facilities and equipment and training e.g. standing desks, for employees to engage in an active workplace
- Take steps to ensure facilities, spaces and equipment are safe
- Report back to employees the impact an active workplace is having on employee health and wellbeing, absenteeism, sickness and missed days from work and where possible productivity
- Adopt and embed the North Wales Healthy Travel Charter

Through voluntary participation our employees will be encouraged to:

- Seek to remain active throughout the day
- Act as role models for other staff or support others to be more active
- Consider becoming an active workplace champion
- Contribute ideas to encourage themselves and others to become more active
- Actively seek opportunities to participate in active workplace activities and challenges
- Look for opportunities to develop active workplace behaviours and contribute towards an active workplace culture
- Have an awareness of the advantages of healthy active lifestyles

(In addition to the above, for those whose role is dependent on physical fitness)

- Maintain fitness levels to meet the requirements of the role as set out in contract of employment
- Invest time (during working hours/outside working hours – delete as appropriate) to develop/maintain fitness
- Establish and participate in support groups and social activities to support colleagues and their physical fitness
- Address any shortfalls in fitness in an acceptable timescale for both employee and employer

4. Active Workplace Culture and Environment

We **all** have a role to play in improving the health and wellbeing of our employees. The organisation will embrace an active workplace culture and environment that reinforces and supports the value of being active.

The behaviours and attitudes of all employees contribute towards the workplace culture. The easiest way to build opportunities to move more is to enable employees to prioritise it.

The organisation will: (delete as appropriate)

- Adopt a person-centred approach to encourage physical activity and develop an active workplace culture
- Ensure equity and inclusion
- Encourage employees to discuss workload with their line mangers , and how to make a space to move more throughout the working day
- Promote conversations about being active
- Support flexible working hours to promote work-life balance e.g., allowing sufficient time during lunch breaks for physical activity
- Encourage active travel and provide safe storage for equipment e.g. bikes
- Give permission for employees to wear active footwear to work
- Encourage active break and lunchtimes
- Encourage employees to take walking meetings and to use the stairs
- Ensure a high profile for approaches that encourage an activity when working e.g. active soles
- Liaise with external organisations to connect active workplace initiatives to wider health and wellbeing initiatives e.g. 5 ways to wellbeing.
- Introduce all employees to positive role models from within the organisation (active workplace champions)
- Involve those who are enthusiastic about being active (including but not limited to the active workplace champions) to help motivate those who are less willing to participate
- Ensure opportunities to be active are engaging and enjoyable for all
- Provide attractive displays/noticeboards and regularly share information which highlight activities associated with an active workplace e.g., posters that illustrate a desk stretching routine
- Share information on available activities, clubs, and achievements, and ensure that they are frequently updated and changed
- Ensure all facilities and areas that support and encourage physical activity are well maintained
- Provide clean and adequate changing and showering facilities
- Ensure catering provision, including vending machines, provide and highlight healthy options throughout the day

- Highlight the importance of remaining hydrated and ensure easily accessible drinking water is available to all staff
- Negotiate a corporate discount for gym memberships
- Support active workplace challenges such as e.g. step counts, between teams/branches within organisations and between organisations

i) Active Sustainable Travel

The organisation encourages active sustainable travel to work and has:

- A cycle to work scheme in place
- Secure storage facilities for equipment e.g. bikes
- Changing and showering facilities for employees
- Sustainable travel millage allowance for employees

ii) Active when working

The organisation promotes: (delete as appropriate)

- Active soles policy
- Active (walking/wheeling) meetings/discussions
- Standing up during meetings/phone calls
- Flexible workspaces and standing desks
- Minimising email 'ping pong' – walk to a colleague's desk to hold a face to face conversation
- Allowing time for physical activity 'on the clock' as part of the working day
- Designated active space within the organisations' premises
- *(**For those whose role is dependent of physical fitness**)* the use of time when at work to develop and maintain fitness to meet contractual obligations including active recovery when possible

iii) Active when working from home

The organisation promotes:

- Mutually agreed flexible working hours
- Using time that would otherwise be spent commuting to instead undertake physical activity
- Online participation in meetings whilst being active e.g. walking and attending meetings using mobile devices
- Regular breaks for activity e.g. stretching and walking between periods of inactivity
- Reduce or limit back-to-back 'online' meetings and periods of collaborative online working
- Equipment such as 'sit stand desks' or 'sit stand desk convertors' for employees who work from home

iv) Active break and lunch times

The organisation encourages activity by:

- Ensuring open spaces are accessible by all, marked for a range of activities and well maintained
- Managing any open spaces and encourage participation in a **range** of break time activities
- Encouraging active break and lunch times as social activities (see below)
- Encouraging lunchtime (or after-hours) walks by sharing information on local parks and walking paths
- Mapping out walks around larger sites with an estimation of distance covered step count etc.

v) Social activities

The organisation encourages employees to:

- Establish a designated break time or coffee time to encourage breaks and build camaraderie
- Organise inclusive, equitable opportunities for all to engage in physical activity that support an active workplace
- Introduce ‘walking buddies’ or active lunch time groups
- Continue to engage in activities outside work and/or online
- Organise family activities, tournaments etc. outside of normal working hours with entertainment and healthy refreshments

Active Soles Insights Report

Betsi Cadwaladr University Health Board
Public Health Team

February 2024

Contents

1 Introduction

It is widely recognised that the environments in which we live and work in, is inextricably linked to health and wellbeing outcomes (Welsh Government, 2019). Evidence shows us that being active has a positive impact on physical health, mental health and wellbeing, social cohesion and economic development (Public Health England, 2020), however opportunities to move more are being rapidly designed out of everyday life. Increased rates of sedentary behaviour linked to office working has been shown to negatively impact on mental health and wellbeing, and is one of the leading causes of occupational musculoskeletal conditions, including neck and back pain (Dzakpasu, et al. 2021). Workplaces must think differently about how to engineer movement back into the workplace.

2 Background

Active Soles is movement that was created by Hayley Lever from Greater Manchester Moving in 2017. The campaign encourages employees to move more comfortably in work by allowing staff to wear active footwear throughout the working day instead of formal or uncomfortable types of work footwear.

Active Soles is based on the theory of 'enclothed cognition', which recognises how clothes systematically influence wearers' mental processes and the way they think and act (Adam and Galinsky, 2012), Embracing the concept of 'you are what you wear' and allowing staff to wear comfortable shoes to work, may contribute to increasing physical activity levels during working hours.

Across the England and Wales, organisations such as Manchester City Council, Cardiff Council, and Cardiff and Vale Health Board are adopting Active Soles as an approach to encourage employees to move more throughout the working day.
To understand the acceptability of Active Soles and how it could be adopted by Betsi Cadwaladr University Health Board (BCUHB), the Public Health Team have worked with key stakeholders in the organisation to answer the following questions:

1. What percentage of staff in BCUHB meet the CMO guidelines for physical activity and how does the workplace impact employees achieving these guidelines?
2. Does exiting workforce policy support or prevent the organisation from embedding Active Soles?
3. Is Active Soles acceptable to BCUHB employees?
4. How can Active Soles be embedded across the organisation?

This purpose of this report is to provide a summary of the key findings, and offer a number of recommendations to support the implementation of Active Soles across BCUHB.

3 BCUHB Staff Health and Wellbeing Survey Findings

3.1 Overview

Between July and September 2023, a health and wellbeing survey was conducted with BCUHB employees to understand the health and wellbeing needs of staff. An online survey, containing demographic and lifestyle questions, including alcohol consumption, smoking, mental health and wellbeing, nutrition and physical activity was promoted to staff via a range of communication channels. A total of 1.026 employees completed the survey, resulting in a 5.4 percent response rate.
The survey findings provide a unique opportunity to understand how active the workforce are and the barriers to staff becoming more active.

3.2 Findings

The results show that out of the 1,026 staff who completed the survey, 38 percent said they did not meet the recommended guidelines for physical activity (i.e. not active for 150 minutes per week). When asked ‘do you class yourself as a sedentary worker (i.e. desk based), 63.7 percent of staff answered yes, with those working in administration and clerical roles (48 percent) considered the most sedentary. Furthermore, the largest percentage of staff who regarded themselves as a sedentary worker are aged 50 years and over (45 percent).

The top five reasons why staff did not meet the physical activity recommendations (1 = most common reason) included:

1. Lack of time (due to home life and work hours & commute)
2. Fatigue (some due to long day sat at a laptop / long shift / due to menopause)
3. Physical health problems (including pain)
4. Lack of motivation
5. Chronic illness

Analysis collated from free text answers also showed that nearly half of those surveyed said they did get the option to be active in their working day, and 56 percent said they feel work has a negative impact on their physical health.

3.3 BCUHB Staff Health and Wellbeing Survey Conclusion

The survey found that over one third of staff who took part did not meet the recommended guidelines for physical activity. Interestingly, time (including work and home-life balance) and fatigue (linked to work practices) were cited as the top two reasons why staff did not meet the guidelines. While these results are not representative of the whole organisation, they do demonstrate that in some parts of BCUHB, current working environments have a negative impact on people’s ability to move more throughout the day. As a consequence of this, over half of the survey respondents felt that work had a negative impact on their physical health. This evidence base presents an opportunity to reflect on current working practices, and the need to take a whole-workplace approach to support and improve the physical and mental health and wellbeing needs of the workforce. Increasing opportunities for

staff to move more throughout the day by adopting Active Soles, is one of many actions that could contribute to improved staff health and wellbeing outcomes.

4 BCUHB and National Workforce Policy and Guidance Review

4.1 Overview

The key purpose of reviewing BCUHB and NHS policy is to ensure Active Soles aligns and is compliant with current workplace practices, regulations and standards. For the purpose of this paper, the review of BCUHB and NHS policy and guidance sought to:

- Assess all BCUHB and NHS Wales policies and guidance related to dress code, infection control requirements and health and wellbeing.
- Identify factors in policies and guidance that may support or hinder the implementation of Active Soles.

4.2 Findings

The review identified the following BCUHB and NHS Wales policy and guidance where dress code, infection control and health and wellbeing were mentioned:

- WP62 - BCUHB Dress Code Guidelines
- IPC03 - Standard Precautions Procedure
- WP66 - NHS Wales Menopause Policy - V1
- OHW02 Staff Health and Wellbeing Guidance

Table 1 highlights the potential opportunities and challenges from the above policies and guidance that could support or prevent the implementation of Active Soles.

Table 1.Workforce policy and guidance review

Policy/Guidance	Opportunity	Challenge
WP62 - BCUHB Dress Code Guideline	All staff must wear footwear that complies with the relevant health and safety requirements, for example, soft soled for reduced noise, low heeled for manual handling and ease of movement, and closed toes for protection Smart casual dress is usually considered appropriate for a non-clinical setting; work wear must be clean, in a good	Staff must wear dark coloured footwear e.g. plain black or navy with no bright logos. Staff moving into different areas which include high-risk areas, must change before entry and/or returning to the area i.e. closed areas for infection prevention/outbreak management. Footwear should be replaced after reasonable wear and tear.

	state of repair, and in keeping with the promotion of a professional image Footwear must be wipeable Open sandals/flip flops and footwear that do not adequately cover and protect the feet and cannot be cleaned or are absorbent to spillages, must not be worn. Staff must wear footwear that complies with the relevant health and safety requirements, for example, soft soled for reduced noise, low heeled for manual handling and ease of movement, and closed toes for protection Footwear should be comfortable and practical for the role undertaken	
IPC03 - Standard Precautions Procedure	To maintain accurate infection prevention at all times, footwear must be non-slip, impervious, clean and well maintained, and support and cover the entire foot to avoid contamination with blood or other body fluids or potential injury from sharps Employees must clean and decontaminate footwear upon removal and when visibly soiled with blood and/or body fluids follow manufacturers recommended instructions for cleaning and disinfection.	None identified.
WP66 – NHS Wales Menopause Policy – V1	Managers are to be fully supportive to their staff going through the menopause Wear suitable workplace clothing made from natural fibres if at all possible. Try to reduce stress levels and improve mood through, activities such as	None identified.

	mindfulness, yoga, and tai chi. Rely on coping mechanisms when possible. This may include doing more exercise, wearing layers of clothing, obtain breaks flexibly.	
OHW02 Staff Health and Wellbeing Guidance	To raise awareness amongst the workforce of the health related benefits of physical activity and the health risks of physical inactivity.	None identified

4.3 Factors that may prevent the implementation of Active Soles

The review identified that clear footwear rules exist for clinical staff to ensure infection control and prevention precautions are strictly followed. For infection prevention and outbreak management procedures, staff moving into different areas including high-risk areas, must change their footwear before and on return. As a result, clinical staff are restricted from leaving their designated workstation. Given the physical nature of clinical roles, and the strict infection control requirements, staff working in clinical areas are more likely to be wearing active footwear during the working day. While this is not a direct barrier to the implementation of Active Soles, consideration should be given to who, and how Active Soles is targeted at, to ensure messages are delivered appropriately and sensitively to different staff groups.

To inspire confidence in the public, the WP62 BCUHB Dress Code Guidance recommends that staff should present a professional image, and dress neat and tidy at all times, including when working from home. While there is no stipulation about the type of footwear non-clinical staff should wear, the guidance does expect staff to wear dark coloured footwear (black or navy) with no bright logos. In light of the current cost of living crisis, strict and outdated guidance about the colour of footwear may inhibit some staff from wearing active footwear, due to the additional cost of purchasing dark coloured shoes. The organisation should consider how it can influence wider NHS Dress Code policy to enable staff to wear footwear of their own choice, as long as adherence to infection control and prevention procedures are maintained.

The OHW02 Staff Health and Wellbeing Guidance provides guidelines on how opportunities to be active in the workplace are embedded and promoted. Reasonable adjustments for staff with disabilities should be made to increase access to, and eliminate discrimination in physical activity. Within the scope of Active Soles, consideration should be given to the accessibility of Active Soles, and how messages are communicated to staff with physical disabilities.

4.4 Factors that may support implementation of Active Soles

Despite the requirement that BCUHB staff should present professionally and appropriately, uniform-related policy and guidance does not specify formal footwear. Therefore, wearing comfortable shoes such as trainers that provide the wearer with 'mobility and comfort' (WP62-BCUHB Dress Code Guidelines, 2022) may not contradict existing policy or guidance, as long as footwear is clean, maintained and dark coloured.

Clinical staff are advised to wear comfortable footwear at all times, therefore comfortable footwear such as trainers could be worn in accordance with BCUHB Dress Code Guidelines (2022), IPC03 Standard Precautions Procedure (2022) and WP66 - NHS Wales Menopause Policy - V1 (2019). However, this footwear must not be worn outside of work areas. WP62 - BCUHB Dress Code Guidelines, (2022) considers 'smart casual wear' as appropriate for non-clinical staff as long as workers maintain a professional appearance.

The NHS Wales Menopause Policy V1 (2019), may also support the implementation of Active Soles. Whilst the policy does not directly mention footwear, it encourages individuals to wear comfortable clothing and uniform at all times, to work flexibly and take breaks when possible. It also advises managers to be understanding and considerate of individuals experiencing menopause symptoms by supporting the need for flexible working and promotion of physical activity. Encouraging staff to wear active soles in the workplace, could be one approach to support staff menopausal symptoms.

To improve the health and wellbeing of employees, The OHW02 Staff Health and Wellbeing Guidance supports and encourages the promotion and implementation of physical activity interventions during the workday, including walking meetings, taking the stairs instead of the lift, and active travel. Active Soles is a free and sustainable intervention that could support behaviour change in the workplace by encouraging sedentary workers to be more active throughout the working day.

4.5 Policy and Guidance Review Conclusion

The review has highlighted that current NHS and BCUHB policy and guidance would be supportive of Active Soles, as long as health and safety requirements and a professional appearance were upheld at all times. Strict and outdated rules about the colour of footwear may be seen as a barrier to the implementation of Active Soles, however changes to national policy could shift this. If Active Soles was adopted by the organisation, consideration should be given to the language and accessibility of messages, and which staff groups should be targeted, to ensure messages are delivered sensitively and appropriately to different BCUHB employees.

5 BCUHB Staff Insights

5.1 Overview

To understand the acceptability of Active Soles with BCUHB employees, the Public Health Team engaged with a range of internal equality and workforce network and partnership groups, including:

- Anti-Racism Action Plan Implementation Group
- People and Organisational Development Leadership Meeting
- Staff Wellbeing Operational Group
- BAME Unity Network
- Workforce Partnership Group

A presentation was prepared to provide an overview of Active Soles and the three questions outlined below were subsequently asked to each group –

- Do you think Active Soles is acceptable?
- What do you think the challenges may be to implementing Active Soles?
- If Active Soles is adopted, how can we work together to implement the campaign?

The section below summarises the key feedback from all of the groups that were engaged with,

Active Soles Posposal.pptx

5.2 Findings

5.2.1 Acceptability of Active Soles

The proposal received wide acceptance amongst all staff groups who attended the network and partnership group meetings, with one Health and Safety employee commenting they had always advocated the idea of comfortable shoes for work.

"It's a great initiative, timing is good as the All Wales Uniform Guidelines are being reviewed and ensuring staff can wear comfortable shoes is excellent".

Attendees referenced that a high proportion of BCUHB employees work in sedentary jobs, which would make Active Soles acceptable to most staff. A member of the Clinical Psychology Team shared that while seeing outpatients, they would remain seated for hours. This reflects the need for such an initiative to be adopted amongst clinical staff as well as non-clinical or corporate staff.

"Active Soles is very welcomed, it is needed to encourage office staff to move a lot more". It can be utilised to encourage staff to go for walks".

Due to long hours spent on teams meetings, with little screen breaks, homeworking was noted as another reason for sedentary behaviour. While Active Soles might not be suited for home working; introducing the initiative has emphasised the importance of reminding home workers to move more, and to take regular breaks from their

screen. Setting aside time for a walking or wheeling break in the calendar was suggested by one colleague.

BCUHB Workforce and Organisational Development employees and those working in the Occupational Health and Wellbeing Team were great supporters of Active Soles and showed readiness to embrace the campaign, should it be adopted by the organisation.

5.2.2 Possible barriers to implementing Active Soles

A number of colleagues from the People and Organisational Leadership Group explained that traditional concepts of what is considered as professional, for instance the expectation for GPs and Clinical Professionals to look smart when treating patients or attending external meetings may prevent some staff from wearing trainers. In addition, one colleague added that in his understanding, wearing trainers to work may be prohibited.

Factors relating to time and full diaries, with little gaps between meetings to enable staff to move was also highlighted as a barrier to being more active in the workplace.

5.2.3 Working together for an effective implementation

It was widely recognised and accepted that buy-in and support from BCUHB Executives and senior leaders is key to the success of Active Soles, with one colleague adding “we need to lead by example”. The planned BCUHB Wellbeing Road Show was seen as an opportunity to reach out to senior leaders as well as other staff groups. The BCUHB Public Health Team were welcomed to participate in the roadshows by colleagues.

It was suggested that large-scale, and consistent communication was critical to the success of Active Soles. Participants highlight the importance of working with BCUHB Communications Team in the design, and communication of messages via the intranet and social media. The Alpha Academy Team at Bangor University was suggested as a useful link to understand and embed behavioural science or nudge theory in communications messages with staff.

A large proportion of outside spaces (courtyards for example) on hospital grounds are currently closed off to both patients and staff. Colleagues suggested that outside spaces should be opened up, and made accessible to encourage staff to move more and access outside space during working hours.

5.3 Staff insights conclusion

The insights demonstrated widespread support for Active Soles across all of the internal groups that were engaged with. Feedback highlighted the importance of Executive and Senior Leadership buy-in to ensure the whole organisation was committed and ‘leads by example’ from the top down, as well as the bottom up. The BCUHB Communications Team were identified as being an important partner in the design and delivery of Active Soles to ensure maximum reach across the

organisation. This would also support the development of communications messages to reach homeworkers.

6 Conclusion

This paper has sought to understand the potential barriers and enablers to the successful implementation of Active Soles in BCUHB. In doing so, the Public Health Team has developed an understanding of the physical activity levels of staff across the organisation, and the link between current workplace environments and health and wellbeing outcomes. The information generated from the BCUHB Staff Health and Wellbeing Survey provides a helpful evidence base to support the need for wide-spread change across the organisation in relation to how staff are supported to move more throughout the working day.

The review of existing BCUHB and NHS policy and guidance has proved to be a useful exercise in understanding how Active Soles aligns to, and is compliant with current workplace practices, regulations and standards. It is encouraging to learn that Active Soles would complement current policy and guidance in supporting staff to improve their health and wellbeing and is aligned to dress code requirements and infection control measures.

The insights generated through staff engagement reflects a widespread support for Active Soles, and the need to embed more opportunities to be active during working hours. Gaining the Senior Leadership and Executives buy-in and working collaboratively with other teams such as Communication, Occupational Health and Wellbeing and Workforce Development is crucial to the long-term success of Active Soles.

7 Recommendations

- The BCUHB Senior Leadership Team endorse the Active Soles initiative as an initiative to increase physical activity levels in the BCUHB workforce

- The Executive Director of Public Health presents a proposal to the BCUHB Executive Team to endorse the implementation of the Active Soles initiative as part of a wider programme of work to encourage staff to be more active in the workplace

- Work in collaboration with BCUHB Communications Team to develop an internal communications and engagement plan for the launch and roll out of Active Soles.

- Work in partnership with Workforce Development and Occupational Health and Wellbeing Teams in BCUHB to review current policy and guidance documents where physical activity/being active is mentioned to ensure Active Soles is included as a workplace intervention.

- Work in partnership with Workforce Development and Trade Union colleagues to influence local and national NHS Dress Code Guidance to change restrictions on recommended footwear colour.

- Work closely with Health and Safety and Infection Control Teams to ensure Active Soles messages complies with footwear guidance for infection control measures in clinical or high risk areas.

- Consider how the impact of Active Soles will be measured through qualitative and quantitative measures including capturing staff case studies and repeat staff health and wellbeing surveys.

8 References

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Healthy Travel Charter
North Wales

We're taking steps to reduce carbon emissions, improve air quality and support staff health and well-being

Working together across North Wales, over the next two years we commit to...

Communications and leadership

Establish a sustainable travel champion network
Establish a network of proactive sustainable travel champions, including senior staff, managers and where relevant, elected members, who routinely promote and model active and sustainable travel behaviour, in line with the sustainable travel hierarchy

Use consistent communications messages
Agree and use regular and consistent communications messages with the public, visitors and staff on healthy travel and reducing unnecessary travel, including targeting people of different backgrounds, gender, age, abilities and disabilities

Consider healthy travel across our wider functions
Promote and consider healthy travel options and benefits across wider functions, such as: procurement, conferences, and when advertising roles in our organisations

Encourage sustainable travel through expenses policies
Review our travel expense policies and journey planning processes for staff, to align with the sustainable transport hierarchy

Provide strategic leadership on healthy travel
Collaborate with partners and provide strategic leadership and planning on healthy and sustainable travel, including infrastructure and services where relevant

Support staff driving fleet vehicles to be responsible road users
Support staff driving fleet vehicles to be responsible and considerate road users (e.g. driving within speed limits and not parking in cycle lanes), to enable safe walking and cycling

Public transport

Promote public transport discounts for sustainable travel
Explore discounts for staff on Transport for Wales rail services and with local transport providers

Walking, cycling and public transport

Provide information on how to reach our sites sustainably
Make information easily available on how to get to our main site(s) by walking, cycling and public transport links, for example by contributing to an interactive map

Cycling and walking

Offer the cycle to work scheme
Offer the cycle to work scheme to all staff, including e-bikes

Provide staff with facilities and accessories to encourage active travel
Assess and provide secure and accessible cycle storage, showers and lockers at all suitable sites

Enable staff to access bicycles more easily at work
Improve access to bicycles at work where appropriate, e.g. pool bikes, hire bikes and cargo bikes

Promote cycle training and maintenance sessions
Explore and promote cycle training and maintenance sessions where appropriate

Agile working

Support flexible working
Provide flexible working options for staff wherever possible, including home and/or hub working, and promote a culture of agile working across public sector sites

Ultra low emission vehicles (battery electric or hydrogen)

Review provision of electric vehicle charging facilities
Review the current and future need for electric vehicle (EV) and e-bike charging infrastructure on our sites

Look at options for ultra low emission vehicles in our fleets and procurement
Review our fleet and procurement arrangements (where applicable) for introduction of ultra-low emission vehicles, including e-cargo and e-bikes where appropriate

For signatories, more info and support visit: **healthytravel.wales/northwales**

Teitl adroddiad: ***Report title:***	North Wales Gypsy, Roma, Traveller Health Needs Assessment
Adrodd i: ***Report to:***	Planning, Population Health and Partnership (PPHP) Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 10 December 2024
Crynodeb Gweithredol: ***Executive Summary:***	This paper presents the findings and recommendations of a Health Needs Assessment (HNA) of the Gypsy, Roma and Traveller (GRT) communities living in and travelling through North Wales.
Argymhellion: ***Recommendations:***	The PPHP Committee is asked to endorse and support the implementation of the recommendations in the GRT HNA to enable a whole-system approach to improve health outcomes and tackle health inequalities for the GRT population in North Wales. **Recommendations for BCUHB:** 1. To minimise health inequalities, healthcare services should ensure the ethnicity of all patients is robustly recorded to monitor the uptake and engagement of different ethnic groups with preventative and treatment services. 2. All NHS staff working with patients should complete Gypsy, Roma and Traveller awareness training. 3. To improve knowledge and understanding of the communities' cultural values and beliefs, all NHS staff working with patients should complete cultural competence training 4. To ensure the needs and experiences of the GRT community are considered in the planning and design of local and regional healthcare services, BCUHB should consider how GRT people are represented at internal stakeholder equality network groups. 5. Healthcare services should be designed and delivered in an equitable manner, making reasonable adjustments were relevant, including the following for this population: • Assessing and recording any additional needs relating to the individual • Method of communication • Complexity of communication 6. Prevention of ill-health needs to remain a priority for this group and the providers of these services should seek to actively engage with the GRT community through assertive outreach. Prioritised services include mental health, screening and immunisations and drug and alcohol services. 7. Prevention services should seek to engage with the GRT population to improve understanding of the barriers to accessing services, and should work in collaboration with the community to co-design solutions to reduce inequalities in health and improve health and wellbeing across the life-course.

	8. To improve the quality and access to local accommodation, BCUHB should explore how it can influence local authority planning decisions regarding the identification and development of future local authority owned Traveller sites. 9. Primary care and secondary care services should review internal processes and communication approaches for registering and communicating with GRT patients, to ensure health literacy barriers are identified and broken down. This should include how support services are integrated into a patient's care where consent has been given. 10. The opportunity to support and develop the influential network of family and friend peers to deliver evidence-based information and advice on health and wellbeing, when to access healthcare and how to access healthcare should be considered. An additional 3 partner recommendations are mentioned in the report below.
Arweinydd Gweithredol: ***Executive Lead:***	Dr Jane Moore – Interim Executive Director of Public Health
Awdur yr Adroddiad: ***Report Author:***	Hannah C Lloyd – Principal Public Health Practitioner Dr Faye Sheldon – Consultant in Public Health

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	This programme of work will contribute to the following strategic objectives: Objective 4 – Improving quality, outcomes and experience
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	There are no legal implications for this programme of work.

Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The following Datix risk is associated with health inequalities: ID 5146 – Tier 1 – Population Health. There is a risk that the Health Board fails to adequately support the improvement of population health and reduce health inequalities.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Potential initial associated costs linked to: • Cultural competance and GRT awareness training • Development of accessible resources • Upskilling and coordination of peer health mentors Longer-term costs: • Long term ambition for investment in a regional Health Inclusion Service
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	There are no workforce implications as a result of implementing the recommendations the work will be undertaken using the existing health board workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Staff consultation on this work has taken place through: - BCUHB Population Health EDG - BCUHB Anti-Racism Action Plan Group Staff were consulted with to explore how the findings and recommendations from the HNA could be embedded across the organisation.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	See above Corporate Risk Register risk.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Next Steps:	

- BCUHB Public Health Team will work collaboratively with BCUHB colleagues and wider partners to develop a supporting action plan to take forward the findings and recommendations from the GRT HNA.
- BCUHB Public Health Team will chair and contribute towards the on-going development of a Regional GRT Strategic Partnership Group who will oversee the delivery of the action plan.
- BCUHB Public Health Team will work in partnership with BCUHB colleagues, and wider partners to share the findings of the GRT HNA with members of the GRT community in North Wales and co-produce solutions.

List of Appendices:

Appendix A – Gypsy, Roma, Traveller Health Needs Assessment

PPHP Committee

North Wales Gypsy, Roma, Traveller Health Needs Assessment

1. Introduction

Gypsy, Roma, and Traveller (GRT) communities experience some of the greatest inequalities in society. Evidence demonstrates that people from the GRT community often face stigma and discrimination, have poorer access to services, have lower levels of educational attainment, experience poor housing quality, and have significantly higher rates of morbidity and mortality compared to the general population. Data suggests that Gypsy and Traveller men die on average 10 years earlier than the general population and Gypsy and Traveller women die on average 12 years earlier than the general population.

In 2018, Welsh Government published a cross governmental plan Enabling Gypsies, Roma and Travellers to tackle the disparities faced by the GRT population living in, and travelling through Wales. The plan requires all Health Boards in Wales to '*ensure Gypsy and Traveller Health Needs Assessments are conducted and results fed into service planning'.* Tackling racism and improving the life chances of people from the GRT community is also key priority in the Welsh Government Anti-racist Wales Action Plan (2022).

2. Current Situation

In response to the requirement for health boards to conduct assessments of the GRT health needs, the BCUHB Public Health Team in partnership with Cumbria University and Arc4 have produced a Health Needs Assessment (HNA) of the GRT communities living in and travelling through North Wales. This HNA took a mixed methods approach and includes a literature review of the health and wellbeing needs of the GRT community, routine published data profiling the GRT communities across North Wales, health board data on health service use and data gathered directly from the GRT communities in North Wales using surveys, semi-structured interviews and focus groups.

Key findings from the HNA include:

- Health is of central importance to the GRT life
- Tackling the wider determinants of health is crucial to reducing health inequalities in the GRT community
- The lack of data on the health care usage of members of the GRT communities in North Wales makes it extremely challenging to profile the health needs of the population

- Person-centred culturally appropriate non-judgemental health care services that promote inclusion are crucial to ensuring that members of the GRT community access the right services at the right time
- GRT community members are highly reliant on other community members for health information and advice and are often reluctant to seek advice outside the community until things become unmanageable
- Engaging the community in preventative services is crucial but requires a model of outreach into communities

The report has produced 13 recommendations 10 of which are directed at the health board (see page 52 of the report).

BCUHB Recommendations:

1. To minimise health inequalities, healthcare services should ensure the ethnicity of all patients is robustly recorded to monitor the uptake and engagement of different ethnic groups with preventative and treatment services.
2. All NHS staff working with patients should complete Gypsy, Roma and Traveller awareness training.
3. To improve knowledge and understanding of the communities' cultural values and beliefs, all NHS staff working with patients should complete cultural competence training
4. To ensure the needs and experiences of the GRT community are considered in the planning and design of local and regional healthcare services, BCUHB should consider how GRT people are represented at internal stakeholder equality network groups.
5. Healthcare services should be designed and delivered in an equitable manner, making reasonable adjustments were relevant, including the following for this population:
    - Assessing and recording any additional needs relating to the individual
    - Method of communication
    - Complexity of communication
6. Prevention of ill-health needs to remain a priority for this group and the providers of these services should seek to actively engage with the GRT community through assertive outreach. Prioritised services include mental health, screening and immunisations and drug and alcohol services.
7. Prevention services should seek to engage with the GRT population to improve understanding of the barriers to accessing services, and should work in collaboration with the community to co-design solutions to reduce inequalities in health and improve health and wellbeing across the life-course.
8. To improve the quality and access to local accommodation, BCUHB should explore how it can influence local authority planning decisions regarding the identification and development of future local authority owned Traveller sites.
9. Primary care and secondary care services should review internal processes and communication approaches for registering and communicating with GRT patients, to ensure health literacy barriers are identified and broken down. This should include how support services are integrated into a patient's care where consent has been given.
10. The opportunity to support and develop the influential network of family and friend peers to deliver evidence-based information and advice on health and wellbeing, when to access healthcare and how to access healthcare should be considered.

Partner Recommendations:

11. A regional, multi-agency group, involving public and third sector stakeholders working with the GRT community should be established to ensure a coordinated whole system approach to improving the health and wellbeing of the GRT community in North Wales is taken.

12. Greater consideration should be given to the design and ongoing maintenance of local authority traveller sites to ensure the environment enables the community living on the site to live a healthy life.
13. Stakeholders should work in an integrated way to engage with the community to avoid duplication and engagement fatigue, ensuring the engagement is meaningful and offers clear outcomes.

Crucial to the delivery of these recommendations is:

- The robust recording of patient demographic data
- Training and development of a culturally competent workforce
- Considering the needs of the GRT community in service planning and design
- Integrating reasonable adjustments within service delivery to make services accessible for the GRT community
- Engaging with the community to co-produce solutions to improving health and wellbeing

The Public Health Team are now seeking health board endorsement of the report and support to implement the recommendations in the GRT HNA to enable a whole-system approach to improve health outcomes and tackle health inequalities for the GRT population in North Wales.

3. Budgetary / Financial Implications

The work associated with the implementation of these recommendations should initially be able to be delivered by existing resource within both the health board and wider partner organisations. However, the co-production and delivery of cultural competence and Gypsy, Roma and Traveller awareness training, the production of accessible health and wellbeing resources and upskilling and coordination of Peer Health Mentors may result in additional costs to BCUHB.

It is acknowledged that long-term the solution to reducing health inequalities across a range of vulnerable groups that experience high levels of health inequalities in North Wales may be the investment in a health inclusion service. The GRT community would be one group that would be included within the eligibility criteria for this service.

Costs and timescales associated with the above will be considered as part of the regional GRT plan co-produced with stakeholders and members of the GRT community.

4. Risk Management

This work will contribute to reducing the risk score for the Tier 1 Risk ID: 1546 – Population Health. This risk identifies the ongoing concern that the health board will fail to improve population health and reduce health inequalities due to a lack of investment and commitment to prevention.

5. Equality and Diversity Implications

The recommendations within the HNA have been developed with the purpose of reducing health inequalities within the GRT communities across North Wales. Any significant changes to service delivery that occur as a result of this work will have the relevant EQiA and SEIA completed.

Appendix A – North Wales Gypsy, Roma and Traveller Health Needs Assessment

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Betsi Cadwaladr University Health Board (BCUHB) Gypsy, Roma and Traveller Health Needs Assessment

November 2023

Authors:

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Contents

1 Introduction

In North Wales, partners identified that there is a lack of understanding about the health needs of Gypsy and Traveller people. It was agreed that a Health Needs Assessment (HNA) would be completed to begin to develop a picture of the population living and travelling through North Wales, the health needs they are presenting to services with, and the health and wellbeing priorities of community members.

The Equality and Human Rights Commission (EHRC) (2019) identified Gypsy, Roma and Traveller (GRT) people as experiencing multiple disadvantages across different aspects of their lives. This includes educational attainment, housing, access to health care and health outcomes (EHRC, 2019). It is recognised that the causes of these disadvantages and subsequent poor health outcomes are complex, and worsened by prejudice and discrimination (EHRC, 2019). The lack of robust recording of ethnicity data often makes it challenging to understand the health needs of this population.

2 Definitions

Achieving consensus in agreeing the terms 'Gypsy, Roma and Traveller' is arguably difficult to achieve. Definitions are context dependent, and associated with notions of self-representation, both from within and out with the community. Within the literature, there is agreement that the population is defined by a) self-identification as Gypsy, Roma or Traveller, and b) the tradition of nomadism (McFadden et al, 2018). In accordance with the Welsh Government (2018a) definition, the terms 'Gypsy, Roma and Travellers' refer to different ethnic or cultural groups, which include, but are not limited to, Romani Gypsies, Irish Travellers, Roma, and New Travellers. Under the terms of the Equality Act (2010) Romani Gypsies, Irish Travellers and migrant Roma are considered distinct ethnic groups and are therefore protected, by law from discrimination in the United Kingdom.

3 Aim and Objectives of the HNA

3.1 Aim

To understand the health needs of Gypsies, Roma and Travellers (GRT) who usually reside in or travel through North Wales.

3.2 Objectives

- Understand the health issues the GRT population residing in and travelling through North Wales are currently prioritising
- Describe the current health care services available to GRT population in North Wales
- Establish the GRT populations engagement with healthcare services

- Identify opportunities to improve the health outcomes of the GRT population residing in and travelling through North Wales

4 Methodology

A health needs assessment is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities (Cavanagh & Chadwick, 2005).

This needs assessment will use a range of approaches to gathering evidence of the health needs of the GRT population resident in and travelling through North Wales including:

- Analysis of national routine data gathered on the population of interest
- Analysis of local health board service data
- A literature review of all published research into the health of GRT
- Gathering the views of the GRT population of North Wales through semi-structured interviews and focus groups
- Gathering the views of key stakeholders working with GRT across North Wales

5 National Policy

In 2015 the Welsh Government published 'Travelling to Better Health', policy implementation guidance for healthcare practitioners on working effectively with Gypsies and Travellers. The guidance is designed to assist healthcare practitioners in working effectively with Gypsies and Travellers as well as assist Local Health Boards in meeting their statutory duty to advance equality. The guidance recognises "*there is wide disparity between the experience of Gypsies and Travellers and the rest of the population of Wales in relation to health and this has been a consistent position over the long term*" (Welsh Government, 2015: 2). The guidance identifies key areas for action including addressing barriers to accessing services, cultural competence, approaches to encourage participation, peer support and ethnicity monitoring.

In June 2018, the Welsh Government published the strategy 'Enabling Gypsies, Roma and Travellers'. The strategy outlines how the Welsh Government will support the GRT community to achieve their full potential. The strategy recognises that in some parts of Wales the GRT communities are the largest ethnic minority groups living within the community. The strategy is focused on reducing inequalities increasing access to opportunities and improving relations between the GRT communities and wider society. The strategy contains key actions across areas including accommodation, employment, poverty, health, education and community cohesion.

In July 2022, the Welsh Government published the first 'Anti-racist Wales Action Plan'. A long-term plan, and vision to achieve a 'Wales which is anti-racist' by 2030' (Welsh Government, 2022a). The plan identifies six key aspects of their lives where ethnic minority people, including GRT experience racism:

1. In their every-day life
2. When experiencing service delivery
3. Being part of the workforce
4. Gaining jobs or opportunities
5. When they lack visible role models in positions of power
6. As a refugee or asylum seeker

The plan proposes a number of long-term, system-wide actions across health, social-care and education to achieve significant culture change and embed an anti-racist approach across all polices, structures and service delivery.

6 National data

6.1 2021 Census Data

6.1.1 2021 Census Ethnicity data

Historically the Census only began recording ethnicity in 1991, and it was not until the 2011 Census that White: Gypsy and Traveller were recognised as an ethnic group category. Prior to 2011, Gypsies and Travellers were required to write their ethnic group under 'other'. The Roma ethnicity continued to be omitted from the ethnicity categories until the 2021 Census where it was included for the first time.

The recently released ethnicity data from the 2021 Census, reported 168,721 people in England and Wales who identify as either White: Gypsy or Traveller or White: Roma (Office for National Statistics (ONS), 2022a). White: Gypsy or Traveller totalled 67,757 and White: Roma totalled 100,964. Of the 168,721 GRT people identified in the 2021 Census, 5,394 reside in Wales and 840 of them were resident in North Wales when the Census was completed. The Census 2021 population data for North Wales estimates the population to be 687,000. GRT make up 0.1% of the population of North Wales (ONS, 2022a).

Below is a breakdown of the 2021 Census data for North Wales.

Table 1. 2021 Census Ethnicity Data for North Wales

Local Authority	White: Gypsy or Irish Traveller	White: Roma
Wrexham	119	64
Flintshire	123	74
Denbighshire	62	32
Conwy	104	19

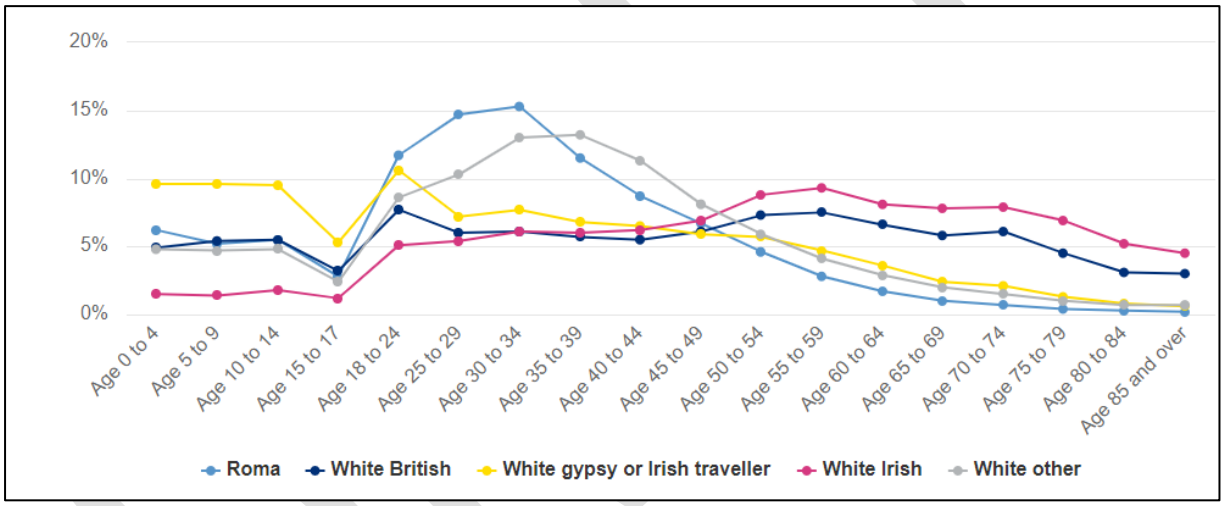
Gwynedd	111	45
Isle of Anglesey	54	33
Total	**573**	**267**

Source: ONS (2022a)

It is acknowledged that the accuracy of this data may underestimate population size, due to a reluctance to disclose ethnicity due to stigma (Cromarty, 2019; McFadden et al 2018).

Age profile data (figure one) from the 2021 Census highlights the stark disparities between different white ethnic groups (ONS, 2023b). The data shows that the percentage of people aged 60 and over was highest in the white Irish ethnic group (40.2 percent), followed by the white British ethnic group (29.1 percent) compared to 4.3 percent in the Roma ethnic group.

Figure 1. Percentage of people in each age group, by ethnicity (white ethnic groups) England and Wales Census 2021



Source: ONS 2023b

6.1.2 2021 Census Data on Ethnic Group Differences in Health

2021 Census data found that those who identify as 'White: Gypsy or Irish Traveller' had the highest percentage of people saying their health was very bad at 3.8% compared to 1.2% reporting this across the whole population (ONS, 2023c). Sixteen percent of those who identified as 'White: Gypsy or Irish Traveller' reported they were disabled and limited a lot in their daily activities by a long-term physical or mental health condition (ONS, 2023c). This is twice the rate for the whole population of England where 7.5% of people reported being limited a lot by a long-term health condition (ONS, 2023c). Gypsies and Travellers were also more likely to be providing unpaid care with 5.2% providing more than 50 hours per week of unpaid care, the highest rate among the 19 groups analysed (ONS, 2023c).

6.2 Caravan Count

In July 2006, bi-annual census counts of Gypsy and Traveller (G&T) caravans were reintroduced in Wales following recommendations from the Review of Service Provision for Gypsies and Travellers in 2003, and a Welsh Government review undertaken in 2006 by Pat Niner of Birmingham University. Data is produced for a specified census date in January or July each year, giving a snapshot of the number and location of caravans on the specific date.

In July 2022 a total of 1,166 G&T caravans, and 168 sites were reported in Wales (Welsh Government, 2022b). In North Wales there were a total of 50 G&T caravan sites (authorised and unauthorised) and 271 caravans. The data for North Wales demonstrates that the East of North Wales (Wrexham and Flintshire) has the most caravan sites and the most caravans. The North West (Gwynedd and Isle of Anglesey) has the fewest sites and caravans. Compared to July 2021 data, trends demonstrate a 28% increase in caravans and 56% increase in G&T sites across North Wales.

Table 2. G&T Caravan Sites Data for North Wales July 2022

Local Authority	Authorised sites	Unauthorised sites	All Sites
Wrexham	8	4	12
Flintshire	12	6	18
Denbighshire	0	10	10
Conwy	1	1	2
Gwynedd	2	4	6
Isle of Anglesey	0	2	2
Total	**23**	**27**	**50**

Source: Welsh Government (2022b)

Table 3. Caravan Count Data for North Wales July 2022

Local Authority	Caravans on Authorised sites	Caravans on unauthorised sites	All Caravans
Wrexham	36	9	45
Flintshire	132	26	158
Denbighshire	0	36	36
Conwy	4	3	7
Gwynedd	14	8	22
Isle of Anglesey	0	3	3
Total	**186**	**85**	**271**

Source: Welsh Government (2022b)

There are a number of limitations to the caravan count data. The data only provides data for a snap shot in time for a population that are nomadic, meaning many caravans that are usually resident in North Wales may have

been missed if the family are temporarily travelling in another part of the country. The caravan count also fails to include G&T people that reside in bricks and mortar accommodation. It is estimated that two thirds of the G&T population live in bricks and mortar households (Marsh, 2020). There are also concerns that the process itself is intrusive and discriminatory as there is no equivalent 'count' for the settled community (Niner, 2004).

The caravan count also only counts the number of caravans without actually counting the people resident in these caravans. Using the Romani Cultural and Arts Company assumption of 5.6 family members per caravan, it can be estimated that approximately 1,518 people live in the 271 caravans counted in the last North Wales caravan count (Marsh, 2020). Based on the 2021 Census data for North Wales, the population was 687,000, therefore the G&T resident on authorised and unauthorised caravan sites make up 0.2% of the North Wales population compared to the 0.1% estimate based on the 2021 Census data (census data also includes Roma data).

7 Local Data

7.1 Health Care Services

Although ethnicity data should be routinely collected within NHS services, local and national evidence suggests this is not the case (NHS Race and Health Observatory, 2022). There are many reasons why this data is not routinely collected for GRT. This includes GRT reluctance to disclose this information due to fear of stigma and discrimination as well as healthcare staff being reluctant to ask for this information because of the perceived sensitivity of asking patients about their ethnicity (ONS, 2023a).

7.2 Maternity

Between April 2021 and March 2022 in Betsi Cadwaladr University Health Board (BCUHB), there were 6024 live births. Of these 6024 live births, 10 mothers had their ethnicity recorded as Gypsy or Irish Traveller, this is 0.1% of all live births during this period. It is unlikely that this data is an accurate reflection of the proportion of GRT women that have given birth in North Wales. Although ethnicity data is relatively complete for the maternity dataset (only five out of 6024 records had 'not stated' recorded for ethnicity), it is likely that births have been underreported either due to incorrect recording or the mother's reluctance to disclose they are of GRT ethnic origin.

7.3 Emergency Department Attendances

Between 1 April 2021 and 31 March 2022, there were 205,271 emergency department presentations across the three acute hospital sites in BCUHB. Seventy-nine percent of these presentations (162,073 records) had 'not stated', 'NULL' or 'unknown' recorded against ethnicity. None of the remaining 43,198 records stated GRT as the ethnic origin of the patient.

Evidence suggests that due to the barriers some members of the GRT community experience with accessing healthcare, presentation at emergency departments is more common when a health condition progresses to crisis point (Lewis, 2013). The lack of accurate ethnicity data for emergency department presentations in BCUHB makes it difficult to establish whether this is the case in North Wales.

7.4 Outpatient referrals

Between 1 April 2021 and 31 March 2022, there were 381,601 outpatient referrals in BCUHB. Eight-two percent of these referrals (311,046 records) had 'not stated', 'NULL' or 'unknown' recorded against ethnicity. Less than five records stated the ethnic origin of the patient was GRT. The lack of accurate ethnicity data for outpatient referrals makes it difficult to establish what the common health conditions are that GRT are requiring secondary care for and whether there are any opportunities to put in place preventative measures to reduce the risk of certain health conditions.

7.5 Inpatient admissions

Between 1 April 2021 and 31 March 2022, there were 176,962 inpatient admissions in BCUHB. Seventy-one percent of these referrals (125,869 records) had 'not stated', 'NULL' or 'unknown' recorded against ethnicity. Less than five records stated the ethnic origin of the patient was GRT. As with other health care services, the lack of accurate ethnicity data makes it difficult to establish a clear understanding of the reasons that GRT access healthcare and the associated health conditions they are experiencing.

7.6 Primary Care

The current QAIF disease registers published through Stats Wales also fail to report on the prevalence of the diseases recorded on the disease registers by ethnicity. Data on registered patients in Wales is not routinely available meaning it is difficult to ascertain whether accuracy of ethnicity recording is also an issue within GP Practices.

8 Literature Review

Full details of the literature search criteria can be found in Appendix A of this document.

8.1 GRT Health

As the largest minority ethnic group in Europe, GRT populations experience substantially worse health outcomes compared with the general population (McFadden et al, 2018). GRT communities experience higher morbidity and mortality rates, lower rates of vaccine uptake, and encounter higher rates of mental illness and suicide (Cook et al, 2013; Peters et al, 2009; The Traveller Movement, 2019). Little has changed to make a material difference to the health status of GRT communities in the intervening years

since the work of Parry et al, (2007) and the publication of the Marmot Review (2010).

The lack of routinely gathered data on GRT communities makes it difficult to profile the health and wellbeing of the GRT communities. It is generally accepted that life expectancy in these ethnic groups is significantly lower than the general population. The frequently quoted statistic is that G&T men die on average 10 years earlier than the general population and G&T women die on average 12 years earlier than the general population (Barry et al, 1989). This data is based on research undertaken in Ireland. More recent research also undertaken in Ireland suggests that the life expectancy reported in 1987 had worsened for men by 2008 with Traveller men dying on average 15 years earlier than the general population, whilst Traveller Women's life expectancy remained 12 years less than the general population (Department of Health (DoH), 2010). In 2005, the average life expectancy of G&T living in Leeds was found to be 28 years lower than the general population (Baker, 2005). The data in figure one outlining the age profile of the GRT population from the 2021 Census, also supports existing evidence that life expectancy for GRT communities is significantly lower compared to the general population.

Infant mortality is also thought to be significantly higher in the GRT population. The All Ireland Traveller Health Study found that infant mortality rate for Travellers living in Ireland in 2008 was 14.1 per 1,000 live births compared with 3.9 per 1,000 live births for the general population (DoH, 2010). Infant Travellers were found to be 3.6 times more likely to die than the general population (DoH, 2010). Loss of a child was also found to be significantly more likely in a study conducted by Parry et al, (2007) where the health outcomes of a sample of Gypsies and Travellers in England were compared to a matched non-Traveller sample.

8.2 Physical Health

GRT generally report poorer health and wellbeing than the general population. In the 2021 Census, G&T has the highest proportion of people with 'not good' general health (ONS, 2023c). In the research undertaken by Parry et al, (2004), G&T reported significantly poorer health and significantly more symptoms of ill health compared to non-Gypsies and Travellers. Self-reported chest pain, respiratory problems and arthritis were more prevalent in the G&T population with key inequalities in respiratory symptoms and chest pain (Parry et al, 2004). The only exceptions were diabetes, stroke and cancer where the age and sex matched comparators had higher prevalence (Parry et al, 2004). Interestingly the poorest health was found in those who travelled the least and those living in houses (Parry et al, 2004).

8.3 Long-term health conditions

Evidence suggests that G&T people have higher levels of respiratory problems, including asthma, chronic cough and bronchitis compared to age-matched comparators (Parry et al, 2007). Poor quality of council

owned sites, accommodation, air quality and proximity to industrial sites and major roads, are cited as the main causes of poor respiratory health (Greenfields & Brindley, 2016). Providing suitable accommodation has the ability to reduce health and social inequalities and improve long-term health outcomes for G&T people (Van Cleemput et al, 2007).

Due to the lack of routinely collected equality monitoring data within healthcare services, the incidence of cancer within the GRT community is unknown. In a study conducted by Parry et al (2007), self-reported cancer incidence in G&T people was akin to age-matched comparators. However, factors relating to late presentation and non-survival of cancer may be the cause of the lower incidence rates (Van Cleemput, 2018). Condon (2020) notes that factors relating to lifestyle behaviours, health literacy and access to services put GRT people at a higher risk compared to the general population.

It is widely recognised that cancer is a 'taboo subject' within the GRT community (Parry et al, 2004, Condon, 2020; Smith et al, 2020). Attitudes towards fatalism, and avoidance, shape how and when people access services, particularly amongst older adults (Smith et al, 2020). Furthermore, issues relating to cultural competence (Jesper et al, 2008), and communication has resulted in many GRT people seeking information and support about cancer diagnosis and treatment within their own community (Smith et al, 2020). Condon (2020) notes that knowledge of lifestyle factors to reduce the risk of cancer, are well known. However, factors relating to trust and confidence in authorities, and perceptions about risk, prevent the adoption of healthy behaviours within the GRT community.

8.4 Mental health

GRT populations face a variety of challenges, which contribute to an increased risk of poor mental health and suicide. Factors such as discrimination, culture, stress, and homophobia are cited specifically as additional risk factors for GRT communities. Furthermore, experiences of bereavement set within the context of tight-knit family communities, further compounds these risk factors (The Traveller Movement, 2019). Moreover, loss of cultural identity and cultural isolation, caused by the inability to move freely, is a key contributor to depressive illness (Van Cleemput et al, 2007). In influential work by Parry et al, (2007) G&T populations were found to be more than twice as likely to be depressed and almost three times more likely than the general population to be anxious.

The All Ireland Traveller Health Study found that suicide rates for Traveller women are six times higher than that of the general population and, for Traveller men, seven times higher (DoH, 2010). GRT populations are more than twice as likely to attend hospital with suicidal ideation or self-harm than the general population. Of those community members presenting with suicide and self-harm, a significant number are men, with Traveller men more likely to engage in substance misuse and be diagnosed with depression than the general population (Tanner & Doherty, 2022).

In the years since Parry et al (2007) and the All Ireland Traveller Health Study (DoH, 2010) there has been limited high quality empirical evidence published concerning the mental health needs of Traveller communities (McKey et al, 2022). In terms of prevention, it is apparent that the mental health needs of GRT communities are overlooked within national and local suicide prevention plans in England (Sweeney & Dolling, 2020), and this is a stark warning to all home nations that this population needs to be a priority for suicide prevention plans. Action to reduce such disparities, in the form of building positive relationships with communities, providing cultural competence training, ensuring nomadic populations can register with a GP and promoting better bereavement care will go some way to ensuring mental health justice is considered within healthcare delivery (Garrett, 2022).

8.5 End of life care

There is limited research into inequalities in access to palliative and end of life care for GRT people. However, strong family and community values, including the role of the family before and after dying; distinct health beliefs such as the importance of ritual hygiene and, barriers to non-community healthcare provision including health literacy and compassionate care, play an important role in the quality and experience of specialist palliative and end of life care (Dixon et al, 2021). McQuillan and Van Doorslaer (2007) emphasise the importance of individualised care to understand the different beliefs and rituals between ethnic groups. Specialist palliative care services should seek to deliver cultural awareness training to staff to improve understanding of cultural differences and communication needs.

8.6 Patterns of accessing healthcare

Prejudice and discrimination are thought to play a significant role in the avoidable disparities experienced by GRT populations when accessing healthcare services (Marsh, 2017; McFadden et al, 2018). Set within the context of growing economic uncertainty in the United Kingdom, instability of central government, and the legacy of the Covid-19 pandemic, GRT communities face health threats perhaps not experienced in generations. Furthermore, the recent passing of the Police, Crime, Sentencing and Courts Act, (2022) arguably poses an existential threat to the GRT way of life in the United Kingdom. Action to reduce the inequalities gap requires an integrated and inclusive approach which preserves and promotes the cultural practices of GRT populations.

There are a number of complex and diverse social, cultural and environmental barriers which preclude many GRT from accessing healthcare. The design and delivery of healthcare services, discriminatory staff attitudes, culturally insensitive care, health literacy and service user attributes are widely cited in the literature as significant barriers (McFadden et al, 2018; Smith & Rushton, 2013; Jackson et al, 2017; Lewis, 2013).

The business of healthcare design and delivery is highly complex. Positive patient outcomes are dependent on interactions within diverse systems which operate within healthcare. Health systems are naturally process driven, with the existence of numerous protocols governing procedures such as access to medical care, referral pathways and treatment protocols. Low levels of literacy among GRT populations are well documented in the literature. Health information tends to be delivered in written form, in English or Welsh and is therefore inaccessible to many GRT people. Correspondingly, knowledge about healthcare provision is often lacking in Traveller communities (Marsh, 2017). People with low health literacy struggle to make sense of health information necessary to make health decisions. Such individuals may also experience difficulties accessing health promotion materials, making use of digital technology, understanding medical jargon and navigating healthcare services (McFadden et al, 2018; Condon et al, 2021).

Widely cited in the literature are specific barriers related to accessing primary healthcare. General Practitioner registration protocols generally depend on people being able to produce the correct documentation, complete registration application forms and residing in a fixed address. These requirements can present significant challenges for GRT communities (McFadden et al 2018; Jackson et al, 2017; Lewis, 2013). Finally, travelling can mean GRT communities are excluded from routine general practice services such as receiving prescriptions, accessing health screening and long-term conditions management. Moreover, some GP Practices are reluctant to register GRT people as temporary patients during the travelling season, with evidence of some GP Practices de-registering families without warning (Lewis, 2013; McFadden et al, 2018).

GRT perceptions of discriminatory practices understandably result in a reluctance of community members to utilise health services. Smith and Ruston (2013) noted that previous negative interactions with healthcare personnel serve as a template for expectations of future encounters. Additionally, narratives of adverse healthcare interactions are normalised within the community and serve to further alienate individuals from healthcare services. It is common for G&Ts to wait until they are 'really ill' before seeking medical attention, by which time individuals often present in Accident and Emergency with advanced illness (Lewis, 2013). Individuals tend to store up health concerns and visit the General Practitioner with several health issues at once. This is most often seen in male Travellers who are more likely to present with advanced illness (Marsh, 2017, Smith & Rushton, 2013).

Failures of healthcare professionals to deliver culturally sensitive care, further reinforces feelings of exclusion. Disparities in communication styles between professionals and community members can make G&Ts feel exposed when deviating from conventional communication norms. Community members prefer informal and personal communication styles in which healthcare professionals build trust by demonstrating congruence (Smith & Ruston, 2013).

8.7 Housing and health

Housing provision continues to be of concern in GRT communities, with the link between poor housing and health well established. G&T sites are often located in substandard locations, for example, industrial estates, adjacent to motorway junctions and disused brownfield sites. The existence of environmental hazards and lack of safe play areas can be particularly precarious to children and older adults (Van Hout & Stanievicz, 2012; Cush et al, 2020). These locations often cause G&T people to feel segregated from society, which further reinforces feelings of exclusion. This is compounded by the implementation of the Police, Crime, Sentencing and Courts Act (2022) which sends a clear message that the nomadic tradition is incompatible with societal values.

Despite efforts of local authorities to uphold their obligation to undertake accommodation needs assessments for G&T populations, significant problems with planning consent exist. Crucially, Niner and Brown (2011) argue that the very evidence base for planning requirements, based on Gypsy Traveller Accommodation Assessments, undermines planning efforts by failing to adequately collaborate with community members. This position is supported by Garner (2019) who identifies that local authority resistance exists in relation to approving development of existing sites as well as granting permission for new sites. Competition for land in peri-urban locations has caused land prices to soar in recent years. Many G&T populations are being pushed out into 'green belt' areas where land prices preclude many from purchasing land (Garner, 2019). Inevitably, exclusion from land purchase, the lack of suitable 'bricks and mortar' accommodation and availability of transit sites is a significant source of instability within communities (European Union Agency for Fundamental Rights, 2009).

It should also be recognised that nationally three in four G&T live in non-caravan accommodation (Cromarty, 2019). Furthermore, where Irish Travellers and Roma people are accommodated in 'bricks and mortar' properties by the local authority, many fear racism from the wider community. In cases of actual racial abuse, it remains a concern that many individuals will not report this to the police for fear of reprisals (Van Hout & Stanievicz, 2012). The disproportionate focus on accommodation within this population risks ignoring other key policy issues such as Education, Employment, Health and the Criminal Justice System.

8.8 Educational attainment

GRT continue to have the lowest educational attainment of all ethnic groups in England. Attainment 8 scores are a way of measuring how well pupils do in key stage 4 which they usually finish at aged 16. In the 2020/21 academic year, scores were lowest in the White Gypsy and Roma pupils (22.7) followed by pupils with Traveller Irish heritage (30.7), compared to the average attainment 8 score of 50.9 (Department for Education, 2022). Gypsy and Roma pupils have been assessed to be three years behind their White British peers by the end of secondary school, with Travellers of Irish Heritage pupils nearly two years behind (Hutchinson et

al, 2020). Causes of poor educational attainment are multiple and complex. GRT pupils are more likely to be identified as having special educational needs, they also have significantly higher levels of absence, fixed term and permanent exclusion from school than pupils from other ethnic groups (Wilkin et al, 2010).

GRT parents are often seen as a homogenous group in terms of the value they place on education. Parental support has been identified as a key factor to successful educational attainment for GRT pupils. Recent engagement with GRT communities has found that generally there is a desire to develop skills through education for both employment and future prospects purposes (ONS, 2022b). But the lack of parental experience of educational opportunities and cultural expectations often influenced this parental support (Wilkin et al, 2010). Racism, low teacher expectations and conflicting cultures are also key contributing factors (Wilkin et al, 2010). Research undertaken as part of the Traveller Movement education and advocacy project found that many GRT pupils struggle to develop a sense of belonging while in school due to bullying, racism and a lack of representation of their culture within the curriculum (The Traveller Movement, 2020). Key strategies to address this include strong anti-racists bullying policies and the introduction of GRT histories and culture into the school curriculum (The Traveller Movement, 2020).

The education system and the value placed on academic achievement is often counterintuitive to the culture and values of GRT communities. Re-shifting the focus of the system to supporting pupils to achieve their ambitions rather than imposing expected levels of academic achievement may go some way to making the education system more appealing for GRT to engage with.

8.9 Employment

Data from the 2011 Census reported that Gypsy and Irish people were less economically active compared to all other ethnic groups, with only 47 percent of adults, aged 16 and above economically active, compared to an average of 63 percent in England and Wales (ONS, 2022c). Furthermore, people in the G&T group reported the highest percentage (31.2 percent) of 'never worked or long-term employment' in all of the ethnic groups (ONS, 2022c).

Qualitative research conducted by the ONS in 2022 found that educational attainment and particularly literacy skills, affect the employment opportunities available to G&T. Participants preferred vocational jobs, including tarmacking, landscaping and woodwork over jobs that required academic qualifications (ONS, 2022c). G&T also report bias amongst employers due to the perceptions of G&T, with many having to hide their identity to secure employment (ONS, 2022c).

8.10 Immunisations and screening

In the earlier description of patterns of healthcare usage, it is evident that GRT populations prefer to look within the community to seek support for their health complaints. When looking outside of the community, care is often sought from the General Practitioner and unscheduled care. There is a lack of literature relating to how GRT communities interact with the broad range of available preventative health care services and much of the evidence base relates to childhood vaccination uptake.

GRT communities are understood to have lower vaccine uptake rates than their non-GRT counterparts. In research undertaken by Dixon et al, (2017) vaccine completion, at all-time points, was more than 40% lower in Irish Traveller children residing in England compared with non-Traveller children in the same localities. Coverage rates which fall below the World Health Organization (WHO) target of 90% (95% for measles) are problematic because it risks communicable disease outbreaks within communities (WHO, 2013).

The evidence base indicates a degree of ambivalence within GRT communities regarding vaccine uptake. On the whole, GRT communities are not culturally opposed to vaccination (Jackson et al, 2017). Research into uptake of the Measles, Mumps and Rubella (MMR) vaccine suggests structural inequalities, such as a lack of culturally appropriate services, experiences of discrimination and health injustices are at the root of decision making (Smith & Newton, 2017). Wariness and mistrust in health professionals, their interventions, and beliefs about when the MMR should be administered also serve as an important foundation for vaccine decision making (Smith & Newton, 2017). On the whole, with the exception of newly introduced vaccinations such as rotavirus and childhood influenza, most United Kingdom GRT communities studied by Jackson et al, (2017) indicated moderate levels of knowledge about childhood vaccines. Vaccine hesitancy varied between location and ethnic group, with Glasgow Roma populations appearing to be more accepting of immunisations and Irish Travellers in London adopting a more hesitant stance (Jackson et al, 2017). Fears amongst older female Travellers about whooping cough, widespread reticence about the triple MMR, and in some communities, hesitancy about the HPV vaccine were cited as reasons for low uptake. Jackson et al, (2017) describe that many families opt to pay privately for single measles, mumps and rubella vaccines and in relation to the HPV vaccine, parents were concerned that daughters receiving the vaccine would be viewed as promiscuous. The evidence however, points to an intergenerational shift in attitudes towards vaccination in GRT communities. Younger community members are becoming more confident in immunisations, and reasons for this trajectory are cited as wishing to have the best interests of their children at heart and no longer having first-hand experience of vaccine side effects (Jackson et al, 2017; Ellis et al, 2020).

There has long been a deep-rooted fear of cancer among the G&T communities, which has led to a reluctance to engage in cancer screening programmes (Parry et al, 2004). Significantly higher cancer mortality rates

amongst Irish Travellers exist, with 22% of deaths of Traveller men and women specifically caused by cancer (DoH, 2010). However intergenerational shifts in attitudes toward screening and prevention have been found more recently. Condon et al, (2021) in their cancer prevention study found whereas older generations of GRT view cancer as a taboo topic to be avoided, younger generations do not necessarily share these attitudes. Younger female community members in particular were more likely than men, and more likely than older individuals to take up screening opportunities (Condon et al, 2021). Issues such as coronary heart disease, mental illness and diabetes have also become of concern within the community. However, whilst many individuals can identify lifestyle factors such as healthy eating, wearing sunscreen and exercising, as reducing the risk of cancer, fatalistic beliefs among some remain, and serve as barriers to engaging in screening programmes (Condon et al, 2021).

8.11 Healthy behaviours

Smoking and excessive alcohol use, particularly amongst men remain a significant problem within the GRT community (Parry et al, 2004; Peters et al, 2009; Van Hout, 2010). While social exclusion, discrimination, illiteracy and poverty have shown to increase problematic drinking (Van Hout, 2010), health improvement services have failed to target and provide appropriate health improvement advice to GRT people (Welsh Government, 2015).

A proportionate approach, targeting those with the greatest need should be considered when designing and delivering health improvement interventions. Behaviour change interventions that are culturally sensitive, accessible and delivered by trusted outreach workers are found to be the most effective for improving healthy lifestyle behaviours (Lhussier et al, 2015; Van Hout, 2010).

8.12 Interventions to improve GRT health

Whilst there has been renewed research interest in GRT populations in recent years, there remains a lack of empirical evidence to determine the effectiveness of outreach programmes aimed at improving GRT health (Lhussier et al, 2015). It is well recognised that services designed to reduce inequalities are often inadequate and fail to meet the needs of the population, with staff often part-time and lacking capacity (Baker, 2005). It is apparent that policy recommendations from both Parry et al, and the All Ireland Traveller Health Study (Parry et al, 2007 and DoH, 2010) have failed to significantly influence practice in this regard. The evidence base remains weighted towards studies exploring access to, and use of services, rather than evaluating the effectiveness of outreach outcomes (Lhussier et al, 2015). This essentially perpetuates engagement dynamics whereby community members become scapegoats for the failure of outreach activities, thus reinforcing stereotypes associated with poor engagement and mistrust.

8.13 Summary

In terms of the health of the Welsh nation, the impact of an ageing population on the design and delivery of healthcare services, and the reduction of health inequalities are key public health challenges for Wales and its people. Whilst Wales has seen a reduction in the burden of cardiovascular disease, increases in preventable diseases, mental illness, and substance misuse have become national public health priorities (Welsh Government, 2018b). In a range of proposed measures to promote GRT inclusion, the Welsh Government have adopted an approach that strengthens the wider determinants of health and addresses structural factors which perpetuate discriminatory attitudes and practices. These aspirations will be accomplished by seeking to improve accommodation security, incorporating stakeholders in the assessment of health needs and service planning, strengthening educational provision, and fostering positive community relations (Welsh Government, 2018a).

It is evident that, improving health outcomes for GRT communities is both a moral imperative and a national priority. Accurate data pertaining to the size and ethnic characteristics of GRT populations in Wales is likely to be underreported as the result of stigma and prejudice. Correspondingly, the true impact of the burden of ill health is potentially underrepresented by epidemiological data, due to the lack of data to describing the patterns of disease in GRT communities. Moreover, GRT health needs assessments are similarly likely to minimise the level of need, and this requires acknowledgement by policy makers.

Despite the implementation of various policy frameworks aimed at reducing health inequalities, significant health disparities still exist within GRT populations. As cited previously, health outcomes for mothers and infants are concerning poor, and the statistical data describing the mental health crisis in Traveller men presents a deeply unsettling picture.

It is difficult to argue with the reality that difficult times lie ahead for many people. Economic inflation, the energy crisis, the effects of climate change and political instability, will undoubtedly disproportionally impact the most disadvantaged in society. GRT are likely to require significant investment from healthcare providers to mitigate these challenges. The roles of structural inequalities, and the wider health determinants, as both the cause and maintenance of poor health in GRT communities cannot be overemphasised. The literature indicates a plethora of research pertaining to access to, and use of healthcare services by GRT communities. A shift in focus however, towards evaluating the effectiveness of outreach interventions is recommended as a strategy to challenge cultural stereotypes associated with poor community engagement.

Existing literature highlights the use primarily of General Practitioner services and unscheduled healthcare, only when solutions within the community have been attempted and resources exhausted. Given the importance of the role of the General Practitioner, policies which promote inclusion, such as support with GP registration and flexibility within

appointment booking systems would support person-centred culturally appropriate care.

It is apparent that attitudes towards screening and prevention amongst younger GRT people are shifting. Evidence suggests that younger community members have a less fatalistic view of illness and a greater awareness of lifestyle factors that support health. This may indeed signal a new era of engagement opportunities within GRT communities. Seizing such opportunities with a new generation of health empowered young GRT people, may meaningfully, and positively impact the lives of GRTs in Wales.

9 Community engagement findings

9.1 Focus group and semi-structured interviews

The following section describes the key findings from the focus group and face-to-face interviews.

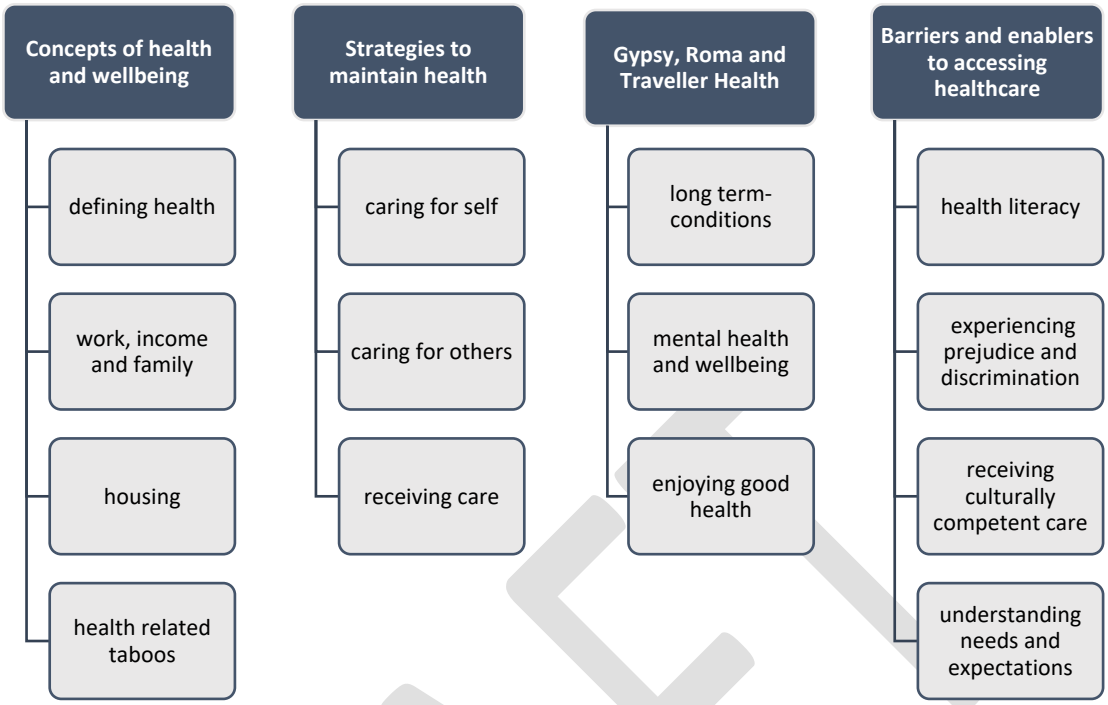
One focus group was held on a Local Authority owned G&T site in North East Wales, four females, aged between 18 and 34 participated. Twenty-three semi-structured interviews were conducted in total, fourteen with females, aged between 18-64 and nine with males (ages not disclosed), living in bricks and mortar, Local Authority and privately owned G&T sites. A full breakdown of the participants can be found in appendix b. The focus group schedule can be found in Appendix c.

Data generated was analysed using Thematic Analysis with the aim of constructing an explanatory framework established on the key themes identified in Figure 3.1 (Braun and Clarke 2019). The following master themes were identified;

- Concepts of Health and Wellbeing
- Strategies to Maintain Health
- Gypsy, Roma and Traveller Health
- Barriers and Enablers to Accessing Healthcare

Each master theme contains within it, a set of constituent themes, each describing the essence and nature of the master theme. Findings are laid out as follows, an introduction to the master theme, description of the constituent themes in turn, and presentation of the data.

Figure 2. Hierarchy of Master Themes and Corresponding Constituent Themes



9.1.1 Concepts of health and well-being

The concepts of 'health and wellbeing' have been the subject of much debate in the public health literature over recent decades. How health is defined by a given population is dependent on many factors. To name but a few, these include the values and beliefs of a given society, prevailing political ideologies, goals and desires for its communities and its economic aspirations. Congruent with this assertion, notions of health and wellbeing within the GRT communities, are heavily intertwined with GRT ways of being, and are strongly associated with the rich cultural practices of its people. This theme addresses how GRT communities define their own health and the interaction of the social determinants, employment, income, family and housing. Finally, the theme describes how health taboos determine individual and community engagement with health improving behaviours and opportunities.

9.1.1.1 Defining Health

In consensus with the World Health Definition of health from 1947, and without exception, all participants described good health as an ideal state, in which individuals are free from illness and disease, acknowledging some level of integration between physical and mental wellbeing and with all agreeing that having good health was of central importance in their daily life. This theme describes the value of good health to GRT communities.

Interviewer, "What does it mean to be healthy?"

Participant, "Oh, Jesus! Its life, isn't it? It's worth more than anything in the world."

(P0507, Female, Irish Traveller)

Participant, "I think having your health is your wealth basically. If you're healthy that's all you need, that's your wealth, that's everything."

(P0817, Female, Irish Traveller)

Participant," To feel healthier and feel mentally well."

(P0501, Female, Irish Traveller)

Participant, "I think good health is when you're not constantly picking up virals and infections…."

(FGP1, Female, Irish Traveller)

Participant, "Anything you put your mind to. If….if you have good health, it can't really stop you from doing anything."

(P0812, Male, Irish Traveller)

9.1.1.2 Work, Income and Family

Cultural expectations associated with marriage, child rearing and the care of older relatives, places 'family' at centre of GRT life. Families are typically large, with three or four children, and it is common for families to live together, or in close proximity with each other in multigenerational households. Families retain an element of nomadic life to pursue work and engage in family rites (Marsh 2017). Work and childrearing practices operate along clearly defined gender roles, with men often undertaking manual labour such as construction, recycling and tarmac laying and women taking responsibility for raising children (Marsh 2017). When describing what it means to be healthy, the majority of participants described a functional-relational association between good health and the ability to conform to normative community values, as expressed in adherence to the roles undertaken by its members. The theme below describes the relationship between health and the ability to perform normative roles.

Participant, "You can do anything, and everything can't you? If you have good health, you can do it can't you? It means I can clean, look after my children, look after my dad more than anything, you know. And just like, live a good life……..."

(P0815, Female, Roma)

Participant, "Everything. To be a good mother, daughter, wife. Having your health is the best thing in the world."

(P0505, Female, Irish Traveller)

Participant, "Being able to do daily tasks and look after your family without help."

(P0610, Female, Irish Traveller)

Participant, "To be able to do the things we need to get done, as well as doing the things you want to get done, and being able to move around freely. For us as a family, we are really busy, especially the boys, as they do the heavy lifting."

(P0609, Female, Roma)

Participant, "Means you can do a lot to be honest. Because if you're not in good health, you can't really work, and you don't want to be sitting in a chair being inactive all day. You wanna do something proper."

(P0812, Male, Irish Traveller)

The theme of gender roles featured significantly in the focus group interview. Participants described the allocation of family responsibilities and explored the health consequences when these roles could not be performed.

Participant, "When a Traveller woman marries, she's gonna take on the role. She's gonna be the mummy to everyone. She's gotta do the cooking, the cleaning, and obviously when she comes to have children, she's gotta do the babysitting, school runs. The man, he goes to work. So, he brings the income in, and to be honest, sometimes he can go working for a month, two months, three months, and he can come back without a penny. And that causes stress."

(FGP1, Female, Irish Traveller)

Women counteracting traditional roles and seeking employment face barriers in the form of discrimination as exemplified by one focus group participant.

Participant, "It's not that Traveller people don't try, it's just that they face discrimination wherever they are. Especially in factory work. You go into a factory, and you see many different cultures, and as soon as a Traveller comes in, it's a completely different atmosphere. It's like the universal credit. They say, "You have to look for work". Yeah! Looking for work, that's easy, but when it comes to getting a job, that's where the stress is. All that is a stress, looking for a job and knowing you can't get one."

(FGP1, Female, Irish Traveller)

9.1.1.3 Housing

Despite local authorities enacting their duty to house G&T families through localised needs assessments, significant challenges, in terms of meeting the demand for appropriately resourced accommodation continues to exist. Whilst trends demonstrate that nomadic travel amongst Roma communities in the United Kingdom is less common, Irish Travellers have largely

retained the nomadic existence (Van Hout & Stanievicz, 2012). The impact of land prices in peri-urban areas have pushed G&T communities to the fringes of the green belt, (Garner, 2019) and the impact of the 2022 Policing Act, can be argued to further disenfranchise G&T communities by criminalising their transient way of life. G&T communities are more likely to reside in poor housing, often on 'brown field' and industrial sites, with poor environmental conditions and in locations which make it unsafe for children to play freely (Marsh, 2017). The theme below describes the impact of housing on health and includes matters related to the quality of housing and the impact of housing insecurity.

Researcher, "During this time, (previous twelve months) who, or what has affected your health and wellbeing?"

Participant, "Well my kids, they've been getting virals, constant virals, it's the situation we are living in. I'm living where there's nothing but green mould everywhere. I've reported it two or three times now but nothing, and it's been like that for two years. We went somewhere for the weekend, and we came back, and we were vandalised……the windows were blown out in the shed. And both of these were reported to the police. And I'm still waiting two years later. I've never been able to turn my kitchen sink on because if you do, you are drowned. I can't use my kitchen cupboards, and I can't put food in there because it will spoil. And there's like small animals in there…my kids are constantly getting sick. Every week they are getting sick. It's the mould isn't it?"

(FGP2, Female, Irish Traveller)

Participant, "Yeah, he gets sick as well doesn't he (referring to her young son). I think he has chest infections and he suffers from asthma. It's the damp in the shed. That's what triggers it off. I think it's how we are living. Like the mould in the kitchen cupboard and the bathroom. And we tell the warden and then he says he's put in for the job, but we don't hear nothing back. They just don't care. The rats in the winter, they don't even put killer down."

(FGP3, Female, Irish Traveller)

Participant, "I suffer from chest, constant pain because of the mould and mildew. We can't even cook because the roof is peeling. The toilet was flooded for a month total. So, in August an assessment man is coming out to assess this. Even if you speak up you get a little bit of help but not much."

(FGP1, Female Irish Traveller)

Participant, "The children have nowhere to play. It's a right, isn't it? They have something like 51 rights and the right to play is one of them. We asked the council, and they wrote back to say they knew about it, but it wasn't on their list to do. They have a right to play! It affects them you know, not having a place to play. They don't do repairs on the site. So, my granddaughter was playing and there were these hooks left in the ground from when they did the site up. Anyway, she fell twice and hurt

her arm. My daughter took her to accident and emergency, and they asked her loads of questions about it."

(P0501, Female, Irish Traveller)

It is widely understood that people from GRT communities face overt racism, largely associated with perceived threats of disorder and disruption which result from centuries of stigma and stereotyping. The use of pejorative language, by settled populations towards those from GRT communities means that community members are faced with the daily challenges of navigating their way through a racialised landscape (Van Hout & Staniewicz, 2012). This is particularly troublesome for those living in 'bricks and mortar' dwellings, where settled and GRT communities are less well integrated, and compounded by the separation from one's community, thus reinforcing the sense of alienation and difference.

Describing her experiences, this participant who lives in temporary local authority 'bricks and mortar' accommodation, (due to a mobility problem) explains her fears, experiences and hopes.

Participant, "I moved out of the caravan…....last year, into temporary accommodation and then the council gave me a house. I haven't got a full contract on that. I'm not really bothered if I don't get a full contract on that actually!.....If anything goes wrong, they can kick us out at any point. And now I've to sign a new contract to say…....[we] aren't going to shout back at anybody…even though they are calling us, "dirty pikeys" and whatever, and telling us to, "eff off back to caravans"……..we'd love to go back into a caravan. I've still got one caravan but we just need a field to put it on because of the new law that says that you cannot now travel without.…….you know, the police, can take your vehicle and your house off you if you pull up on someone else's land. It's mental as well as physical you know, problems!

Researcher, "Would you like to be back in your caravan?"

Participant, "Oh yes, within a heartbeat, yes!"

(P0609, Female, Roma)

9.1.1.4 Health-related Taboos

Taboos are ubiquitous to most global cultures and guide human conduct by the imposition of behavioural norms, which determine the actions of its members (Colding & Folke 2001). Deviation from cultural norms is risky and can result in ostracisation from one's own community. In this way, taboos are self-perpetuating, in that adherence to them safeguards their inter-generational transmission and preservation of normative values. Included in this theme are health related taboos associated with seeking help for health concerns and talking about mental health and sexual/reproductive health, both within and outside the community.

Researcher, "When you have worries about your health and wellbeing, who do usually you turn to for help?"

Participant, "We didn't want to meet other people. We don't want to talk to settled people. We are better talking to each other. We don't go for counselling or anything like that. We don't ask for help for stuff like that. They say, oh you're a Gypsy. I had a house before, and the whole neighbourhood came out to see me when I moved in. "Ooh, what's that gypsy like?" We wouldn't go to use health services. To get a man or a woman to talk to a service, we wouldn't do that….. Like I said, we don't use services, well just the GP……we wouldn't use services, keep stuff to ourselves"

(P0507,Female, Irish Traveller)

Participant, "…..like I say, everything is dealt with in the family. If something is seriously, seriously wrong with any of us, we'd either manage…. before lockdown we'd go to the GP, or accident and emergency and got it sorted. But we won't even go to A&E unless you're bleeding and come off your horse and had a serious accident. Apart from that you just live with it, deal with it, "put some butter on it and you'll be fine, give it a kiss and you'll be fine.""

(P0609, Female, Roma)

Participant, "You see, in the Traveller community with girls, especially with girls but with boys too, it is a regular thing with suicide, and, you think to yourself, "that could've been prevented. If they got the help that they needed, that could've been stopped. Maybe if they had the medication, they wouldn't be doing that." But Travelling communities doesn't get that help. You don't get that help for suicide people thinks, "Oh, she's a Traveller, she or he can take it, you know, he's a man he's not going to suicide!" A man's got a lot of stress, you've got a big family and you're trying to provide for them, and you can't get help because you are a Traveller. THAT IS mental health! To me that's a big pressure on a man's shoulders. And even the women, a Traveller's life is not easy, they have so many bad things that can happen."

(FGP1, Female, Irish Traveller)

Participant, "It's the same, but men don't show it. Men don't even go to the doctors. Men hold their stress in, don't they?"

(FGP2, Female, Irish Traveller)

Participant, "I think it's the way men get mental health. Personally, I think men don't show it. Where a woman will probably open up to each other. If she (about FGP3) was having a bad day, she'd probably come to me or (FGP2) and say, "Oh I feel stressed out today." With a man, you don't see them open up. He might open up to his wife and say I've had a stressful day today. But that IS IT!"

(FGP1, Female, Irish Traveller)

Participant, "…..if they've really gone off their nerves, like my husband, he really does suffer with his nerves but he won't go to the doctor. I've seen him crying and he's a big man……."

(FGP2, Female, Irish Traveller)

Participant, "mental health alongside that, when a Traveller man or Traveller woman asks for help for that, the rest of the community think they cuckoo. So, in a way it's the Travelling community that doesn't help."

(FGP1, Female, Irish Traveller)

The topic of sexual and reproductive health was a significant theme within the focus group with four female, Irish Travellers. The following excerpts describe how focus group participants navigated this topic as it emerged in response to the researcher question below.

Researcher, "You mentioned that you haven't used or attempted to use any health services, can you tell me about this?"

Participant, "Women's health is so….it's not like you think it is. The woman has the church, she has the church, she has to medically get herself…..I mean it's embarrassing."

(FGP1, Female, Irish Traveller)

Participant, "We don't even….. for a woman to have a baby….."

(FGP2, Female, Irish Traveller)

Participant, "There's a lot of shame……a lot a lot of shame. Because we haven't been brought up around that environment. Like when we were in school and stuff and we had to learn things, our parents would take us straight out of school. Because they'd want to learn us them things."

(FGP1, Female, Irish Traveller)

Participant, "…..you figure it out when you're married. When a girl gets married. I tell the older ones, say like when P3 asks me, "does it hurt…you know when you have a baby? Like when you first get married an like…you're….like... is this normal?"(referring to sexual intercourse). We are not even allowed to watch a film. Like you're watching, and there's men and women and they turn it off. It's normal."

(FGP2, Female, Irish Traveller)

Researcher, "When you have your baby who is there? When you're giving birth?"

Participant, "Your Mum".

(FGP3, Female, Irish Traveller)

Participant, "I'd have my husband. That is unusual."

(FGP1,Female, Irish Traveller)

Researcher, "Why?"

Participant, "Because the other men makes a laugh of them. When I go to have my baby, I get dropped off, but he won't come up

until…probably, sometimes, not until I'm home. But he won't go to that hospital to hear the screaming."

(FGP2, Female, Irish Traveller)

9.1.2 Strategies to maintain health

Whilst many participants struggled to articulate exactly what constitutes good health, most were able to provide examples of behaviours that supported or maintained health and wellbeing. This theme describes what participants viewed as important behaviours in maintaining health. Included within this master theme is a description of important lifestyle factors, engagement in screening and immunisations, use of informal and formal healthcare networks.

9.1.2.1 Caring for Self

In considering factors that maintain health, many participants identified healthy behaviours, or the changes they adopted in an effort to remain healthy. The participant excerpts quoted below, reflect the views and experiences of participants who reported good levels of health. These participants tended to be younger, Irish Travellers who articulated a degree of autonomy in relation to health behaviours.

Researcher, "How do you keep well?"

Participant, "The gym, I go the gym daily, it's made a big impact mentally. I can literally feel the endorphins, they make you feel better, don't they? I'm eating healthier and I'm trying to give up smoking. I've got one of these (e-cigarette). It's the cardio work, I'm out of breath. I don't even try to do it now. I used to do it 4 years ago but not now."

(P0501, Female, Irish Traveller)

Participant, "Eat good and fitness. Keeps you fit…."

(P0813, Male, Irish Traveller)

Participant, "Being physically active, you know. Being active outside…..But to me being physically healthy is keeping your body in shape. I go the gym, gym…."

(P0812, Male, Irish Traveller)

Participant, "it's your diet isn't it and what you eat, and like exercise and taking vitamins, regular check-ups."

(GFP2, Female, Irish Traveller)

GRT groups continue to experience poorer health compared with the general population, with higher rates of mortality, morbidity, long-term conditions and low child immunisation levels (Cromarty 2019). Whilst

participants generally spoke ambivalently about attendance for health screening and immunisations, far more significant was the limited narrative around health promotion, prevention and protection. Difficult to articulate in terms of an absence of data, the excerpts below encapsulate participant views on this subject.

Participant, "I was a bit worried about the cervical smear test, you know. It had been delayed because of the baby. I phoned the doctor and said I was worried because I'd had the baby. I phoned for an appointment and got one the same day…because we'd moved around and……this needs sorting"

(P0505, Female, Irish Traveller)

Participant, "like smear tests we don't go get them."

(FGP2, Female, Irish Traveller)

Participant, "She's great. Comes on here and sees the kids, no problems. They've had all their injections. Well except MMR, none of them have had that done. The big one, he had a reaction after his baby jabs, and I was told not to get him done."

(P0506, Female, Irish Traveller)

9.1.2.2 Caring for Others

Participants described the importance of family and peer support as a primary mechanism for health advice. Mothers, daughters, wives, sisters and knowledgeable and experienced female community members were repeatedly cited as sources of health advice and information.

Researcher, "When you have worries about your health and wellbeing, who do usually you turn to for help?"

Participant, "My mum. Health visitor, midwife, doctor…but most of the time, they won't give you anything. They say, "it's just a virus". Tell you what I do, I take a photo and send it to my mum, and I ask her, "What should I do?" She's had seven kids, so she knows what to do."

(P0506, Female, Irish Traveller)

Participant, "Just family usually, discuss things with family. But if it's really, really bad, then get in touch with the doctor. Not that you can get an appt."

(P0609, Female, Roma)

Participant, "I've got my daughter to help. My family are pretty good. I'm one of seven, I can ring them and they help. I might ask my sister what she thinks it is and what should I do. [During Covid] I didn't go out….not at first. My daughter- in-law did the shopping. I wouldn't go out unless I had to"

(P0503, Female, Roma)

Participant, "Probably family members. Say like I'm feeling down today, be like, "Oh what's making you feel like that?" You know, talk it out. I think it's very good to talk it out. I think you're better off talking and getting it off your chest, whatever you're feeling and that….. Like if you really wanted to, you could go to the doctor."

(P0817, Female, Irish Traveller)

The focus group exemplified the nature and value of peer support, especially among younger community members.

Participant, "(about FGP3)… if her baby has a high temperature, she'll go to her (FGP2)".

(FGP1, Female, Irish Traveller)

Participant, "If there's a rash on one of them, they'll go, "have you ever seen this rash before on the baby?" Like we will all ask each other for advice".

(FGP2, Female, Irish Traveller)

Participant "I think she's the most experienced on here [referring to FGP2]. 'Cause her and her husband is really like doctors. Genuinely like doctors……"

(FGP1, Female, Irish Traveller)

9.2.1.3 Receiving Care

Notwithstanding the cultural taboos associated with asking for, and receiving help, discussed earlier in this report, in general, the family doctor was held in high regard by participants. General Practitioners (GP) were viewed as helpful, insofar as participants had exhausted their own health care solutions first. Unscheduled care was occasionally cited as a method of circumventing the GP appointment booking process, which participants often experienced as onerous and frustrating. Generally speaking, the Health Visitor was valued among female participants, particularly in relation to immunisation advice.

Researcher, "Thinking about the support you have needed to be, or stay well, what health services have you used or attempted to use?"

Participant, "The doctor, and my daughter. I wouldn't really use health services. I….I'd phone the doctor. But it's knowing who to go to for help. Sometimes you don't know".

(P0501, Female, Irish Traveller)

Participant, "Only the GP. I can ring the Out of Hours and talk to the nurse. For advice. If I needed a doctor or from the nurse….to be put in the right direction".

(P0503, Female, Romani)

Participant, "Family…doctor. You can talk about your feelings to family. Family...mmm…doctor is the only one we turn to….Yeah, the doctor was

good. He tried to find out more…..they do more than they need to, they are good they are. They give you tablets to calm you down, if you have a bad humour".

(P0507, Female, Irish Traveller)

Participant "Oh we use out of hours".

(FGP2, Female, Irish Traveller)

Participant, "Dentist, optician, doctor…. My son, he got a blood test because he was a little low in iron. So that was good. We've had the Health Visitor; she comes on site".

(P0505, Female, Irish Traveller)

Participant, "…she's the Health Visitor. Whatever we need for the children, we ring. So, the children's injections, and when you first have a baby, she'll come out and see the baby".

(FGP2, Female, Irish Traveller)

9.1.3 Gypsy, Roma and Traveller health

Health inequalities continue to adversely impact GRT health, with individuals experiencing higher levels of morbidity and mortality, and lower levels of life expectancy than the general population (Marsh, 2017; McFadden et al, 2018; Parry et al, 2007). Many research participants spoke of the long-term conditions (LTC) they experienced. Noteworthy was the relatively young age at which LTCs impacted participant daily functioning. Moreover, almost all reported additional co-morbid mental health disorders, with a number of interviewees experiencing multi-morbidity as the result of a combination of physical and mental health conditions. The master theme addresses three discrete areas; long-term conditions, mental health and enjoying good health.

9.1.3.1 Long-term Conditions

Long-term conditions are chronic conditions for which no cure exists, and the focus therefore is centred around management, whether pharmacological or otherwise. The prevalence of long-term conditions is higher in people from low socio-economic groups, moreover, socio-economically deprived communities tend to be disproportionately affected by chronic health conditions (The Kings Fund, 2022). Indeed, the prevalence of multi-morbidity (the existence of two or more long-term conditions) within socio-economically deprived groups is common (Barnett et al, 2012). This constituent theme describes the nature and experiences participants living with one or more LTCs.

Researcher, "Thinking back over the last 12 months, how would you describe your health and wellbeing?"

Participant, "I've got asthma and high blood pressure…..We don't know what causes it…Now I have my machine, I've been told I've got to be monitored by them (hospital doctors). It's my blood pressure, I don't

know why. I get very stressed and that doesn't help much. Having this machine makes me worry. I wake up in the night worrying. I've been told that if I have a stroke or a heart attack I'll die straight away. Especially down here. If I do [die] what about my mum and my wife and the kids? It's constantly on my brain".

(P0502, Male, Roma)

Participant, "Bad, worse! I was passing away two or three times. I took an asthma attack; I had a block in my heart for 15 days. The papers! You know the letters coming through the door, waiting for appointments. It's the worry and pressure. That's what gets you. Being ill is bad, but oh! The letters, waiting for them, it's the worry. Waiting to find out more".

(P0507, Female, Irish Traveller)

Participant, "I've has pancreatitis and a heart problem and sciatica and…..COPD. I have bad shoulders the whole lot….I can't hardly walk from here to that lamppost. My legs start to pain me, I've got to turn around and come back. That's why I stay in my pyjamas the whole time. I can't go anywhere. It went through a really bad point where I could barely walk because it was winter and my bones kill me in the winter you know……Stress, I mean my arthritis go that bad because, well I know we live all around my dad but we are very close, a very close family like that. My dad not being that well has absolutely caused me so much stress. I'm worried all the time, I'm thinking….I'm a constant thinker. You know I over think everything like that".

(P0815, Female, Roma)

Participant, "I've been very depressed the last little while. My health has been extremely poor, it's getting progressively worse as I get older and does limit my ability to look after my family and my children…..as my health deteriorates my choice of living in a caravan becomes more and more difficult to maintain how I wish to live. In the last 12 months it's getting to the point where either I don't have any good days, or if I overdo it on one day, I can still be having chest pain and extreme breathlessness up to a week later".

(P0610, Female, Irish Traveller)

9.1.3.2 Mental Health and Wellbeing

GRT communities experience significantly worse mental health than the general population. Issues relating to health inequalities, discrimination, culture stress and lack of trust in healthcare providers contribute to increase risk factors for mental illness and suicide (The Traveller Movement 2019). The suicide rate amongst young Traveller men aged between 15-25, is seven times higher than that of the general population. For Traveller women, the rate is five times higher than the general population (DoH, 2010). In this constituent theme, participants described their experiences of living with mental illness.

Participant, "I suffers with manic depression….. Nearly all my life. I was bad months back, but I goes the hospital, you know to the psychiatrist. I'm under the doctor there. He is there to help me, and he helps me. They boost up my tablets stronger, you know what I mean? They helps me. My medication… tablets, keep me calm".

(P0818, Female, Irish Traveller)

Participant, "I once cut myself, knew I was depressed. Its shame you know to feel like that! You know its shame. We don't talk. If I don't have tablets, I'd do something bad".

(P0507, Female, Irish Traveller)

Participant, "Over a month ago I was having a very bad depressive episode and I started taking tablets and turned suicidal".

(P0610, Female, Irish Traveller)

9.1.3.3 Enjoying Good Health

Notwithstanding the health inequalities described elsewhere in this report, there were many participants who self-reported good health. In this study, participants who described enjoying good levels of health tended to be young female Irish Travellers residing in private sites. Below is an illustration of this

Participant, "We're never really sick thank God".

(P0811, Female, Irish Traveller)

Participant, "Everything is good".

(P0505, Female, Irish Traveller)

Participant, "Nothing, it's stayed the same really".

(P0506, Female, Irish Traveller)

Participant, "Yeah my health has been alright. I have had low moods, and suffered a bit of depression…."

(P0822, Female, Irish Traveller)

9.1.4 Barriers and enablers to accessing healthcare

In this theme, participants spoke about how they accessed and interacted with healthcare services and healthcare professionals. Included within this master theme are participant perceptions of the factors that help or hinder access and engagement. It contains the constituent themes of health literacy, experiences of prejudice and discrimination, receiving culturally competent care and understanding needs and expectations.

9.1.4.1 Health Literacy

In simple terms, 'health literacy' describes a person's ability to understand information related to their health. It includes the ability to understand health information, know how to act on this information and how to make

appropriate use of services. It is important because it enables people to participate in decisions about their health (NHS England, 2021). Health information is rarely available in forms accessible to many people from GRT communities (Marsh, 2017). Almost all participants stated that they could not read and write and were reliant on others to read letters and book appointments. Issues such as GP registration, re-booking missed appointments, knowing which service to use and when, and understanding important health information were sources of stress and anxiety for community members. The excerpts below illustrate participant views and experiences.

Researcher, "Can you tell me about your experiences of using/attempting to use health services; what was that like for you?"

These participants explain what happened when they attempted to register with a new GP.

Participant, "Sometimes doctor's receptionists are unhelpful. If you can't read or write, they won't do it for me. They wouldn't let me take it away [referring to registration paperwork]….I had to fill it in, in the surgery. How are you supposed to fill it in?"

(P0503, Female, Roma)

Participant, "It can be hard to register, you know with the forms, not being able to read and write. There are so many of them to fill in. One for each of the children".

(P0609, Female, Roma)

Healthcare protocols around missed appointments can be particularly problematic for GRT communities. Issues such as needing help from others to re-book missed appointments, being removed from waiting lists and later re-referred to tertiary services via the GP, left many feeling frustrated and confused.

Participant, "Yeah, but if you miss an appointment, then well if you can't read or write, and you miss that one appointment, then you're completely out".

(FGP2, Female, Irish Traveller)

Participant, "I'm supposed to be under the cardiologist. I missed a few phone calls. Now I've got to be referred back by my doctor…..I've seen them once. I had to be monitored for a few days. But I missed a few calls and it could take ages. I'm on [redacted mobile phone network] and the reception is really bad. I should be monitored, if I have a heart attack or stroke, I'll die straight away. I worry that I'm not monitored for it. It's on my mind when I'm working".

(P0502, Male, Roma)

Participant, "They say we have to do everything on the phone now and by letters. So, we can't do the things. I can't do the things. Cause I can't read or write, none of us [can]".

(P0822, Female, Irish Traveller)

Participant, "…she [referring to FGP2] doesn't have a phone. She doesn't know how to work it".

(FGP1, Female, Irish Traveller)

Participant, "Sometimes I miss my appointments because I can't walk. I go to hospital to the 'General' but I can't walk. I misses my appointments…..I have to wait for a friend that can read that out and book for me. I've got an appointment there [letter on side] I don't know what it is for. I've had problems up there [points to vulva] they've found a black spot there. I can't ask the boys." [To the researcher] "Would you read that for me when you finish?"

(P0816, Female, Irish Traveller)

Gaining timely access to a GP was particularly challenging for participants. Many attributed delays in gaining appointments to reductions in GP capacity and the after effects of the Covid-19 pandemic. Many participants acknowledged that problems in accessing health appointments was a national, rather than exclusively GRT issue.

Participant, "It depends, when you do ring the doctors, you can't get through to them love. When you do need them, you have to stay in bed for three days for four days. Because every time I do ring that doctors, it says….no appointments. So I'm mad about that. 'Cause there's no appointments and you ring back tomorrow and say can you get the doctor to ring me back? And you can't there's no doctor on, there's only one doctor on. That's all you get off them".

(P0818, Female, Irish Traveller)

Participant, "The doctor, I haven't been for quite a while. I've been trying for the last 2-3 weeks to get an appointment, but I can't get an appointment. Every time I try to call there's no availabilities left. It's the phone lines that you've got to ring at eight [am]. And when I got through, it's like, there's no appointments left".

(P0822, Female, Irish Traveller)

Participant, "We don't get much help. If you ring the doctor, there's no appointments. And they say, "ring tomorrow, ring tomorrow". And you get fed up of ringing and you say to yourself, 'leave it, forget it'".

(P0505, Female, Irish Traveller)

9.1.4.2 Experiencing Prejudice and Discrimination

Despite GRT individuals being protected under the Equality Act (2010), prejudice and discrimination towards GRT communities is a common experience and one which is well documented in the literature. This is experienced as direct racism and from more subtle forms of discrimination such as being treated differently because of one's GRT status. Many participants described having good relationships with their healthcare

professionals and reported experiencing a good level of care, particularly from the GP and Health Visitor. In this constituent theme, participants describe how they navigate health services so as to reduce the risk of discrimination.

Participant, "Well, we've gone in and filled in paperwork. We don't usually put down that we are Travellers down on it. It's just because of the stigma. Once they know, some are ok, some aren't".

(P0609 Female, Roma)

She goes on to describe an experience of discrimination in hospital.

"When I was in [hospital]……the ladies on the ward were fine…I sort of knew one of the ladies….and we were talking, and one or two of the nurses heard the conversation and from it, it came out that we were Travellers, and you could see their face had changed completely. Apart from that, I don't tell anyone and that's because of the stigma".

(P0609 Female, Roma)

She continues to explain the impact of this.

"It's awful that you have to hide it in certain ways. I've got a Romani tattoo, so it's hard to hide that I'm a Gypsy. Unless you don't know what it [the tattoo] means. But I don't have an Irish accent and I know Irish Travellers have a different problem than we have. Because as soon as someone will hear the Irish talking, they will know straight away that they are a Traveller and they come out with different stuff. I've seen it myself , they are treated differently. I can talk posh if I want to, but I can talk back to my normal lingo when I need to. I've learned over the years to lose a bit of the twang. But we shouldn't have to lose our way of being just to fit in and get what we need".

(P0609, Female, Roma)

Participant, "You get stared at differently, you get treated different. I don't care what it is, as soon as that address pops up, you're gonna get treated a million percent, as soon as you mention what your…you gotta write down, ethnicity isn't it? Which one are you. As soon as you mention that you're a Gypsy, before God, and I don't care who it is, [talking about professionals] straight away looks different, talks different, the care is different, it's like "you got this, you got that, just go!" And that's the truth".

(P0815, Female, Irish Traveller)

Participant, "I can't get registered with a dentist. Once they know you are a Traveller, they won't register you".

(P0817, Female, Irish Traveller)

9.1.4.3 Receiving Culturally Competent Care

Cultural competence is associated with reducing health inequalities through the provision of person-centred care, which challenges cultural stereotypes

and takes the diverse backgrounds of health service users into consideration. It is important as it supports inclusion and addresses power imbalances between provider and service user (Lekas et al, 2020). As has already been stated, many participants in both the focus group, and those interviewed reported being satisfied with care delivered. Below, are excerpts of participant experiences of healthcare professionals.

This is exemplified by one participant living in an unauthorised encampment.

Participant, "She doesn't like coming here. One particular day, she had to leave early because she needed to go to the toilet. I offered for her to use my Portaloo® and she said, "there's no way I'm sitting on THAT!"....I'm aware that she doesn't feel this way of life is suitable for me or, I don't think anyone is really…..She's meant to come out and see me, she hadn't actually been out since my suicidal attempt".

(P0619, Female, Irish Traveller)

She goes on to explain that the mental health professional thinks the health issues are due to her choice to live in a caravan.

Participant, "….she has got the opinion that I'd feel better, and I wouldn't feel trapped, I wouldn't feel all these things if I had a different form of property…. I can't say to her how much I'm struggling here or I'm struggling live my daily life, 'cause she'll just say this is an inappropriate living situation….She wouldn't be as dismissive, or couldn't be bothered to come up here if I was in housing. I've had mental health treatment before, and when I was in housing, it was totally different….If I said I wasn't coping in a house, they'd help, they'd be willing to help, they wouldn't then be trying to use the excuse that the living accommodation is the issue, "If you were outside of that you wouldn't be feeling as trapped". I feel trapped because of how I feel not because of where I live. But when I lived in housing, they wanted to deal with the way I felt. I felt the same kind of way in housing, but they wouldn't then say it's my housing that the issue...You wouldn't be saying that if I lived in a house. You wouldn't have said it's you house that's causing it".

(P0619, Female, Irish Traveller)

Temporarily living in bricks and mortar accommodation, this local authority tenant describes how her caravan provides a place of solace and restoration.

"I've been a bit depressed. And it doesn't help where I live at the minute. So erm, I've got a field that I rent at the minute, so I come here most days and de-frazzle. I just need to be in the outdoor space because it is having a detrimental effect on all of us in the house because we can't even walk outside without someone saying something snide".

(P0609, Female, Roma)

Some participants described their fear and mistrust of using healthcare services, preferring instead to treat their own symptoms where possible.

This was particularly apparent for those with young children, many of whom expressed a deep fear of their children being removed from their care.

Participant, "As soon as you say what, what you are, you get prejudice…. I had a sickness, if my children were sick, I'd think to myself, 'Oh my God', if my children get bad they are going to get took off me. You know what I mean?.... And young girls now, is that frightened to take their children to the doctor. Young people, young Gypsy women, and this is before God, will try their best to get the children well at home. They'll, when they've taken the children to school, they'll make sure the children are dressed in their vest. In a second, they'll have one bad report go against them you know what I mean. You've always gotta be on top of it for the children…. Very very rare I'll call a doctor, but I will you know? But for my kids I usually do everything myself to the point where I, the children need medication and I'll call the doctor or something. I'll make sure that's the last resort, and that's how everyone…we will make sure we've done everything we could before we can take them to a doctor".

(P0815, Female, Roma)

Participant, "We are not understood anymore, and the government have made it worse with this new bill. We can't get planning permission for sites either. They want to put us on council sites, that's so they can keep an eye on us. You put us on a council site and there's all cameras around".

(P0609, Female, Roma)

Understanding Needs and Expectations

In general, participants expressed having low expectations of healthcare providers and many experienced positive interactions with healthcare professionals. Participants described their desire, when interacting with healthcare professionals, to feel included, respected, and understood.

Researcher, "Thinking about your experiences of using/attempting to use health services, what is important to you?"

Participant, "For the doctor to know what's wrong with me when I first come".

(P0501, Female, Irish Traveller)

Participant, "Not a lot. I wish he's given me something for the pain, they don't do no good. If he could help with my pain and tell me what's wrong with me".

(P0503, Female, Roma)

Participant, "To be helped. For you to be better about yourself. You phone the doctor only for them to tell you there are no appointments. You want to tell that doctor what that problem is. They're not giving you

the allocation that you need. It's all respectful but you still don't get the help that you need".

(FGP1, Female, Irish Traveller)

Participant, "I'd feel better if I had better monitoring. You can't say to someone that you're going to have a heart attack and let them walk out. And not having the doctor ask you if you're alright. Knowing I could drop dead. Better monitoring, that'd be a load off me".

(P0502, Male, Romani)

Most participants explained a need to be heard and understood by those delivering healthcare. There was a general consensus that positive health outcomes could arise when professionals demonstrate a genuine desire to build relationships and understand something of the GRT culture.

Participant, "I think because a Traveller goes through so much and faces such discrimination that to sit there and listen for a doctor to listen to your problems and to try and help you, I think it means an awful lot. I appreciate that so much and it's the simplest of things…...I think it's to know the Traveller woman more. Get to know the Traveller ways." "And how hard our life is and what we go through to ask for help. And when we ask for help what it really means for us to ask for help".

(FGP1, Female, Irish Traveller)

The following excerpts describe participants' desire for healthcare professionals to demonstrate respect through their actions.

Participant, "Be with us like you are to everybody. Treat us like you treat, don't…not only go in there and [big sigh] say, "this is just a……" you know what I mean? You have to be there to know what you go through when you got to these places, you know?"

(P0815, Female, Roma)

Participant, "Like when I go to hospitals they treat me same as everyone else. I guess the awkward ones treat you differently….the awkward ones. When you talk to people. It depends on what kind of person you are, if you're nice to that nurse or doctor, you know, they'll be nice back, they'll then help you. It's how you treat them and the way they treat you back. I think half of them, can be a bit ignorant to nurses. They are underpaid, they are tired".

(P0817, Female, Irish Traveller)

Finally, participants described the health services they believed would make a positive difference to their health.

Researcher, "What health services do you feel you need but don't have access to?"

Participant, "A walk in centre for people who are new on site and aren't registered. It's really important. With the doctors? Being accepted. Because it's hard you know, being accepted. Because there are things we don't have, like our NHS number, sometimes you gotta be living in an area before you can register. They need to make it easier to access, make it welcoming for us".

(P0505, Female, Irish Traveller)

Participant, "Just like……the dentist now. Like for someone that can't drive. 'Cause we're out in the middle of nowhere. So err… the dentist like what we used to have [a van visiting the site for on-site dental care] and just like…..like a healthcare centre where you can go and read letters because half of us can't read or write…..Like filling forms in. We used to have a worker here. He comes to help us fill forms in".

(P0817, Female, Irish Traveller)

Participant, "A nurse to come out in a big bus. And people would come to a bus. People are picking up scabies and they have dirty hair. Like they used to do, a big bus. Why don't they find out more about it?"

Researcher, "What would be on the bus?"

Participant, "Medicines and nurses could give out medicines. Check babies and children. See those old women with big legs and dry skin? They could see a nurse. They can't walk. Sometimes you want to speak to a doctor, you don't need medicines. If I was helping Gypsies and Travellers, that's what I would do".

Researcher, "Would they come?"

Participant, "Some would come, and some wouldn't".

(P0507, Female, Irish Traveller)

10 Household surveys

To enable a wider range of community members to engage with the health needs assessment, a short survey on health needs and experiences was carried out. A sample of GRT household representatives from across North Wales took part in the study. A copy of the survey can be found in Appendix e.

A loose quota sample was devised based on location, residential setting, age group and gender. Twenty-three people completed the survey on behalf of 86 people living in a range of properties. The location, property type and demographic breakdown of survey respondents can be found in table four and five below.

Table 4. Survey participants by Local Authority and dwelling type

Local Authority	No. interviews	Respondent setting
Gwynedd/Anglesey	6	1 bricks and mortar; 1 unauthorised pitch; 4 council pitches
Conwy	1	1 private pitch
Flintshire	10	5 council pitches; 5 private pitches
Wrexham	6	3 council pitches; 1 bricks and mortar; 2 private pitches
Total	**23**	

Table 5. Survey participants by age and gender

Age Group	Male	Female	Total
Under 30	5	2	7
30 to 64	2	12	14
65 and over	2	0	2
Total	**9**	**14**	**23**

Given the small target sample of households and to maintain confidentiality, data analysis is based on the results of all households.

10.1 General health

The vast majority of people self-report they and the people living in their household had very good or good health (70.8%).

Table 6. General health of survey participants.

General health	%
Very good	67.4%
Good	3.4%
Fair	11.2%
Bad	7.9%
Very bad	10.1%
Total	100.0%
Base (number)	86

10.2 Health issues

Respondents were asked if they or anyone in their household had particular health issues which have lasted or expected to last for 12 months (Table 7). The three most mentioned were hay fever, (10.1%) asthma (10.1%) and long-term illness, disease or condition (7.9%).

10.3 Preventative health

Respondents were asked if they or anyone in their household had received screening (if relevant) and immunisation (if relevant). Table 8 and 9 sets out uptake of screening and immunisations against the estimated relevant population. Uptake of childhood vaccinations was generally high, along with flu vaccinations and pneumococcal vaccine. Uptake of Covid-19 was at 52.6%. Uptake of cervical and breast cancer screening was below 50%.

Table 8. Cancer screening uptake

Screening (if relevant)	Total	Estimated relevant population	% of relevant population	Est. relevant population assumptions
Cervical cancer	6	14	42.9%	F 25-64
Bowel cancer	1	2	50.0%	All 60-74
Breast cancer	2	5	40.0%	F 50-71

Table 9. Immunisation uptake

Immunisation (if relevant)	Total	Estimated relevant population	% of relevant population	Est. relevant population assumptions
Baby vaccinations in first year (such as 6 in 1 vaccine and MMR)	37	41	90.2%	All under 18
Pre-school booster vaccinations	17	41	41.5%	All under 18
HPV vaccine (12-13 years)	5	15	33.3%	All 12 to under 18
Teenage booster (14 years) (3 in 1; Meningitis)	18	29	62.1%	All 14 to 29
Flu vaccine (50+ age group)	5	9	55.5%	All 50+
Shingles vaccine (70+ age group)	1	3	33.3%	All 70+
Pneumococcal vaccine (pneumonia)	6	9	66.7%	All 50+
Covid-19	30	57	52.6%	All 12 +

10.4 Day to day limitations

Respondents were asked if they or anyone in their household had day to day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months. The majority (53.3%) had no limitations but 25% were limited a lot which was mainly due to underlying health conditions and not necessarily linked to age.

Table 10. Day to day limitations

Day to day limitations	% of people in households
Yes, limited a lot	12.8%
Yes, limited a little	17.4%
No	69.8%
Total	100.0%
Base (number)	86

10.5 Registration with GP and Dentist

Most respondent households (91.3%) were registered with a GP and 50% were registered with a dentist.

Table 11. Registration with a GP and Dentist

	% of respondent households registered with a GP	% of respondent households registered with a Dentist
Yes	91.3%	50%
No	8.7%	50%
Total	100.0%	100%
Base (number)	22	22

For those not registered with a GP, the main reasons were travelling and not having a permanent address, but some had tried and not been able to get registered. For those not registered with a dentist, all respondents said they had tried but been unable to get registered.

10.6 Use of health services

Respondents were asked if they or anyone in their household had used any health services in the past 12 months, or have needed them but not been able to access them. Table 12 sets out the top three services accessed in the past 12 months based on the 86 people living in the 22 households surveyed. This analysis shows that the most frequently mentioned services used were visiting doctors including home visits, visiting pharmacies and getting basic medicines from supermarkets. The data would indicate that services needed can be accessed by GRT communities.

Table 12. Use of health services

Type of support	Number	% of people
Doctors visit (home and elsewhere|)	31	36%
Visited chemist/pharmacy to get prescriptions	30	34.9%
Getting basic medicines from supermarkets	24	27.9%

10.7 Satisfaction with health services and support offered

The household survey asked about the satisfaction with health services and support received by households. Table 13 shows that most were very satisfied or satisfied with services. A net satisfaction score is also calculated which shows 100% scores across many services. Lowest net satisfaction was with doctors' visits, visiting Accident and Emergency and physiotherapy.

Table 13. Satisfaction with health services used

Type of support	Very Satisfied %	Satisfied %	Neither satisfied nor dissatisfied %	Dissatisfied %	Very Dissatisfied %	Total %	Net satisfaction %	Total No. households receiving service
Pregnancy support - at home	100.0	0.0	0.0	0.0	0.0	100.0	100.0	2
Pregnancy support – elsewhere	0.0	100.0	0.0	0.0	0.0	100.0	100.0	1
Post-natal support - at home	66.7	33.3	0.0	0.0	0.0	100.0	100.0	3
Post-natal support – elsewhere	0.0	100.0	0.0	0.0	0.0	100.0	100.0	1
Doctors visit - at home	25.0	25.0	0.0	12.5	37.5	100.0	0.0	8
Doctors visit – elsewhere	50.0	25.0	0.0	25.0	0.0	100.0	50.0	4
Medical treatment at home	100.0	0.0	0.0	0.0	0.0	100.0	100.0	3
Occupational Therapy - at home	100.0	0.0	0.0	0.0	0.0	100.0	100.0	1
Counselling - at home	0.0	100.0	0.0	0.0	0.0	100.0	100.0	2
Counselling – elsewhere	100.0	0.0	0.0	0.0	0.0	100.0	100.0	1
Visited your dentist	80.0	0.0	0.0	0.0	20.0	100.0	60.0	5
Accident and Emergency (A&E) at a hospital	60.0	20.0	0.0	0.0	20.0	100.0	60.0	5
Visited chemist/pharmacy to get prescriptions	77.7	11.1	11.1	0.0	0.0	100.0	88.8	9
Have medicines/prescriptions delivered to your home	66.7	33.3	0.0	0.0	0.0	100.0	100.0	3
Getting basic medicines from supermarkets	100.0	0.0	0.0	0.0	0.0	100.0	100.0	6
Physiotherapy - elsewhere	50.0	0.0	0.0	50.0	0.0	100.0	0.0	2
Opticians - elsewhere	88.9	11.1	0.0	0.0	0.0	100.0	100.0	10

Net Satisfaction = Very Satisfied + Satisfied – Dissatisfied – Very Dissatisfied

10.8 Preferred method of contact

Respondents were asked, what are the most helpful ways of making contact regarding health-related matters. Table 14 shows that telephone calls are the best way of contact followed by letter and face to face visits.

Table 14. Preferred method of contact

Contact option	All ways %	Best way %
Face to face visit	39.1%	13.0%
Telephone call	87.0%	60.9%
Text	43.5%	0.0%
Email	26.1%	4.3%
Letter	43.5%	17.4%
Base (number)	23	23

Note:

All Ways: Respondents could tick more than one option to describe their preferred ways to be contacted (so for instance someone could tick telephone call, text, email)

Best Way: The single best way of contact from the list of contact options

10.9 How to improve access to healthcare

Respondents were encouraged to think about the three most important things that would give them better access to healthcare. Of those responding to this question (14) 35.7% said access was OK and no further assistance was required. Around 42.9% said help with accessing GP services was needed and some respondents felt that service providers needed to be sensitive to Traveller needs.

Table 15. Improving access to healthcare

Response	Number	% of households responding
All fine/good/nothing	5	35.7
Access to GP	6	42.9
Accessing services	2	14.3
Better understanding of my illness	2	14.3
Being accepted and being sensitive to Traveller needs	1	7.1
Better accommodation to meet my needs	1	7.1
Total responses	17	-
Total households responding	14	-

10.10 Knowledge of PALS

Respondents were asked if they were aware of the Patient Advice and Liaison Service. This is a department within BCUHB who can provide patients with information, advice and support to resolve any issues or concerns that arise from using BCUHB services. Most respondents had not heard about this service.

Table 16. Awareness of PALS

Awareness of PALS	%
Yes	10.0
No	90.0
Total	100.0
Base	20

10.11 Adaptations required

Only a small number of households said they required adaptations. These included space for oxygen and internal handrails.

10.12 Access to transport

Respondents were asked what types of transport they had access to. The majority of respondents had access to cars (73.9%) and other modes of transport were also used.

Table 17. Access to transport

Type of transport	%
Car/Van	73.9%
Public transport	39.1%
Taxi	56.5%
Motorbike	4.3%
Base (number)	23

10.13 Health and Wellbeing

A majority of respondents did not smoke or drink alcohol and had access to healthy food. For the small number that said they did not, cost was raised as an issue.

Table 18.

	Smoking%	Vapes %	Alcohol consumption	Access to Healthy Food
No	69%	94%	75%	12.5%
Yes	31%	6%	25%	87.5%
Total	100.0%	1	100.0%	100.00
Base (number)	16	16	16	16

10.14 Summary

This section has considered responses to a household survey which aimed to obtain views on access to healthcare and whether there were barriers to accessing services. Encouragingly, the majority of households reported being able to access the services needed, but some key findings were:

- GP registration was high, with most households registered with a GP. For those not registered, this was often because they did not have a permanent address.
- Uptake of cancer screening was low.
- Registration with dentists is challenging.
- Telephone was the best way of contacting community members.
- Only a small number of community members had heard of PALS.

11 Stakeholder discussions

Alongside the interviews and surveys conducted with the GRT community a number of meetings were held with key stakeholders who work with the GRT community in North Wales including:

- Education Lead for Gypsies and Travellers Wrexham County Borough Council (WCBC)
- Gypsy and Traveller Support Officer WCBC
- Education Lead for Gypsies and Travellers Flintshire County Council (FCC)
- Resettlement Coordinator FCC

The key theme from these discussions was the challenge of sharing information across organisations as outlined in the examples below.

GRT children who are resident in the Local Authority and eligible to start school. The Education partners identified a number of challenges with some GRT communities either sending children to school too early as a way of accessing free child care or too late. By understanding the annual eligible population it was felt that members of the GRT communities could be better supported to access both free child care and school spaces at the most appropriate time.

GRT children who are eligible for routine vaccinations and have not taken up the offer. Local data has indicated that is some GRT communities in North Wales uptake of routine vaccinations is low, but there are often a range of reasons for this. It was felt that working collaboratively across health and the local authority there could be the opportunity to facilitate catch-up clinics but the refusal of health colleagues to identify the eligible families meant this had not been possible to implement.

GRT patients who are trying to access healthcare. Services were also reported to be unwilling to allow appointment letters to be copied to other professional working with GRT families despite the families consenting to this arrangement. This often resulted in appointment letters going unread due to literacy levels and non-attendance at appointments. It was reported that families were often removed from waiting lists due to non-engagement and required to re-start referral processes that could have been avoided if support services were integrated into the health service process.

12 Conclusion

The findings demonstrate that health, as defined by participants in this Health Needs Assessment, is an aspirational state of being, and of central importance to GRT community life. Perhaps unsurprisingly, the value placed on health and wellbeing is ubiquitous to most communities, not least because experiencing good health enables individuals to participate in society and benefit from its opportunities. What seems particularly significant however, is the function of health and wellbeing as it relates to GRT community life and culture. Consistent with Marsh (2017), it is apparent that the ability to perform normative roles, such as fulfilling caring responsibilities, maintaining employment, travelling, and engaging in community rites and practices, is dependant, to an extent on individuals' state of health.

There is a tendency within GRT communities to be self-sufficient and a reliance on other GRT community members. Often the communities are reliant on 'expert mother' roles with health and information and advice offered to younger females via peer networks. This reluctance to seek help from outside of the community often leads to seeking help only when something has become serious and unmanageable. This was particularly evident when participants were discussing the care of their young children. Participants described a tendency to avoid, or delay seeking medical attention when children were unwell. Largely associated with the fear of coming to the attention of 'the authorities,' and fears of children being removed from their care, some participants expressed a preference to exhaust all treatment options independently, before turning to doctors and nurses. This pattern of health-related behaviour is likely to be interpreted negatively by health professionals and could potentially result in the very scenario participants are seeking to avoid, thus perpetuating fears associated with accessing healthcare for children.

Challenges such as literacy levels, movement between areas and stigma and discrimination often act as barriers to those who do want to engage with healthcare services. The lack of health professionals understanding of GRT culture is often a contributing factor to this. When receiving health services there was a lack of understanding from health professionals about the cultural significance of living in a caravan and this was often blamed as the cause of health problems. Future expectations and predictions of discrimination arose from past experience of prejudice and discrimination and may account, to some extent, for the level of mistrust in institutions

delivering health and social care. The communication methods and punitive nature of appointment processes also meant that those with long term conditions often struggled to remain engaged with healthcare services. Although it should be recognised that GPs, Community Nurses and Health Visitors were all viewed positively by the community members spoken to.

Research data demonstrates a dichotomy between the need for GRT communities to receive timely, culturally appropriate, effective, person-centred care, and the desire to maintain a level of self-sufficiency. This tension exists, in part because of centuries of discrimination which have contributed to feelings of mistrust and resulted in social exclusion (Marsh 2017). Navigating this landscape is risky because upholding the GRT community desire for self-sufficiency, risks key health needs being overlooked, and health inequalities aggravated. What seems apparent from this research is that seeking help from healthcare professionals takes courage for GRT communities, who must overcome a variety of visible and invisible barriers. Findings suggest that individuals have often exhausted their own resources, navigated complex healthcare systems and prepared themselves to encounter discrimination, before actually attending with their health professional. Having an awareness of the inherent risks in reaching out for help, and understanding the meaning of this within GRT culture could go some way to breaking down existing barriers. At the heart of it, participants wished for culturally competent care, which not only considers, but seeks to celebrate the GRT culture and heritage. When individuals are included, respected and understood, they feel safe to explore their health concerns, and moreover, those health concerns which are more difficult to discuss (McCormack & McCance 2017).

This is best exemplified by the following focus group participant.

> "I think because a Traveller goes through so much and faces such discrimination that to sit there and listen for a doctor to listen to your problems and to try and help you, I think it means an awful lot. I appreciate that so much and it's the simplest of things…...I think it's to know the Traveller woman more. Get to know the Traveller ways." "And how hard our life is and what we go through to ask for help. And when we ask for help what it really means for us to ask for help."
>
> (FGP1, Female, Irish Traveller)

Finally this HNA has also identified the importance of the environment in which GRT live as being a key determinant of their health rather than the health services they receive. In our role improving the health and wellbeing of GRT people it is crucial that we recognise how factors such as housing, income, education, employment and the environment we live in all influence the health choices we make. It is essential that partners from across the wider system also recognise the role they play in determining the health and wellbeing of GRT communities.

13 Recommendations:

13.1 Internal to BCUHB

a) To minimise health inequalities, healthcare services should ensure the ethnicity of all patients is robustly recorded to monitor the uptake and engagement of different ethnic groups with preventative and treatment services.

b) All NHS staff working with patients should complete Gypsy, Roma and Traveller awareness training.

c) To improve knowledge and understanding of the communities' cultural values and beliefs, all NHS staff working with patients should complete cultural competence training

d) To ensure the needs and experiences of the GRT community are considered in the planning and design of local and regional healthcare services, BCUHB should consider how GRT people are represented at internal stakeholder equality network groups.

e) Healthcare services should be designed and delivered in an equitable manner, making reasonable adjustments were relevant, including the following for this population:
   - Assessing and recording any additional needs relating to the individual
   - Method of communication
   - Complexity of communication

f) Prevention of ill-health needs to remain a priority for this group and the providers of these services should seek to actively engage with the GRT community through assertive outreach. Prioritised services include mental health, screening and immunisations and drug and alcohol services.

g) Prevention services should seek to engage with the GRT population to improve understanding of the barriers to accessing services, and should work in collaboration with the community to co-design solutions to reduce inequalities in health and improve health and wellbeing across the life-course.

h) To improve the quality and access to local accommodation, BCUHB should explore how it can influence local authority planning decisions regarding the identification and development of future local authority owned Traveller sites.

i) Primary care and secondary care services should review internal processes and communication approaches for registering and communicating with GRT patients, to ensure health literacy barriers are identified and broken down. This should include how support services are integrated into a patient's care where consent has been given.

j) The opportunity to support and develop the influential network of family and friend peers to deliver evidence-based information and advice on health and wellbeing, when to access healthcare and how to access healthcare should be considered.

13.2 External Partners

k) A regional, multi-agency group, involving public and third sector stakeholders working with the GRT community should be established to ensure a coordinated whole system approach to improving the health and wellbeing of the GRT community in North Wales is taken.

l) Greater consideration should be given to the design and ongoing maintenance of local authority traveller sites to ensure the environment enables the community living on the site to live a healthy life.

m) Stakeholders should work in an integrated way to engage with the community to avoid duplication and engagement fatigue, ensuring the engagement is meaningful and offers clear outcomes.

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Appendix A

A Methodical Literature Searching Strategy

Research question

What are the health needs of Gypsy, Roma and Travellers in North Wales?

Database search strategy

Table 1:

Concept Set 1	Concept Set 2	Concept Set 3
"health needs"	"Gypsy, Roma and Traveller"	"North Wales"
Health and wellbeing needs	Traveller*	Wales
Health needs assessment	Travell* Communit*	Welsh
Health and wellbeing	Gyps*, Roma*, Travell*	United Kingdom
Public health needs	Transient	
	Nomad*	

Databases selected

Database Name	Coverage, date range and size
CINHAL	Include Academic Search Complete, Medline, Soc Index From 2012- Present

Inclusion/exclusion criteria

Include	Exclude
Irish Traveller	Showman
Traveller	New Age Traveller
Gypsy	New Traveller
Roma	Travel Health
Romany	
Full text available	

Database search results
(Add more rows as required)

Search no.	Search Term	Results in CINHAL
S1	"Health Needs"	23, 616
S2	"Health and Wellbeing Needs"	83
S3	"Health Needs Assessment"	746
S4	"Health and Wellbeing"	15, 962
S5	"Public Health Needs"	655
S6	S1, S2, S3, S4, S5, OR	655
S7	"gypsy, Roma, Travell*"	8
S8	Traveller (not travel health)	4716
S9	"travell* communit*"	237
S10	"Gyps*, Roma*, Travell*"	13
S11	Transient (not TIA)	260,253
S12	Nomad*	14,151
S13	S7, S8, S9. S10, S11, S12, OR	14,151
S14	"North Wales"	3, 713
S15	Wales	25,7654
S16	Welsh	27, 692
S17	United Kingdom	1,067,999
S18	S14, S15, S16, S17, S18	1, 067,999
S19	"Irish Traveller"	287
S20	S19, S6, S13, S18 AND	515
	Limit to 2012 -present and full text	107

Results following expanded searches, screening, and deduplication

Database results after screening and deduplication	67
Results from 'citation searching', 'hand searching' and 'grey literature'	4
Total results	71

Appendix B

Household samples achieved

Methodology

Focus Groups

Location	Date	Number of female attendees	Number of adult attendees	Age range (if available)
Local Authority site Ruthin Road Wrexham	29/06/22	4	3 1	18-24 25-34

Interviews

A loose quota sample was based on location, gender and age group

Location	Date	Number of female interviews	Number of male interviews	Age range (if available)
Private site Conwy	16/08/22	1	0	Redacted
Local Authority site Flintshire	11/08/22	2	3	M under 30 F 30 to 64
Private sites Flintshire	24 to 25/05 22; 11/08/22	4	1	F under 30 F 30 to 64 M redacted
Local Authority site Gwynedd	23/05/22	2	2	F 30 to 64 M redacted
Unauthorised site Gwynedd	23/06/22	1	0	Redacted
Bricks and Mortar Anglesey	23/06/22	1	0	Redacted
Bricks and Mortar Wrexham	12/08/22	0	1	Redacted
Private sites Wrexham	12/08/22	2	1	F 30 to 64 M redacted
Local Authority site Wrexham	12/08/22	1	1	F redacted M redacted

Health Survey

Location	Date	Number of female interviews	Number of male interviews	Age range (if available)
Private Site Conwy				
Riverside Queensferry, Flintshire				

Private sites, Flintshire				
Local Authority site , Bangor, Gwynedd				
Unauthorised site, Gwynedd				
Bricks and Mortar Anglesey				
Bricks and Mortar resident Wrexham				
Private Sites, Wrexham				
Local Authority Site, Wrexham				

Appendix C

Focus Group schedule

Focus Group Schedule

Guidance notes for interviewer here:

1. What does the term 'being healthy'/'having good health' mean to you?

2. Thinking back over the last 12 months, how would you describe your health and wellbeing?
   Prompt: How healthy do you feel? What changes to your health? What (if any) concerns have you had about your health and wellbeing?

3. During this time, who, or what has affected your health and wellbeing?
   Prompt: Think about any significant life events experienced, matters within your community/relationships, day to day things and the people who may have affected your health.

4. When you have worries about your health and wellbeing, who do usually you turn to for help?
   Prompt: Think about the people/agencies/services that support you.

5. Thinking about the support you have needed to be/stay well, what health services have you used or attempted to use?
   Prompt: Think as widely as possible about these

6. What did you need and expect from these services you described?
   Prompt: Why did you use the service and what were you hoping they would do?

7. To what extent do you feel included in making decisions about your own health?
   Prompt: Please tell me more about this

8. Can you tell me about your experiences of using/attempting to use health services; what was that like for you?
   Prompt: How did you access the service? How were you treated? What was helpful/unhelpful about the experience?

9. You mentioned that you haven't used or attempted to use any health services, can you tell me about this?
   Prompt: What were the reasons for not using/attempting to use the service?

10. What health services do you feel you need but don't have access to?
    Prompt: If you could run the NHS, what services would you introduce that aren't presently available to you?

11. Thinking about life in your community, what should people delivering healthcare know and understand about you?
12. Of all the things we have talked about today, what is the most important to you?

Appendix D

Semi-structured interview schedule

Interview Schedule

Guidance notes for interviewer here:

1. What does the term 'being healthy'/'having good health' mean to you?

2. Thinking back over the last 12 months, how would you describe your health and wellbeing?
   Prompt: How healthy do you feel? What changes to your health? What (if any) concerns have you had about your health and wellbeing?

3. During this time, who, or what has affected your health and wellbeing?
   Prompt: Think about any significant life events experienced, matters within your community/relationships, day to day things and the people who may have affected your health.

4. When you have worries about your health and wellbeing, who do usually you turn to for help?
   Prompt: Think about the people/agencies/services that support you.

5. Thinking about the support you have needed to be/stay well, what health services have you used or attempted to use?
   Prompt: Think as widely as possible about these

6. What did you need and expect from these services you described?
   Prompt: Why did you use the service and what were you hoping they would do?

7. To what extent do you feel included in making decisions about your own health?
   Prompt: Please tell me more about this

8. Can you tell me about your experiences of using/attempting to use health services; what was that like for you?
   Prompt: How did you access the service? How were you treated? What was helpful/unhelpful about the experience?

9. You mentioned that you haven't used or attempted to use any health services, can you tell me about this?
   Prompt: What were the reasons for not using/attempting to use the service?

10. What health services do you feel you need but don't have access to?
    Prompt: If you could run the NHS, what services would you introduce that aren't presently available to you?

11. Thinking about your experiences of using/attempting to use health services, what is important to you?

12. Is there anything else you'd like to say?

Appendix E

Household Survey

North Wales Gypsy and Traveller NHS Health needs assessment

1 Local Authority Area

Interviewer instruction: Please state area in box below

2 Site/B&M

Question: Can I confirm is this (pitch) a council, private or unauthorised site; or
Can I confirm this (bricks and mortar) property is social rented, private rented or owner occupy

Interviewer instruction: Tick appropriate response

Interviewer instruction:	
Local Authority ("Council") residential site	
Council transit site	
Private site with planning permission	
Private site currently without planning permission	
Unauthorised encampment	
Bricks and Mortar – Socially Rented	
Bricks and Mortar – Privately Rented	
Bricks and Mortar – Owner Occupied	

3 You and your household

Question: The following question asks information about you and your household.
Can you then describe the people who live with you in your household?

	Respondent	Person 2	Person 3	Person 4	Person 5	Person 6	Person 7	Person 8
Relationship to you								
Age								
Gender								
Ethnicity								
Registered disabled (Y/N)								

4 General health

Question: For each person in your household, please describe their general health from very good to very bad

Interviewer instruction: Please tick relevant response for each person

	Respondent	Person 2	Person 3	Person 4	Person 5	Person 6	Person 7	Person 8
Very Good								
Good								
Fair								
Bad								

Very bad								

5 Health needs

Question: Do you or anyone in your household have any of the following, which have lasted or expected to last at least 12 months

	Respondent	Person 2	Person 3	Person 4	Person 5	Person 6	Person 7	Person 8
Deafness or partial hearing loss								
Blindness or partial sight loss including Glaucoma								
Learning disability								
Learning difficulty								
Physical disability								
Bad nerves / anxiety (mental health issues)								
Dementia								
Alzheimer's								
Long-term illness, disease or condition								
Heart disease								
Stroke								

COPD (Chronic Obstructive Pulmonary Disease)								
Cancer								
Diabetes								
Asthma								
High blood pressure								
Epilepsy								
High Cholesterol								
Depression								
Eczema								
Hay Fever								
Continence issues								
Other (please say what)								

Further detail on conditions

Learning disability	A condition that you have had since childhood that affects the way you learn, understand information and communicate
Learning difficulty	A specific learning condition that affects the way you learn and process information
Physical disability	A condition that substantially limits one or more basic physical activities such as walking, climbing stairs, lifting or carrying

Mental health condition - best to refer to this as 'bad nerves'	A condition that affects your emotional, physical and mental wellbeing
Long-term illness, disease or condition	A condition, not listed above, that you may have for life, which may be managed with treatment or medication

6 Health prevention

Question: Can you please tell me about

Interviewer instruction: Interviewer instruction:

	Respondent	Person 2	Person 3	Person 4	Person 5	Person 6	Person 7	Person 8
Screening (if relevant)								
• Cervical cancer								
• Bowel cancer								
• Breast cancer								
Immunisation (if relevant)								
• Baby vaccinations in first year (such as 6 in 1 vaccine and MMR)								
• Pre-school booster vaccinations								
• HPV vaccine (12-13 years)								

• Teenage booster (14 years) (3 in 1; Meningitis)								
• Flu vaccine (65+ age group)								
• Shingles vaccine (70+ age group)								
• Pneumococcal vaccine (pneumonia)								
• Covid-19								

If you've not had any screening/vaccinations, can you tell us why?

7 Day to day limitations

Question: Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months.

This includes problems related to old age

Interviewer instruction: This includes problems related to old age

	Respondent	Person 2	Person 3	Person 4	Person 5	Person 6	Person 7	Person 8
Yes, limited a lot								
Yes, limited a little								

No								

8 Registration with doctor's surgery

Question: Are you and members of your household registered with a doctor and/or dentist?

Interviewer instruction: Please tick relevant response for each person

	Respondent	Person 2	Person 3	Person 4	Person 5	Person 6	Person 7	Person 8
Doctor (Y/N)								
Dentist (Y/N)								

9 If not registered with a Doctor/GP

Question: If you or someone in your household is not registered with a doctor's surgery, can you please say why you are not registered

Interviewer instruction: Please tick relevant response for each person

	Respondent	Person 2	Person 3	Person 4	Person 5	Person 6	Person 7	Person 8
1. Not had time								
2. Travelling and don't have a permanent address								
3. Have tried but have not been able to get registered								
4. Other (please say why)								

If you have not been able to get registered, can you please say why?

10 If not registered with a dentist

Question: If you or someone in your household is not registered with a dentist, can you please say why you are not registered

Interviewer instruction: Please tick relevant response for each person

	Respondent	Person 2	Person 3	Person 4	Person 5	Person 6	Person 7	Person 8
1. Not had time								
2. Travelling and don't have a permanent address								
3. Have tried but have not been able to get registered								
4. Other (please say why)								
1. Not had time								

If you have not been able to get registered, can you please say why?

11.

Question: Have you or anyone in your household used any of these health services in the past 12 months; or have you needed them but not been able to access them

Interviewer instruction: Please tick relevant response for each person

	Respondent	**Person 2**	**Person 3**	**Person 4**	**Person 5**	**Person 6**	**Person 7**	**Person 8**
Pregnancy support - at home								
Pregnancy support - elsewhere								
Post-natal support - at home								
Post-natal support - elsewhere								
Family planning support - at home								
Family planning support - elsewhere								
Doctors visit - at home								
Doctors visit - elsewhere								
Medical treatment at home								

Medical treatment- elsewhere								
Occupational Therapy - at home								
Occupational Therapy - elsewhere								
Counselling - at home								
Counselling - elsewhere								
Visited your dentist								
Accident and Emergency (A&E) at a hospital								
Visited chemist/pharmacy to get prescriptions								
Have medicines/prescriptions delivered to your home								
Getting basic medicines from supermarkets								
Dietician - elsewhere								
Speech therapy -at home								
Speech therapy -elsewhere								

Physiotherapy - elsewhere								
Chiropody/Podiatry - at home								
Chiropody/Podiatry - elsewhere								
Orthotist (fitting splints, prosthetic limbs, braces)								
Opticians - at home								
Opticians - elsewhere								

12 Satisfaction with help/support received

Question: How satisfied or dissatisfied were you with the help/support you received?

Interviewer instruction: Please prompt for answers for each aspect of support/help received

	Very Satisfied	Satisfied	Neither satisfied or dissatisfied	Dissatisfied	Very dissatisfied	**Any particular things you'd like to mention?**
Pregnancy support - at home						
Pregnancy support - elsewhere						
Post-natal support - at home						

Post-natal support - elsewhere						
Family planning support - at home						
Family planning support - elsewhere						
Doctors visit - at home						
Doctors visit - elsewhere						
Medical treatment at home						
Medical treatment- elsewhere						
Occupational Therapy - at home						
Occupational Therapy - elsewhere						
Counselling - at home						
Counselling - elsewhere						
Visited your dentist						

Accident and Emergency (A&E) at a hospital						
Visited chemist/pharmacy to get prescriptions						
Have medicines/prescriptions delivered to your home						
Getting basic medicines from supermarkets						
Dietician - elsewhere						
Speech therapy -at home						
Speech therapy - elsewhere						
Physiotherapy - elsewhere						
Chiropody/Podiatry - at home						
Chiropody/Podiatry - elsewhere						

Orthotist (fitting splints, prosthetic limbs, braces)						
Opticians - at home						
Opticians - elsewhere						

13 Question: I would like to ask you what are the most helpful ways of contacting you and your household about health-related matters. From this list, what would you find helpful and what is the best way of contacting you and your household?

Interviewer instruction: Please tick as appropriate

	Always	Best way
Face to face visit		
Telephone call		
Text		
Email		
Letter		

14 Patient Advice and Liaison Service

Question: Do you know about PALS - Patient Advice and Liaison Service

Interviewer instruction: Tick as appropriate

Yes	
No	

15 Adaptations and equipment

Question: Do you or someone in your household need any of the following equipment or adaptations in your home?

Interviewer instruction: Tick as appropriate

	Caravan	Shed/Utility block	Bricks and Mortar
Better heating			
More insulation			
Adaptations to kitchen (e.g. accessible/drop-down units)			
Adaptations to bathroom (e.g. level-access shower/wet room)			
Adaptations relating to sensory needs (e.g. to radiators, floors, sockets			
Internal hand/grab rails			
External hand/grab rails			
Lever door handles			
Wheelchair adaptations (including door widening and ramps)			
Other adaptations (please say what is needed)			

16 Access to transport

Question: Which of the following do you or our household have access to enable travel away from home

Interviewer instruction: Tick as appropriate

Car/Van	
Public transport	
Taxi	
Motorbike	
Other (please say what)	

17 Finally, can you think of the three most important things that would give you better access to health care?

Interviewer instruction: Prompt for responses

	1
	2
	3

Teitl adroddiad: ***Report title:***	BCU Diabetes Transformation Programme			
Adrodd i: ***Report to:***	PPHP Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	10th December 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide the PPHP Committee with assurance through an evaluation of the programme's progression and governance processes. This assurance aims to demonstrate accountability and ensure that the programme's intended outcomes are achieved through genuine multi-professional and multi-agency collaboration, while also incorporating broader public and service user co-production.			
Argymhellion: ***Recommendations:***	The Committee is asked to receive this summary update.			
Arweinydd Gweithredol: ***Executive Lead:***	Jane Moore, Acting Executive Director, Public Health			
Awdur yr Adroddiad: ***Report Author:***	Robert Atenstaedt, Consultant in Public Health Sarah Lawrence, Transformation Pathway Facilitator			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Improving quality, outcomes and experience			
Goblygiadau rheoleiddio a lleol:	N/A			

Regulatory and legal implications:	
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	The EQIA process has commenced, with input from expert within the Equalities team.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	An SEIA will be undertaken as core component of the EQIA
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	A summary of the risks and issues associated with the delivery of this objective is included within the report.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	We will be in a better position to assess the financial implications once the revised model of care is finalised and agreed upon
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	We are collaborating closely with clinicians, management teams, and data analytics colleagues to assess the workforce implications of the revised model of care. These implications will become clear once the new model is finalised and agreed upon.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF SP1 / CRR24-09 (inc CR 22-21, 22-20, 23-34)
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** Continue to work collaboratively with multi-professional, multi-agency staff and service user stakeholders, to develop an agreed model of care which can support the future case for change.	
Rhestr o Atodiadau / *List of Appendices:* 1. High-level Programme Timeline	

1. Background

In March 2024, executive colleagues received and approved a proposal aimed at enhancing services to prevent diabetes and improve outcomes for those living with the condition.

The proposal emphasises collaboration across multiple agencies and broader stakeholder groups to create an effective model of primary and community diabetes care. This initiative aims to address the growing demand and promote better population health. The main outcome of the program is the development of a case for change, clearly outlining the need for transformation, the consequences of maintaining the status quo, and a model built on taking a consensus approach.

Guided by an overarching steering group, three key subgroups were formed, each tasked with contributing expertise from clinical, intelligence, and third-sector/service user perspectives.

The proposal initially set a deadline to deliver the case by the end of January 2025. However, progress has been delayed, primarily due to insufficient project management resources needed to coordinate and advance the work plan. As a result, the target completion date for development of a case for change has been extended to the end of March 2025.

2. Curent Postion

Despite earlier delays, the program team has made significant progress and remain on schedule to meet the revised March 2025 deadline [Appendix 1: Programme Timeline]

In collaboration with Public Health Wales Data Science Unit and BCU Public Health colleagues, the Data and Intelligence Group, co-chaired by Public Health and the BCU Data, Intelligence & Insight Team, has prepared data and evidence reports outlining the current state of diabetes and diabetes services, best practice, and health technologies. Additionally, they have developed an interactive dashboard that showcases the current health of the service and the likely consequence of a ‘do-nothing’ approach. [Appendix 2: Modelling]

The process of collecting qualitative information is ongoing, aimed at capturing the ‘voice of the service user’ which is a critical component of the project and will provide clarity on important areas for consideration, and feed into the iterative equalities and socio-economic assessment cycle. The Stakeholder Group, attended by key representatives from a number of third-sector and partner organisations, is coordinating, and contributing to, this work. [Appendix 3: Pre-Engagement Report, November 2024]

The Clinical Model of Care group, led by Dr Eilir Hughes, is actively engaging professionals from various fields to gather feedback and identify key areas that may have been overlooked in the initial insight and evidence reports. The results of this feedback will provide essential details for shaping the preferred future care model, which will be developed through a series of upcoming in-person consensus building events. [Appendix 4: Evidence papers]

These events, funded by a £30,000 grant from the Public Health Wales Tackling Diabetes Together program, will be held at an external venue. An experienced external partner agency has been engaged and will work with us to facilitate the discussions to help build consensus on the way forward. [Appendix 5: Draft Programme -Day1]

After the conclusion of the consensus events and the subsequent modelling of the preferred care model by the PHW Data Science Unit, the case for change will be developed. This will include an assessment of potential resource requirements and their implications.

3. Risks and Challenges

There remains 5 'high' or 'very high' risks, which have the potential to delay or prevent the successful delivery of the programmes' objective. These are:

RISK ID	DATE RAISED	RISK OWNER	RISK TITLE	RISK DESCRIPTION	IMPACT DESCRIPTION	SCORE AFTER MITIGATION
R002	13/03/2024	Clinical Model of Care Group	Clinical engagement and participation of the diabetes programme	Lack of clinical engagement and participation in the development of new models of care and for the need to change	Failure to deliver an evidence-based, clinically considered and agreed case for change	12
R004	13/03/2024	Executive team	Commitment to Resource	The current operational conflicting priorities/ challenges prevent staff resources required to deliver the programme	Overall failure in project delivery - case for change not produced. Engagement and enthusiasm of clinical staff will wane	20
R007	24/06/2024	Data & Intelligence Group/PHW	Resource availability and capability	Insufficient capacity and capability within our team/PHW for modelling work on future options	Inability to produce accurate modelling analysis (future options) will hinder the development of a best-performing, cost effective and efficient service model	12
R016	24/06/2024	Executive team	Opportunity cost	Impact to other projects / work	Prioritisation of the PH diabetes programme will impact other work across specialty areas	12
R018	16/09/2024	Clinical Model of Care Group	Specialist Clinical Availability	Meetings arranged clash with Consultant clinical commitment	Non-representation at the meetings will prevent full and rounded clinical discussion	12

Other key challenges include:

1. **Data Availability, Completeness, and Integrity**:
    - **Issue**: Access to data across multi-agency sectors (such as Primary Care), availability, completeness, and integrity is a concern. Incomplete or inaccurate data may lead to flawed insights and decision-making.
    - **Impact**: Relying on assumptions due to data gaps can introduce risks.
    - **Mitigation**: Close collaboration with DDaT and PHW Analysts, validate assumptions, and consider alternative data sources where possible.

2. **Conflicting Priorities and Slippage**:
    - **Issue**: Balancing competing priorities can cause delays in completing essential tasks, like workforce mapping.
    - **Impact**: Slippage affects project timelines and resource allocation.
    - **Mitigation**: Regularly reassess priorities, communicate openly about resource constraints, and issue available information as it becomes available

Appendix 1: Programme Timeline

TASK ID	TASK NAME	OWNER	CATEGORY	TASK DESCRIPTION	PLAN START	PLAN END	PLAN DURATION	REVISED/ ACTUAL START	REVISED/ ACTUAL END	REVISED/ ACTUAL DURATION	PERCENT COMPLETE	PROJECT SLIPPAGE	STATUS
T1.000	START UP		STAGE	0	13-Mar-24	31-Mar-24	18	13-Mar-24	30-Apr-24	48	100%	30	Complete
T1.001	PID sign-off	JM	Milestone	Proposed outline of work presented to ELT	13-Mar-24	13-Mar-24	0	13-Mar-24	13-Apr-24	31	100%	31	complete
T1.002	Project Manager	JM/RA	Task	Project Manager allocated	13-Mar-24	01-Apr-24	19	13-Mar-24	12-Jul-24	121	100%	102	Complete
T1.003	Workstream Leads	JM/RA	Task	Workstream leads identified	13-Mar-24	01-Apr-24	19	13-Mar-24	01-Apr-24	19	100%	0	Complete
T2.000	PROJECT INITIATION		STAGE	0	01-Apr-24	30-Apr-24	29	01-Apr-24	29-Oct-24	211	80%	182	Off-Track
T2.001	**Steering Group membership**	**Leads**	Task	**Agree membership of the steering group to include VCSE and diabetes patient group representation**	01-Apr-24	14-Apr-24	13	01-Apr-24	29-Jul-24	119	**100%**	106	Complete
T2.002	**Terms of reference for all Groups**	**Leads**	Task	**TOR to be drafted and signed off**	01-Apr-24	30-Apr-24	29	01-Apr-24	29-Jul-24	119	**100%**	90	Complete
T2.003	**Stakeholder mapping and communication plan**	**PM/Comms Lead**	Task	**Stakeholder mapping and communication plan to be drafted**	30-Jul-24	12-Aug-24	13	30-Jul-24	30-Sep-24	62	**70%**	49	Overdue
T2.004	**Kickoff Meetings**	**Leads**	Task	**Initial meetings to be held for all workstreams and steering group**	01-Apr-24	30-Apr-24	29	01-Apr-24	29-Jul-24	119	**100%**	90	Complete

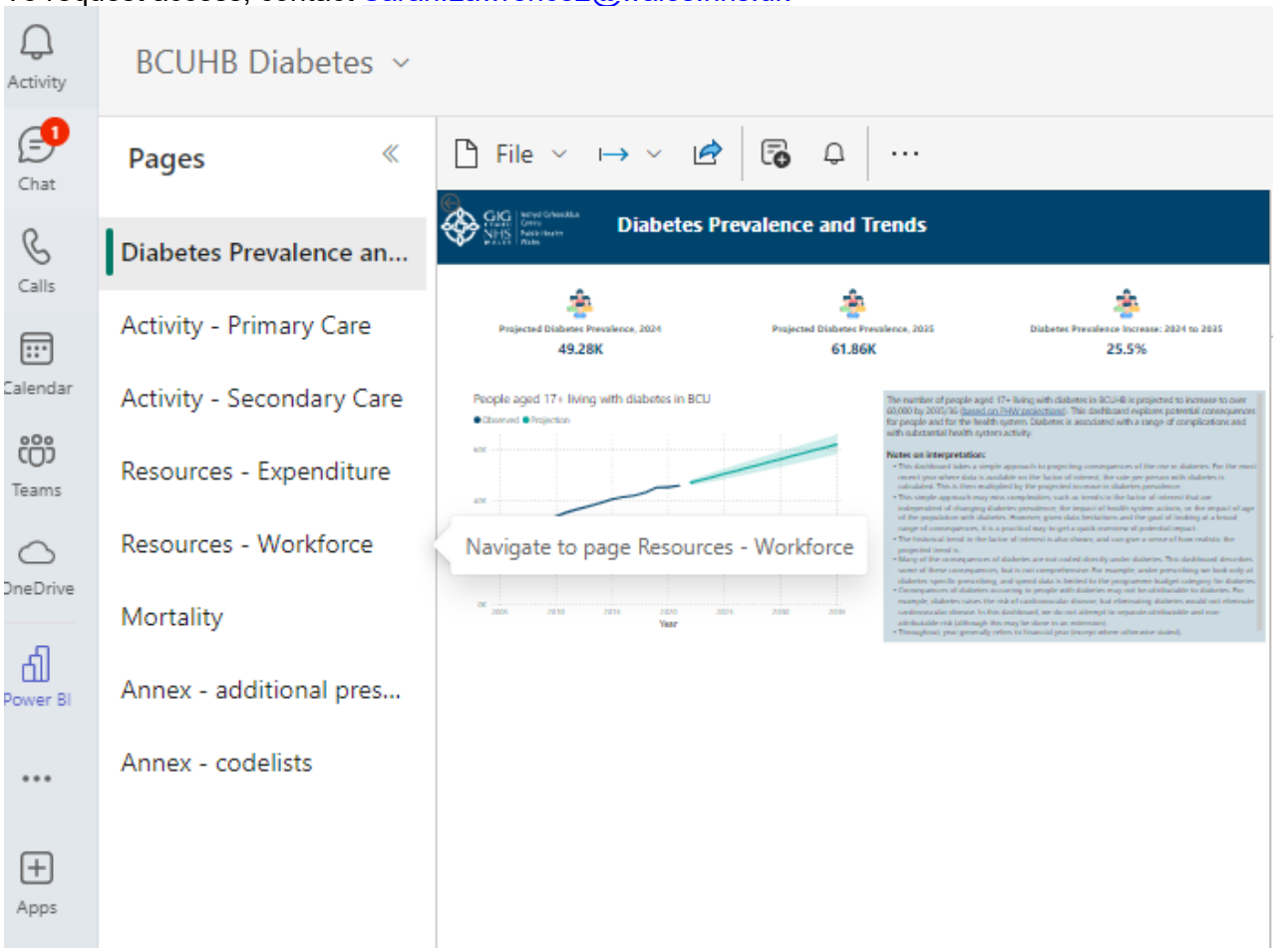
TASK ID	TASK NAME	OWNER	CATEGORY	TASK DESCRIPTION	PLAN START	PLAN END	PLAN DURATION	REVISED/ ACTUAL START	REVISED/ ACTUAL END	REVISED/ ACTUAL DURATION	PERCENT COMPLETE	PROJECT SLIPPAGE	STATUS
T2.005	**EQIA drafted (for regular review and update)**	**Leads**	Task	**Undertake to commence equalities impact assessment**				01-Oct-24	29-Oct-24	28	**30%**	45594	
T3.000	PROJECT DELIVERY | Sub-Stage 1		STAGE	Data and Intelligence Group	01-Apr-24	01-Feb-25	306	01-Apr-24	01-Feb-25	306	63%	0	Off-Track
T3.001	Modelling future options	**Modelling sub-group**	Task	**Modelling activity to understand consequences of case for change options over next 5-20 years**	01-Apr-24	31-Aug-24	152	01-Dec-24	31-Jan-25	61	0%	153	Not Due to Start
T3.002	Current position review of evidence and data	**KL/RA**	Task		01-Apr-24	01-May-24	30	01-Apr-24	31-May-24	60	100%	30	Complete
T3.003	Modelling current position	**Modelling sub-group**	Task	**Modelling activity to understand future impact over 5-20 years (maintaining current position)**	01-Jun-24	31-Aug-24	91	01-Jun-24	03-Sep-24	94	100%	3	Complete
T3.004	Technology, Clinical Model of Care & modelling lit review	**CJ**	Task		01-May-24	31-Jul-24	91	01-May-24	31-Aug-24	122	100%	31	Complete
T3.005	Modelling current position shared with clinical group	**SO PHW**	Milestone	**Presentation to Clinical Model of Care Group**	16-Sep-24	16-Sep-24					**100%**		Complete
T3.006	Modelling future options shared with clinical group	**SO PHW**	Milestone	**Presentation to Clinical Model of Care Group**	01-Feb-25	01-Feb-25					**0%**		Not Due to Start

TASK ID	TASK NAME	OWNER	CATEGORY	TASK DESCRIPTION	PLAN START	PLAN END	PLAN DURATION	REVISED/ ACTUAL START	REVISED/ ACTUAL END	REVISED/ ACTUAL DURATION	PERCENT COMPLETE	PROJECT SLIPPAGE	STATUS
T4.000	PROJECT DELIVERY | Sub-Stage 2	HSJ	STAGE	Stakeholder Group	01-Apr-24	05-Nov-24	218	12-Sep-24	05-Nov-24	54	0%	0	Off-Track
T4.001	Insight report: Current qualitative data 'voice of the customer'	**HSJ/Stakeholder Group**	Task	**Collate and present a summary of qualitative data regarding patient and tertiary service user experience of the current service model**	16-Jun-24	01-Sep-24	77	12-Sep-24	01-Nov-24	50	**60%**	61	Off Track
T4.002	Share report with CMoC group and present findings at Consensus Event	**HSJ**	Milestone	**Present findings to Clinical Model of Care Group for consideration**	01-Nov-24	05-Nov-24	4						Not Due to Start
T5.000	PROJECT DELIVERY | Sub-Stage 3	EH	STAGE	Clinical Model of Care Group	01-Apr-24	28-Feb-25	333	01-Apr-24	30-Nov-24	243	20%	-90	Off-Track
T5.001	Review summary of data, evidence and description of current services	**EH / Clinical Model of Care Group**	Task	**Review current evidence and highlight gaps**	01-Apr-24	30-Apr-24	29	02-Sep-24	16-Sep-24	14	**80%**	139	Overdue
T5.002	Develop summary of data, evidence and current evidence of best practice models	**PH Principal Practitioner**	Task	**Produce a document setting out the current evidence base of different clinical models of diabetes care and look at existing models in BCU/Wales**	01-Apr-24	30-Jun-24	90	01-Apr-24	31-Aug-24	152	**100%**	62	Complete

TASK ID	TASK NAME	OWNER	CATEGORY	TASK DESCRIPTION	PLAN START	PLAN END	PLAN DURATION	REVISED/ ACTUAL START	REVISED/ ACTUAL END	REVISED/ ACTUAL DURATION	PERCENT COMPLETE	PROJECT SLIPPAGE	STATUS
T5.003	Draft future models of care for modelling	**EH/ Clinical Model of Care Group**	Task	**Produce a document setting out future models of care based on evidence and learning from the data and intelligence and stakeholder group output**	01-Sep-24	01-Dec-24	91	16-Sep-24	01-Dec-24	76	**0%**	0	Off-Track
T5.004	Review future modelling and recommend case for change model	**EH/ Clinical Model of Care Group**	Task		01-Feb-25	28-Feb-25	27						Not Due to Start
T6.000	PROJECT CLOSURE		STAGE	Confirmation of project deliverables	01-Mar-25	31-Mar-25	30				#DIV/0!	0	**#DIV/0!**
T6.001	Draft case for change	**Leads**	Task	**Submit case for discussion a**	01-Mar-25	20-Mar-25	19						Not Due to Start
T6.002	Communicate outcome to all stakeholders	**PM**	Task										
T6.003	Submit case for change	**JM/RA**	Milestone	**Submit case for discussion**									

Appendix 2: Modelling

To request access, contact Sarah.Lawrence2@wales.nhs.uk



Betsi Cadwaladr University Health Board Diabetes Transformation Programme
Pre-engagement report
11 November 2024

Background

Over 45,000 people are currently living with Type 2 Diabetes across North Wales and this is expected to increase by 25% over the next ten years. Diabetes is a serious chronic condition that has a great impact on people's lives and on our health services.

As part of an organisational approach to transformational change, the Diabetes Transformation Programme is looking to:

- Prevent people from developing diabetes wherever possible (Type 2)
- Develop effective diabetes care and services as close to where people live as possible
- Improve the way we are able to plan for and manage diabetes care

We are at the start of an ambitious project to improve diabetes services now and for the future and between September 2024 and March 2025, we are gathering as much intelligence, data and insights as possible to understand what we can about services as they currently are, people's experience of them and will be working with a wide range of stakeholders to consider and co-produce options for how Diabetes services can be improved over the coming years.

Communications and engagement approach

The approach to communications and engagement activity is being led by the programme itself and can be broken down into three phases:

Phase one (October 2024 to December 2024) has so far focused on raising awareness of the Diabetes Transformation Programme; it's focus and aims as well as supporting the programme in gathering intel as to, "what we know already" about people's experiences of our diabetes services so far. The consensus events will also form a key part of our stakeholder engagement during this period as we work to co-produce potential future service options.

Phase two (December 2024 to March 2025) will continue to support awareness raising of the programme as well as more bespoke involvement and engagement with areas as identified in the EQIA. All information gained from targeted involvement of all relevant stakeholders will support the development of a Case for Change at the end of March 2025.

Phase three (April 2025 onwards) will be led by any proposed next steps for diabetes services across North Wales with the scale of communication and involvement being representative.

Activity so far

Focus on raising awareness of the work, it's rationale and better understanding people's experiences of diabetes services, whether as a service user, parent/carer of a service user or someone who works within our services, the following activity took place throughout October:

Overarching

A draft communications and engagement plan and approach is in place, with an overarching narrative developed to describe the programme and it's aims. This will be further developed for the next phase based on the EQIA (session taking place on Thursday 14 November).

A feedback survey was also developed and made available in both Welsh and English. A total of 124 responses were received with the feedback and key themes summarised in the section below.

Internally

Ensuring references to the wider approach to change of which this programme is a part, information on the Diabetes Transformation Programme was made available on BetsiNet and distributed three times within the weekly communications update to all staff with email access. The following page gained 572 page views: Help shape the future of Diabetes care in North Wales

Externally

Information was shared, with the opportunity to share experiences, across key digital channels from BCU – namely facebook and LinkedIn for a period of three weeks. In this time, the following was achieved:

Impressions: 17,500
Engagements: 492
Clicks: 392

Other stakeholders

The survey was provided to all Stakeholder Group members for distribution across their own channels as well as ways of providing existing feedback.

Paper-copy surveys were also provided at x2 engagement events with information being available about the wider programme. These were:

Workplace Health Event, the Optic Centre: 16 October 2024.
Diabetes service user event, Abergele: 1 November 2024.

Existing information and feedback held via MS/MP Correspondence and via the BCUHB Patient Experience team was also analysed for key themes and is summarised below.

Key themes

By analysing existing feedback (held by PALs, from compliments, complaints and from MS/MP Correspondence) and feedback from the short survey, a number of key themes have been identified.

Throughout the information and feedback available there is an appreciation of the dedication, compassion and professionalism of healthcare staff within diabetes services which is important to note.

The following key themes are apparent in all areas of feedback:

- Access to services
- Medication management and technology integration
- Communication between services and service users
- Personalised, patient-centred care

Further feedback:

- Support services and patient advocacy
- Integrated services that can respond with urgency when needed (or services that are easily accessible in times of need)
- Prevention and early detection.

Feedback in full can be accessed here: Communication and Engagement

Next steps

Next steps will be to ensure the above feedback and known intelligence is incorporated into further thinking as the programme develops as well as the continued involvement of stakeholders over the coming months.

Further awareness raising and updates will continue as part of the organisational approach to change which is developing and being supported by teams

Appendix 4: Evidence Papers [under review]

- Best practice*
- Service profile
- Technologies*

Not included, but available on request.

BCUHB Diabetes Data & Service Profile – Summary of the key findings

V0a, 22/8/24

1. Purpose

The aim of this paper is to summarise the key messages and evidence from the full Profile report, in order to inform the development of the BCUHB Diabetes Transformation Project. It should be read in conjunction with the two other summary papers, namely 'Best Practice in Diabetes Services in Primary and Community Care', and 'Diabetes Technologies'. This paper is presented in the following sections:

2. Diabetes Context

Diabetes is a chronic and progressive disease, which if left uncontrolled can lead to severe illness such as heart disease, stroke, amputation, blindness and kidney failure. However, risks of complications are reduced if the condition is carefully managed and individuals have healthy lifestyles and good glucose control.

There are two main types of diabetes: Type 1 diabetes and Type 2 diabetes. In addition, gestational diabetes is diabetes that can develop during pregnancy. The condition is

less common than Type 1 or Type 2 diabetes, but the prevalence has been increasing. In 2021/22, almost one in 12 people aged 17 years and over were diagnosed with Type 1 or Type 2 diabetes in Wales (8.0%). Between 2017-18 and 2021-22, there was a percentage increase of 18.7% in Type 2 diabetes among those aged under 40 compared to an increase of 11.3% in those aged between 40 and 79 years.

3. Epidemiology of Diabetes

In 2021/22, almost one in 12 people aged 17 years and over were diagnosed with Type 1 or Type 2 diabetes in Wales (8.0%), which is an increase of almost 60,000 people (40%) in the 12 years to 2021/22. Over the same time period, the number of people registered as having diabetes in BCUHB increased by 14,000 people (43%), which is mostly due to an increase in Type 2 diabetes. Diabetes prevalence is higher in the older population.

The percentage of adults registered by their GP as having diabetes in BCUHB (7.9%) is similar to the Wales average. The prevalence across BCUHB Primary Care Clusters, which range from 6.4% in Arfon to 9.3% in Meirionnydd. In terms of numbers, Isle of Anglesey and North Denbighshire Primary Care Clusters have the highest numbers of patients with diabetes. There is considerable variation in prevalence rates between them. It is important to note that QAIF data only provides recorded prevalence; it does not refer to or report on expected prevalence or estimated prevalence.

Recently published data from the Diabetes Insight & Variation Atlas provides the prevalence rate per 10,000 population.

Diabetes prevalence per 10,000 population, Betsi Cadwaladr UHB and Primary Care Clusters, 2022-23

	per 10,000 population
Betsi Cadwaladr UHB	791
Anglesey	899
Arfon	658
Dwyfor	1,259
Meirionnydd	525
Conwy East	899
Conwy West	756
North Denbighshire	905
Central & South Denbighshire	746
North East Flintshire	732
North West Flintshire	763
South Flintshire	764
North & West Wrexham	768
Central Wrexham	759
South Wrexham	763

Source: Diabetes Insight & Variation Atlas (NHS Wales Executive)

- Type 1 and Type 2 diabetes are more prevalent in males (53.7% Type 1 and 55.9% Type 2) compared to females (43.3% and 44.1%) in BCUHB.
- The prevalence of diabetes rises steeply with age: one in 20 people over the age of 65 in the UK has diabetes and in people over the age of 85 years this rises to one in five. The population of North Wales is aging which will increase the burden of diabetes.

- People from Black African, African Caribbean and South Asian backgrounds are at a higher risk of developing Type 2 diabetes from a younger age.
- People living in the most socio-economically disadvantaged communities have much higher rates of both Type 1 and Type 2 diabetes.
- There were 139,255 people with Type 2 diabetes under the age of 40 years, accounting for 4.8% of all Type 2 diabetes cases under the age of 80 in England and Wales. Between 2017-18 and 2021-22, there was a percentage increase of 18.7% in Type 2 diabetes among those aged under 40 (Figure 29 and Table 36) compared to an increase of 11.3% in those aged between 40 and 79 years.

3.1 Future prevalence of diabetes

The projected trends (medium projection scenario) of diabetes, based on patients registered with a GP in BCUHB, indicates that the number of diabetes registrations is predicted to rise from 46,994 in 2022/23 to 61,861 in 2035/36. This represents an increase of 31.6%, compared to 29.6% across Wales.

4. Risk factors for diabetes

Type 1 diabetes is caused by an absolute insulin deficiency, which usually results from autoimmune destruction of the insulin producing beta cells in the pancreas (NICE, 2024a). Risk factors include genetic and environmental factors.

As well as increasing age, the key risk factors for Type 2 diabetes include (NICE, 2024b) are summarised below.

4.1 Healthy Weight

Obesity accounts for 80-85% of the risk in developing Type 2 diabetes and is the predominant risk factor. Adults reporting to be obese (BMI of 30 or more) are more than twice as likely to have diabetes as those who do not (Public Health Wales Observatory, 2023).

4.1.1 Low birthweight

There is some evidence that preterm birth before 35 weeks of gestation is associated with an increased risk for Type 2 diabetes in later life. The proportion of low birth weight births in North Wales is similar to that of the Welsh average, and is decreasing over time. There is a strong link between low birth weight and socio-economic disadvantage, where the rate of low birth weight births in the most deprived quintile in Wales is 58% higher than in the least deprived quintile of the population (statistically significant difference). The key risk factor for low birthweight is maternal smoking and maternal exposure to environmental tobacco smoke.

4.1.2 Children and young people overweight and obesity

According to the most recent Childhood Measurement Programme report (2022/23), the proportion of children categorised as 'overweight not obese' in BCUHB was 13.8% (Wales average 13.4%), which was slightly lower compared with the 14.4% observed for BCUHB in 2021/22, and statistically significantly lower than the pre-pandemic

2018/19 report of 15.9%. The proportion of boys and of girls categorised as 'overweight not obese' was similar.

The proportion of children categorised as having obesity was 12.1% (higher than the Welsh average of 11.4%). This result was slightly lower than the 13.2% reported last year for BCUHB and the 12.8% reported in 2018/19. The proportion with obesity was higher for boys compared with girls at 13.1% versus 11.2%, respectively

There was a statistically significantly higher proportion categorised as having obesity in the most deprived quintile (13.9%) compared to the least deprived (9.3%) in North Wales. Children living in the most deprived quintile of deprivation were at a 50% higher risk of being obese than those living in the least deprived quintile, similar to the data for 2021/22.

4.1.3 Adult overweight and obesity

The percentage of adults reporting to be overweight and obese in BCUHB (58.9%) is below the average for Wales (61.8%); at unitary authority level, percentages range from 54.3% in Denbighshire to 62.7% in Conwy. The percentage of adults who report being obese in BCUHB (23.4%) is lower than the Wales average (25.4%) and ranges from 17.1% in Denbighshire to 29.8% in Gwynedd. The trend for adults with obesity in Wales is increasing over time, and will likely contribute to a subsequent increase in Type 2 diabetes.

4.1.4 Maternal overweight and obesity

Almost a third of women are defined as obese at their initial pregnancy assessment, and this seems to be increasing over time in line with the data for the general adult population. Approximately 31.1% of women had a BMI 30+ (obese) at their initial assessment in 2022 both in BCUHB and at an all-Wales level.

4.1.5 Older people overweight and obesity

Obesity is also an issue in older adults, who are more likely to have Type 2 diabetes. The proportion of older people (aged 65+) in BCUHB (40.6%) is slightly higher than the Welsh average (39.6%). In North Wales, the lowest proportion of older adults of healthy weight are in Conwy UA (33.4%) and the highest proportion are in Flintshire (48.9%). Females are more likely to be of healthy weight compared to males.

4.2 Nutrition

4.2.1 Fruit and Vegetables

The proportion of adults in BCUHB (25.3%) who report eating the recommended portions of fruit and vegetables in 2021-23 is lower than the average for Wales (29.1%), with proportions ranging from 15.9% on the Isle of Anglesey to 29.2% in Flintshire.

4.2.2 Infant Feeding

Breastfeeding has both health benefits for babies and mothers. Breast milk provides a baby with optimal nutrition and supports healthy growth and development. There are inequalities in breastfeeding initiation and continuation rates, whereby mothers from disadvantaged communities are least likely to breastfeed.

Across BCUHB, 35.1% of babies are breastfed at 10 days, which is just below the average for Wales (36.2%). Across North Wales, breastfeeding at 10 days ranges from 30.7% in Denbighshire to 39.1% in Gwynedd. At Cluster level, percentages range from 25% in North West Flintshire to 48.4% in Meirionnydd.

Similar to other risk factor data presented in this paper, there are stark inequalities in breastfeeding rates based on socio-economic deprivation, where 26.8% of babies are breastfed at 10 days in the most deprived quintile in Wales, compared with 47.3% in the least deprived.

4.3 Physical Activity

People who have a physically active lifestyle have approximately 50% lower risk of developing Type 2 diabetes mellitus compared to those who have a sedentary lifestyle (Public Health Wales, 2016).

People in North Wales are becoming less active. Fewer than half of all adults (45.8%) meet the physical activity guidelines in 2022/23, which is lower than the proportion in 2020/21 (57.6%) and 2021/22 (52.6%), and significantly lower than the Welsh average (55.4%). In addition, 35% of adults in North Wales reported being inactive (doing less than 30 minutes a week of physical activity), which compares to 30% for the whole of Wales. Children and young people aged 11-16 years are also becoming less active, with just under 17 percent in North Wales achieving the recommended 60 minutes of physical activity that increases heart rate, per day.

4.4 Smoking

Tobacco smoking is a major cause of premature death and one in two long-term smokers will die of smoking related diseases (BCUHB, 2015). There is evidence that people who smoke cigarettes are 30% to 40% more likely to develop Type 2 diabetes than people who do not smoke.

In BCUHB, just under 11% of adults reported smoking in 2022/23 compared to almost 13% across Wales. At a local level, smoking ranges from 7.7% in Conwy to 14.9% in Gwynedd. There are stark differences in smoking prevalence between different socio-economic groups, with 21.8% of adults reporting to smoke in the most deprived areas of Wales compared to 7.1% in the least deprived areas.

Across BCUHB, 3.6% of 11 to 16 year olds report smoking weekly, which is just above the average for Wales (3.0%). Across the region, percentages range from 2.5% in Denbighshire to 4.3% on the Isle of Anglesey.

4.5 Alcohol

Alcohol is a significant risk factor for the major causes of premature death and a direct cause of 5% of all deaths in Wales (BCUHB, 2015). It is thought that excess alcohol intake is associated with an increased risk of Type 2 diabetes.

In BCUHB, 16% of adults report drinking alcohol above the weekly recommended guidelines in 2022/23, compared to 17.2% across Wales. Across the region figures range from 9.9% in Denbighshire UA to 20.4% in Flintshire. Drinking alcohol above recommended guidelines is significantly higher among adults in the least deprived areas (21.3%) compared to the most deprived areas of Wales (14.6%).

4.6 Family History

People with a parent, brother, sister or child with diabetes have a higher risk of developing diabetes.

4.7 Ethnicity

Black, Asian and Minority Ethnic (BAME) groups have a higher risk of diabetes. BCUHB has a lower percentage of non-white residents compared to the average for Wales. At UA level, Wrexham has the highest proportion of people who are Black, Asian and Minority Ethnic (4.5%), and lowest in Anglesey and Conwy (2.2%).

4.8 History of gestational diabetes

Women with a history of gestational diabetes have a seven-fold increased risk for developing type 2 diabetes in later life.

4.9 Drug treatments

Statins, corticosteroids and combined treatment with a thiazide diuretic and a beta-blocker can increase the risk of developing Type 2 diabetes.

4.10 Females with polycystic ovaries

Polycystic ovary syndrome (PCOS) is one of the most common endocrine disorders affecting women of reproductive age. The prevalence ranges from 2.2–26% (depending on the criteria used and the population studied) with many affected women undiagnosed (NICE; Prevalence | Background information | Polycystic ovary syndrome | CKS | NICE).

The cardio metabolic profile is adversely altered in PCOS, and many cardiovascular disease (CVD) risk factors (such as body mass index, dyslipidaemia, hypertension, insulin resistance, metabolic syndrome, and deficiencies in insulin secretion) are increased. Insulin resistance is present in around 65–80% of women with PCOS. This is independent of obesity but is further exacerbated by excess weight.

Insulin resistance has been shown to worsen reproductive and metabolic features and type 2 diabetes in PCOS. The prevalence of impaired glucose tolerance and type 2 diabetes (5-fold in Asia, 4-fold in the Americas, and 3-fold in Europe) are significantly increased in PCOS, regardless of the age of the person. This is independent of obesity but is further exacerbated by excess weight. About 20–40% of obese women with PCOS have glucose intolerance or type 2 diabetes by the end of their fourth decade.

4.11 Metabolic Syndrome

Insulin resistance is commonly associated with metabolic syndrome, which is a combination of high blood pressure, dyslipaemia, fatty liver disease, obesity and a tendency to develop thrombosis.

The risk of Type 2 diabetes is increased if a persons have ever had hypertension (Diabetes UK n.d.). In BCUHB in 2021/22, over 120,900 patients (17.0%) were registered by their GP as having high blood pressure, which is higher than the Welsh average of 15.7%, and ranged from 18.7% in the Dwyfor Cluster to 13.8% in Arfon. However, this could be an underestimate of the true number of residents with high blood pressure.

4.12 Inequality & Deprivation

Deprivation is strongly associated with reduced life expectancy and healthy life expectancy, as well as health care use. It is also associated with increased risk of Type 2 diabetes.

BCUHB has some of the most disadvantaged areas in Wales, particularly along the North Wales coastline. Rhyl West 2 and Rhyl West 1 are the first and second most deprived LSOAs in Wales. Denbighshire UA has the highest percentage of LSOAs in the most deprived 10% LSOAs in Wales also the greatest number of LSOAs in the most deprived 10%.

4.13 Other risk factors include mental health conditions such as schizophrenia, bipolar disorder and depression (Diabetes UK, n.d.).

The Primary Care Quality Assurance and Improvement Framework (QAIF) records the percentage of patients with Schizophrenia, Bipolar affective disorder and other psychoses who have a record of blood pressure, BMI, smoking status and alcohol consumption in the preceding 15 months and in addition to those aged 40 or over, a record of blood glucose or HbA1c in the preceding 15 months (Welsh Government, 2022).

The percentage of patients registered with GP practices who have been recorded as having a mental health condition ranges from 0.8% in South Flintshire to 1.4% in Central Wrexham.

5. Primary Care Diabetes Activity and Services

The vast majority of diabetes care takes place in Primary Care as planned contractual activity in chronic conditions (Lewis, J. 2023). For diabetes, this will include the annual review, interim review, completion of essential care processes and referral to national programmes such as Diabetes Eye Screening for Wales (DESW). This also comprises signposting to Health Board 'system wide' services (where they exist), such as prevention, remission, weight management and recognised self-care programmes (Lewis, J. 2023).

Data from the National Diabetes Audit (NDA) provides a picture of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards, which are (Primary Care Information Portal n.d.):

- Care processes;
- treatment targets; and
- structured education (most recent data is not available due to changes in data collection).

Outcomes from the NDA provide useful comparative information at Cluster level. While data is collected at GP Practice level, Digital Health and Care Wales is not able to share data at that level with Health Boards.

5.1 Care processes

A vital component for the effective prevention of diabetes complications is the Annual Review (Lewis, J. 2023), which consists of nine essential care processes, eight of which are the responsibility of GP Practices. These important elements of planned care identify treatable risks, reduce exacerbations and optimise effective care (Lewis, J. 2023). In addition, they provide important signposting to self-management programmes. The eight care processes NICE recommend are undertaken once a year are:

NICE care processes

1.	HbA1c – blood test for glucose control.
2.	Blood pressure – measurement of cardiovascular risk.
3.	Serum Cholesterol – blood test for cardiovascular risk.
4.	Serum Creatinine – blood test for kidney function.
5.	Urine Albumin/Creatinine Ratio – urine test for kidney function.
6.	Foot risk surveillance – foot examination for foot ulcer risk.
7.	Body mass index – measurement for cardiovascular risk.
8.	Smoking history – question for cardiovascular risk.

- In 2021-22, only 29% of people with diabetes received all eight care processes in BCUHB
- At an individual care process level (see Table below), the highest percentages are approximately 85% for serum creatine and 84% for HbA1c; the lowest were for Urine Albumin (46%) and Foot surveillance (50%).
- At Primary Care Cluster level, the percentage achieving all eight care processes range from 10% in Conwy East to almost 38% in North and West Wrexham. Although the latest data appears to show an improvement in percentages of care processes achieved between 2020-21 and 2021-22, they are not as high as pre-pandemic levels; this is similar across the whole of Wales (National Diabetes Audit, 2022).

Care processes, all diabetes, Betsi Cadwaladr UHB

Care Process	2019-20	2020-21	2021-22
Blood Pressure	90.32	72.74 ↓	79.94 ↑
BMI	78.40	60.97 ↓	69.02 ↑
Cholesterol	81.19	68.32 ↓	73.77 ↑
Foot Surveillence	67.08	37.87 ↓	49.57 ↑
HbA1c	89.81	79.18 ↓	83.71 ↑
Serum Creatinine	90.56	80.80 ↓	84.91 ↑
Smoking	88.46	77.81 ↓	79.90 ↑
Urine Albumin	53.33	38.97 ↓	46.43 ↑
All Eight Care Processes	40.97	20.61 ↓	29.03 ↑

Source: National Diabetes Audit; Primary Care Portal

For people with Type 1 diabetes, factors associated with reduced likelihood of receiving all eight care processes were younger age and people living in more deprived areas. The likelihood of receiving all eight care processes was increased in older people; people of Asian, Black or Mixed Ethnicity; people living in a less deprived area; and diabetes duration of one to four years and five to nine years (when compared with reference group of those with diabetes for 15 years and over) (National Diabetes Audit, 2022). For people with Type 2 diabetes, factors associated with achieving all eight care process were similar to those with Type 1. Reduced likelihood was also associated with females and diabetes duration of less than one year (National Diabetes Audit, 2022).

More broadly, increasing prevalence of diabetes, losing experienced staff and resulting recruitment difficulties, changes in systems of care delivery, diabetes indicators being removed from QoF, and different perceptions of what constitutes 'primary care diabetes' have all contributed to worryingly low completion of care processes (Lewis, J. 2023).

A Diabetes Specification (DS) has existed in Wales as an additional Directed Fund to support practices to improve completion of the requirements for planned diabetes care (Lewis, J. 2023). However, it is understood that this specification has not had the anticipated impact (Lewis, J. 2023).

The attainment of all eight care processes for Type 1 diabetes in BCUHB (13.1%) should be of concern for people living with Type 1 as they may not be offered a recall for annual review in primary care, perceiving that this activity would form part of a secondary care appointment. A clearer pathway to support an improvement in eight care process completion in Type 1 diabetes is very much needed (Lewis, J. 2023).

5.2 Treatment Targets

Better management of diabetes is delivered through attainment of the treatment targets. The role of primary care in overall admissions avoidance through attainment of all three treatment targets is important (Admissions avoidance and diabetes, 2013), including through:

- structured and on-going patient education
- risk stratification
- delivery of the eight care processes
- a care planning approach to agreeing goals
- informing people with diabetes about how to prevent emergencies

The three treatment targets pertaining to diabetes that NICE recommend are:

NICE treatment targets

1.	HBA1c ≤ 58 mmol/mol
2.	Blood Pressure ≤ 140/80
3.	Statins for combined* prevention of CVD

*Combined prevention of CVD: The percentage of people with diabetes that fall into either of the primary or secondary prevention groups during the audit period:

- Primary prevention of CVD: The percentage of people with diabetes aged 40 to 80 years with no history of heart disease that received statins during the audit period;
- Secondary prevention of CVD: The percentage of people with diabetes (any age) with a history of heart disease that received statins during the audit period.

In 2021-22, just over 27% of patients with diabetes in BCUHB received all three treatments recommended by NICE, compared to just over 31% in 2019-20, which is again disappointing. At Cluster level, the 2021-22 figure ranges from 21% in Conwy East to almost 29% in Central and South Denbighshire.

Across England and Wales, the achievement of all three treatment targets has improved for Type 1 diabetes (National Diabetes Audit, 2022). For Type 2 diabetes, there is a downward trend across England and Wales in blood pressure and HbA1c treatment (National Diabetes Audit, 2022); across BCUHB the picture is slightly different for HbA1c which has increased since 2019-2020.

5.3 Immunisations

Primary care provides vaccination services for patients with diabetes. Influenza immunisation uptake in people aged under 65 years with diabetes for the 23/24 Flu Season (data 23rd April 2024) in North Wales was 53.5%, compared to the Welsh average of 51.4%. This ranged from 62.2% in Anglesey to 49.2% in Denbighshire; the target is 75%.

Pneumococcal vaccine coverage for those in the at-risk group with diabetes is above the Wales average across BCUHB as a whole (51.2% vs 41.1%), and at unitary authority level.

5.4 Primary Care Enhanced Services

The Negotiated Enhanced Services (NES) within the Diabetes Specification (DS) provides an opportunity for GP practices to improve the services they provide for patients with diabetes to include initiation and monitoring of diabetes injectable therapies, as well as encouraging repatriation from specialist outpatient services back to primary care (Lewis, J. 2023). It has been noted that the NES in its current state is increasing variation and inequity of access for people living with diabetes as it confuses the remit for contributing services by fixing service delivery within traditional models that are finding it difficult to cope with the increasing demand (Lewis, J. 2023).

Approximately 20 to 30% of people living with Type 2 diabetes will require insulin at some point in their patient journey, either as a temporary or permanent feature of their treatment plan. It has been argued that it is very difficult for a finite specialist resource in North Wales to cope with the influx of referrals of varying clinical indication, coupled with a rapid increase in demand upon specialist diabetes services due to NICE guidance position on glucose sensor technology in both Type 1 and insulin treated Type 2 diabetes (Lewis, J. 2023). Moving forward the new NICE Technology Appraisal for Hybrid Closed Loop systems in Type 1 diabetes will occupy a significant proportion of specialist diabetes activity.

The table below summarises how many (and %) of the 96 BCUHB GP Practices (that were outlined in the source data) provide the five types of enhanced services for diabetes. Further detail by individual Cluster is provided in the main Diabetes Profiled document.

Diabetes Gateway Module DES	**Injectable Incretin Mimetics Monitoring (Module 1) NES**	**Injectable Incretin Mimetics Initiation**	**Insulin Monitoring (Module 3) NES**	**Insulin Initiation (Module 4) NES**
77 (80%)	53 (55%)	54 (56%)	43 (45%)	42 (44%)

5.5 Locality/Cluster Based Diabetes MDT Service

Non-medical, locality-based, diabetes MDT posts (Diabetic Specialist Nurse (DSN)/ Dietitian and Healthcare technicians) were promoted through Programme Management Office (PMO) initiatives, and subsequently resourced via Primary Care funding and also Cluster funded in some areas (Lewis, J. 2023). Furthermore, by working jointly with primary care providers, care establishments and community nursing, it has been possible to create a more resilient diabetes service offer within the area served with a relatively modest investment (Lewis, J. 2023). This has facilitated integration, innovation, and timely access to specialist nursing support, weight loss, remission and prevention programmes (Lewis, J. 2023)

This service currently exists in eight out of fourteen Clusters, comprising of approximately 6.9 WTE Diabetes Specialist Nurses, 2.9 WTE Diabetes Dietitian, and 1 WTE Diabetes Healthcare Assistant. Funding for these posts is not uniform (Lewis, J. 2023). It has been noted that, if this type of approach was available across BCUHB, we would be in a stronger position to manage the majority of Type 2 diabetes services outside of the hospital outpatient setting (Lewis, J. 2023). This would, in turn, allow the hospital-based diabetes teams to focus on delivering the 'Super Six' diabetes services.

5.6 Cluster-based Long Term Conditions Hub (The North Denbighshire Transformation Project)

This Cluster based initiative, funded through Transformation in September 2021, involved the creation of a one-stop diabetes hub. The model completes all eight essential care processes in diabetes annual reviews and uses the clinical assessments and Point of Care Testing (POCT) results to develop a negotiated care plan with the person who has diabetes in one practice visit. It further addresses the cardiovascular, renal and metabolic risk reduction and provides signposting to self-management resources.

For individuals who attended the 'hub' model, between 74.9% and 91% achieved completion of all eight care processes, which compares favourably with the BCUHB average of 29% in 2021-22 (for both Type 1 and Type 2 diabetes). The service has potential to expand for people living with other chronic conditions (Lewis, J. 2023).

Patients have valued the opportunity of completing all their care processes, receiving their results during their appointment and consulting with a diabetes expert to re-negotiate an agreed care plan in a single visit (Lewis, J. 2023). There is a service evaluation and BCUHB have also just had a successful bid for a med-tech accelerated evaluation for the next (last 12 months) of the project.

CMC/North Denbighshire LTC Hub, July – November 2022

	Number	Percentage attendance
Patients invited	522	
Patients attended	460	88

	Number	Percentage completion
BP recorded	442	96.0
HbA1c	430	93.4
Lipids	367	79.7
Foot checks	391	85.0
Creatinine	343	74.5
Albumin	338	73.4
BMI	443	96.0
Smoking status	433	94.0
8 Care process completion average		87.0

Data based on 2 clinic days per week utilising branch practice clinic site (Ty Elan).

5.7 All Wales Diabetes Prevention Programme

The All-Wales Diabetes Prevention Programme (AWDPP), developed nationally by Public Health Wales, offers targeted dietary and physical activity support to individuals who are at increased risk of Type 2 diabetes. This brief intervention is cost effective to deliver, as demonstrated by economic analysis from Swansea University (Lewis, J. 2023). In BCUHB, the AWDPP is currently delivered at two pilot sites in the West, namely Meirionnydd (Dolgellau, Tywyn and Bala Surgeries) and Anglesey (Biwmaris, Llanfairpwll). Many other Health Boards in Wales have widened this service beyond the initial Public Health Wales financed pilots and now incorporate it as a core funded service across their Health Boards (Lewis, J. 2023). Key findings following the initial 12 month review include:

- 31% of patients have been referred for National Exercise Referral Scheme (NERS) and 36% for weight management services; however, it is unclear if they have engaged with services
- There appears to be a higher percentage of patients improving their HbA1c when they have attended the diabetes prevention program than not; however, at present this data is currently based on a small number of patients and further data is being collected.

5.8 Psychology services for diabetes

There is strong evidence that people living with diabetes experience higher levels of psychological distressed compared to people without diabetes (Diabetes UK, 2019). The All Wales Diabetes Implementation Group state that psychological care for people living with diabetes should be integrated, accessible and flexible and with a stepped-model of care approach.

Examples of good practice include:

- SEREN Connect: an education programme for young people with diabetes moving from paediatric to adult diabetes services that integrates psychological knowledge throughout.
- Talking Type 1: a book range developed to meet some of the unmet psychological need for people living with diabetes.

5.9 Remission and weight loss treatment of Type 2 Diabetes

The Public Health Wales Counterweight project is offered to people diagnosed with Type 2 diabetes (less than six years duration) in Gwynedd and Anglesey, and utilises weight loss as an effective treatment (do we have more data on this?) for Type 2 diabetes (Lewis, J. 2023).

In addition, funding from Strategic Planning for Primary Care (SPPC) has enabled the development of a digital virtual group low calorie programme. This investment followed on from work undertaken by the East diabetes team collaborating with primary care diabetes services to offer supported weight loss as an effective treatment for type 2 diabetes (Lewis, J. 2023).

5.10 Dental Services

People with poorly controlled diabetes have a higher risk of tooth and gum problems. People with diabetes access their dental care through NHS dentists or privately. NICE guidance recommends that periodontitis is discussed as part of the plan of care for patients with diabetes and gum inflammation. There is no specific data available on dental patients with diabetes.

5.11 Optometry services

Diabetic eye screening comes through the national screening programme run by Public Health Wales, and is therefore relatively 'light touch' with primary care Optometry. All patients with diabetes are, however, entitled to a free NHS eye examination (WGOS1 appointment) and Optometrists are well placed to identify diabetic retinopathy/maculopathy or other signs of concern. The new Optometry contract incorporates a greater focus on prevention and well-being, so diabetes has now been raised in a number of Optometry collaboratives/clusters as priority.

Outside of the national contract, BCUHB has a localised data capture pathway with 11 primary care practices to support secondary care with patients under their care for diabetic retinopathy. Under this pathway, a number of patients are seen for their 'in-person' assessment by a primary care Optometrist who captures the necessary data and scans/images before sending back to secondary care for medic review. This has proven very successful (Can we be more specific? Outcomes? Experience?) over the past 12 months or more. The new Optometry contract allows for more autonomous pathways in primary care, utilising Optometrists with higher qualifications. There are plans to work with BCUHB medical retina colleagues in secondary care to identify a safe cohort of patients that can be managed in primary care and this will very likely include a number of patients with diabetic retinopathy.

5.12 Diabetic Eye Screening

Diabetic eye screening is available for everyone aged 12 years and over with a diagnosis of Type 1 or Type 2 diabetes. Coverage across BCUHB (36.1%) (coverage still feels low

given the risk/impact – do we know why? Access? Awareness?) is above the average for Wales (31.5%); at UA level, coverage ranges from 30.2% in Conwy to 42.1% in Flintshire.

During 2021/22, there were 10,135 results reported (some individuals may have been screened more than once in a year), with 5,436 records of no retinopathy and 3,737 records of any retinopathy.

5.13 Structured Education

Structured education (SE) is an important NICE recommended intervention to enable people with diabetes to manage their condition. A suite of education options is available via the Self Care team in BCUHB for patients living with diabetes or pre-diabetes, which include:

- Diabetes Self-Management Programme (DSMP): course to help adults living with type 2 diabetes to maintain and improve their quality of life through self-management.
- Diabetes Self-Management Programme (DSMP) & STANCE: A seven week programme covering the diabetes self-management programme and the STANCE diabetes foot education.
- X-pert Diabetes: Course for adults living with Type 2 diabetes, including those newly diagnosed following on from their attendance at the dietician group session.
- X-pert Insulin programme: Designed to help people living with type 2 diabetes and using insulin to self-manage their condition, health and quality of life.
- X-pert Weight: Course to help people to manage their weight in a healthy way.
- X-Pert Diabetes Education Apps: Some of the diabetes education programmes are now available in an App format, to enable access to the programmes at a convenient time of day and week. The eligibility for each of the programmes still applies.
- New to Type 2 Education: Dietetic led intervention seeks to ensure all people newly diagnosed with Type 2 diabetes have access to a reputable standard of education and signposting to further (accredited) self-management programmes.

DG comment: There is a lot of service activity data provided for each of the above, including the average completion rates, but it would be helpful to understand if the following is also available to in order to provide a better picture of the impact (and cost-effectiveness) of attending these courses:
- outcomes e.g. did people who attended have better clinical outcomes either pre-post intervention, or as a whole cohort compared to control groups i.e. those who did not attend the courses?
- do we have robust measures of the value of attending for patients (qualitative evidence)? Case studies?
- Do we know why people DNA/DNC?
- Do we know the number/% patients referred on to lifestyle support e.g. NERS?
- the offered/attended rates for Wales and BCUHB seem low – in particular for Type 1. Do we know why?

5.14 District Nursing

There are on average 2,650 diabetes related DN visits per week across the region (Feb 2023 – Jan 2024), equating to 138,000 visits for the 12 month period, with the vast

majority relating to insulin care. The largest number of visits made are to patients aged 76 to 85 years, which accounted for just under 40% of visits.

6. Secondary Care Diabetes Activity & Services

Secondary care services are usually based in a hospital or clinic, though some services may be community based. They may include planned operations, specialist clinics, or rehabilitation services such as physiotherapy. There are three main acute hospitals in North Wales with Emergency Departments – Ysbyty Gwynedd, Ysbyty Glan Clwyd and Wrexham Maelor, plus a number of community hospitals, such as Llandudno.

The Super Six Specialist Diabetes Services describe the fundamental functions of an expected 'Specialist' diabetes MDT service offer (Lewis J, 2023).

The hospital-based specialist services in Ysbyty Gwynedd work towards this model for their outpatient activity only (Lewis, J. 2023). In order to manage the workflow, much of the diabetes patients outside of Super Six priorities in Ysbyty Gwynedd are either actively repatriated to primary care post-intervention (if the referral is outside of super six, but deemed clinically appropriate for specialist intervention), or are seen sooner and managed by the DSNs in joint primary care clinics (Lewis, J. 2023). Therefore, referrals are less likely from Anglesey and Arfon.

Posts supporting and working jointly in primary and community care settings have increased access to training, education and clinical support for people living with diabetes, as well as health professionals (Lewis, J. 2023). However, although the Ysbyty Gwynedd Diabetes team have not resolved the demand for outpatient diabetes activity, there is learning that can be shared to help improve the workflow between specialist and primary care health providers (Lewis, J. 2023). In contrast, Glan Clwyd and Wrexham Maelor are unable to move to this model due to the demand from non-Super Six outpatient activity (Lewis, J. 2023).

6.1 Emergency Department Attendances

The Emergency Department may well be a first point of call for someone with diabetes who suffers urgent complications. During the period 1st April 2021 to 22nd November 2023 the number of Emergency Department (ED) attendances with a principal diagnosis

of diabetes, including those outside BCUHB (OBCU), have been 2,338; the largest number of attendances has been in Wrexham Maelor Hospital. The small numbers for Ysbyty Glan Clwyd in 2021-22 reflect the transition to the Symphony 'go live' at the end of 2022. At Primary Cluster level, the highest number of attendances were from patients from outside BCUHB followed by those registered with a North Denbighshire GP Practice. ED attendances with a principal diagnosis of diabetes account for around 0.7% to 1.2% of all ED attendances (excluding maternity and mental health).

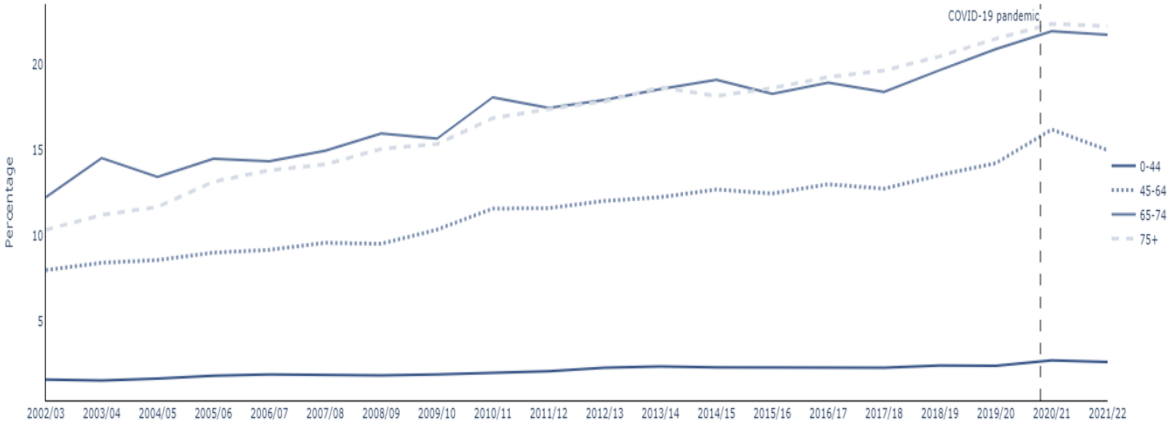
6.2 Hospital Admissions, Wales

In 2021/22, more than one in ten inpatient admissions (11%) across Wales were to patients with diabetes (any mention). In 2019/20, more than one in five of all hospital admissions for people aged 65 years or older included diabetes as a primary or secondary diagnosis (Public Health Wales Observatory, 2023). Diabetes-related hospital spells across Wales were estimated to cost £428 million in 2021/22.

6.3 Hospital Admissions, Betsi Cadwaladr UHB

The figure below shows a steady increase in the percentage of total inpatient admissions with any mention of diabetes in BCUHB since 2002/03.

Percentage of total inpatient admissions with any mention of diabetes (E10-E14), by age group, persons all ages, Wales, 2002/03 to 2021/22
Source: Public Health Wales Observatory



In BCUHB in 2021/22, there were over 17,000 diabetes related spells (excluding amputations), with an emergency, elective or transfer admission method; the average cost is around £5,200 per spell.

The Central IHC has the highest number and proportion of total admissions (41%) of patients with a primary diagnosis of diabetes, admitted into a BCUHB hospital by IHC and per 1,000 head of resident population; the East IHC has the lowest numbers. However, there will be more admissions to non-BCUHB hospitals for this group of patients, which are not included in these figures. The Central IHC also has the highest rates of admissions for Type 1 and Type 2 diabetes.

In 2022/23, over 25,800 residents of BCUHB were treated as inpatients with a diagnosis of diabetes in any position in a hospital within or outside BCUHB.

6.4 Emergency Admissions

The highest number of emergency admissions with diabetes mentioned in any position, from April 2021/22 to July 2023/24, was in the Central IHC. At Primary Care Cluster level, the highest numbers were on the Isle of Anglesey and in North Denbighshire.

6.5 Hospital admissions by diagnosis and age group

Type 2 diabetes accounts for the vast majority of diabetes emergency admissions. The highest number of admissions were among those aged 80 years and over, and were higher for males compared to females.

6.6 Bed days

Occupied bed days are the sum of the number of occupied beds for each day of the period by patients. Diabetes as a primary diagnosis accounted for just over 9,000 beds days (an average of 25 beds per day) across BCUHB in 2022-23 compared to over 13,000 in 2021-22. Wrexham Maelor hospital has the highest number of bed days.

6.7 Length of Stay

The average length of stay is the average number of days that a patient spends in hospital. It is generally measured by dividing the total number of days stayed in hospital by all inpatients during the period by the number of discharges. The average length of stay for emergency admissions for diabetes in all diagnosis positions in BCUHB during 2021/2023 ranges between approximately 8-11 days. Endocrinology has the longest length of stay followed by general medicine.

6.8 Hospital admissions by deprivation

In Wales and BCUHB, the percentage of total inpatients with any mention of diabetes is higher for residents from the most disadvantaged areas compared to the least deprived.

6.9 Paediatrics hospital admissions

There were 55 Children's Ward admissions in BCUHB between 1st January 2023 and 27th February 2024.

6.10 Outpatient Activity

The endocrinology specialty includes diabetes and the following conditions:

- thyroid disease
- lipid disorders
- endocrine disorders of the reproductive system, such as polycystic ovary syndrome
- adrenal disease
- bone and calcium disorders
- pituitary disease
- endocrine late effects of cancer treatment

New outpatient attendances are increasing year on year. The largest number of endocrinology outpatient attendances are by people in the 50 to 59 and 60 to 69 year old age groups, and is higher among females compared to males.

In 2023/24, there were just over 5,900 endocrinology outpatient referrals in BCUHB. The highest number of referrals were made by a General Medical Practitioner, followed by a Consultant or Independent nurse other than in an A&E Department. The East has the highest number of urgent referrals across the health board and they have been consistently higher than their routine referrals since 2019/20. The highest endocrinology appointments DNAs are in the 18 to 29 year old age group and amongst female patients.

6.11 Dietetics

All referrals to dietetic diabetes services in BCUHB are entered onto an electronic records system (Therapy Manager) and added to a waiting list for triage. The average number of patients referred to the service in 2022 and 2023 were 940 in the West IHC, 1,156 in the Central IHC, and 1,095 in the East IHC. Differences in numbers may reflect the differences in population size and age, coding and recording practices, different services and skill mixes, and varying levels of complexities of conditions in each Area. Further details of the dietetic diabetes services in each IHC are provided in the full report.

6.12 Bariatric Surgery

Bariatric/obesity surgery in Wales is commissioned by the Welsh Health Specialised Services Committee (WHSSC) from two providers. The Welsh Institute of Metabolic and Obesity Surgery (WIMOS) in Swansea Bay University Health Board provides services for patients in South Wales, and services for patients from North Wales and Powys are provided by the Salford Royal Hospital. The WIMOS is the larger of the two providers and is commissioned to deliver 100 procedures per annum, comprising a mix of new interventions and revisions; the Salford Royal Hospital has historically been funded to deliver as many procedures as is required, which is helped by the low number of referrals from North Wales.

Over the course of the last year, the Salford Royal Hospital has struggled to return to their pre-Covid position (a situation which the hospital has indicated is unlikely to improve); over the same period, the number of referrals from BCUHB's maturing Level 3 service has grown notably. The result has been low activity levels (only a handful of procedures delivered per year) and growing referrals combining to deliver a worsening waiting list position and regional inequity. Work to explore whether WIMOS – where longstanding performance issues have been addressed over the course of the last 18 months – can temporality provide capacity for BCUHB and North Powys is ongoing,

although there has been no decision thus far; WHSSC will also be investigating whether there is scope for an alternative English provider.

6.13 Welsh Ambulance Service Trust activity

Diabetes related 999 calls
The 999 call data related to diabetes for BCUHB (January 2022 – February 2024) show that a total of 1,405 emergency calls were made, with the highest proportion from Gwynedd (22%) and the lowest from Anglesey (10.2%). People aged 65 years and over account for 42% of all diabetes related 999 calls. 34% of all 999 calls related to diabetes were cancelled prior to arrival of an ambulance and 24% of individuals were taken to hospital.

Diabetes related 111 calls
919 diabetes-related calls were made to 111 during January 2022–February 2024, with the majority (76%) relating to diabetes concerns. Almost 42% of calls were concerning people aged 65 years and over. Almost 16% of calls were streamed to A&E and 14% were streamed to Primary Care Out-Of-Hours services within one hour. Just under 8% of calls resulted in an emergency ambulance being arranged.

7. Complications of diabetes

Diabetes can cause other health problems if it is not managed properly, including eye and sight problems, nerve damage, heart and circulatory diseases, and diabetic ketoacidosis, which mostly affects people with Type 1 diabetes (British Heart Foundation, n.d). Securing consistent delivery of all three NICE treatment targets is key to avoiding such complications, and will result in both financial savings and improved patient outcomes.

The latest data for BCUHB (2020) shows that heart failure admissions were the largest complication from all diabetes. Were Type 1 and Type 2 is specified, chronic kidney disease is recorded as the largest complication.

7.1 Amputations

In 2022/23, diabetes related hospital spells in Betsi Cadwaladr UHB that required an amputation (total of 129 spells) cost over £14,000 per spell and averaged 20 days in hospital. Recently published trend data (April 2016 to November 2023) from the NHS Wales Executive for shows that there were 809 admissions for amputation procedures with diabetes in any diagnosis position in BCUHB, which accounted for 69% of all amputations across BCUHB with any diagnosis.

Trend data from 2009 to 2020 from the National Diabetes Audit dashboard shows the number of major amputations have been increasing in males with Type 2 diabetes and females with Type 1 diabetes.

7.2 Diabetic Foot

Diabetes may lead to poor circulation and reduced sensation in the feet and legs. It is estimated that around 2,000 people with diabetes in Wales have foot ulcers at any given

time with around 330 amputations carried out each year (Diabetes UK, n.d). Podiatry for people with diabetes is one of the most overlooked aspects of diabetes management. Data from the National Diabetes Footcare Dashboard shows that 62.2% of people with diabetes have the first expert assessment by the specialist footcare service within 0 to 13 days, compared to 68.6% across Wales (National Diabetes Footcare Audit Dashboard, 2023). The percentage has declined in BCUHB from 80% in 2018/19 to just over 62% in 2022/23.

7.3 Kidney disease

Almost one in five people with diabetes will require treatment for diabetic nephropathy (Diabetes UK, n.d.). Kidney disease counts for 21% of deaths in Type 1 diabetes and 11% of deaths in Type 2 diabetes (Kidney Research UK, 2018). The number of chronic kidney related cases for people with Type 1 and Type 2 diabetes in BCUHB has increased significantly between 2009 and 2020, with numbers consistently higher for females than males. This increase over time reflects the increase in prevalence of Type 2 diabetes in the population.

8. Mortality

Diabetes related mortality is increasing across Wales; since July 2021, the observed age-standardised rate has been consistently higher than the comparator rate, which is the mean value for the previous five years excluding 2020. As these are age-standardised rates, the rising mortality cannot be attributed to the aging population (Public Health Wales Observatory, 2023).

In most months since the beginning of 2020, the age-standardised mortality rate with any mention of diabetes, but excluding Covid-19, has been higher than the average value of the previous five years, excluding 2020. BCUHB has the second lowest European Age-standardised Rate (EASR) in Wales and has been consistently below the Welsh average since 2014-16.

The diabetes mortality EASR difference between the most and least deprived fifths of the Welsh population has more than doubled, from 37 per 100,000 in 2002, to 87 per 100,000 in 2022 (Public Health Wales Observatory, 2023). The picture is similar in BCUHB, where mortality with any mention of diabetes is higher in the most deprived fifth than the least deprived fifth. This inequality gap has generally increased over time which is concerning.

Inpatient mortality for people with diabetes is considerably higher than for people who do not have diabetes.

9. Medicines Management Information

Wales
During the period 2014/15 to 2022/23, the number of items prescribed to treat and manage diabetes in Wales rose by around one third; the net cost of drugs prescribed to treat and manage diabetes almost doubled to £105 million during this period.

Betsi Cadwaladr UHB

During the period 2014/15 to 2022/23, the number of items prescribed to treat and manage diabetes in BCUHB increased from just over 677,900 to almost 892,000; the net cost of drugs prescribed to treat and manage diabetes rose from £12.5 million to £20.4 million over the same period, an increase of around 63%.

The cost of treating the complications of diabetes is much higher than the cost of treating the disease, with estimates suggesting that for every £1 spent on diabetic medicines, £2 will be spent on non-diabetic medicines for diabetic patients. (Diabetes.co.uk, 2023). The cost of supplying diabetic and non-diabetic medicines to diabetic patients will therefore be in the region of £60 million, which exceeds 40% of the total primary care prescribing spend. With no access to disaggregated prescribing data within NHS Wales, it not possible to accurately quantify this figure.

The data on Primary Care Cluster diabetes related prescribing costs per 10,000 population shows that North Denbighshire has the highest costs across the health board region (£929,000) and Arfon the lowest (£502,500); the BCUHB average was £659,600. Insulin accounts for the highest costs and the second highest number of items prescribed by General Practice in 2022/23. Metformin hydrochloride is the largest item prescribed and accounts for 6% of annual costs of diabetes medications, the third lowest item.

Community Pharmacies in North Wales do not currently collect data on specific diabetes services.

10. Finance

It is widely recognised that approximately 10% of NHS expenditure goes on treating diabetes and the complications of diabetes (NHS England, n.d). BCUHB's expenditure for the 2022/23 financial year was £2 billion. Treating diabetes in its broadest sense could therefore be costing the health board circa £200m per annum.

10.1 Programme budgeting

Programme budgeting is a financial method that health boards in Wales use to identify all health and social care expenditure, including primary care services, to programmes of care based on medical condition, including diabetes.

While programme budgeting supports cross-organisation comparison, the method does not capture the true cost of treating a condition. The data below identifies a figure of £33m which has been directly attributed to diabetes. While useful for comparison purposes this will be significantly below the true cost of diabetes care incurred by the health board.

The total expenditure for diabetes and the percentage of total BCUHB expenditure on diabetes amounted to over £32 million in 2022/23, and 1.63% respectively. In 2019-20, expenditure was just under £26.9 million and the percentage of total expenditure 1.67%. Primary care expenditure dwarfs secondary care by a factor of about 3:1.

The average cost per diabetic patient resident in BCUHB are based on the 2021/22 number of patients aged 17 years and over registered by their GP practice as having diabetes, plus an estimated figure of 450 patients aged under 17 years. The cost in 2022-3 has been calculated as just over £700. Again, this is likely to be a large underestimation. Elsewhere in the literature, a range of costs have been estimated from

around £3,000 per diabetes patient per year (NHS England, 2016) and US $5,859.30 (International Diabetes Federation, 2021).

There has been an overall increase in expenditure per BCUHB resident for diabetes in since 2019-20. However, BCUHB spending per head is lower than the average for Wales and all other health board regions, and has been consistently lower than Wales since 2019-20.

10.2 Diabetes expenditure

Finance data from the recently published by the NHS Executive show costs per spell for diabetes compared with non-diabetes inpatients at Primary Care Cluster level. The average costs per spell of diabetes-related inpatient care in 2022/23 in BCUHB was £4,746, compared to £2,750 non-diabetes inpatients. Variation across Primary Care Clusters can be explained by factors such as the age profile of the population and local practice.

The longest lengths of stay across BCUHB are for patients with Type 2 peripheral circulatory problems. The overall cost of hospital admissions with primary diagnosis of diabetes is £4.3 million during 2022/23. The highest percentage cost seems to be Type 2: peripheral circulatory problems. The average length of stay for the East Area will be higher, reflecting the inclusion of the two rehabilitations wards in Wrexham.

Further details on the costs of diabetic care in secondary care are provided in the full report.

11. Procurement

An all-Wales Framework Agreement is in place to manage the procurement of Diabetes Technology (NHS Wales Shared Services Partnership-Procurement Services, 2021). A number of technology providers are managed on this Framework to enable patient choice and clinical recommendations.

In accordance with NICE Guidelines, patients have the right to choose the technology provider in respect of their Insulin Pump. In December 2023, a NICE Technology Appraisal (TA) mandated hybrid closed looping (HCL) which comprises of three elements: a pump; continuous glucose monitor (CGM); and an app which enables these two elements to communicate. NHS Wales are currently embedding a five-year implementation plan to align with the TA. The priority groups are:

- children and young people;
- people planning pregnancy and those already pregnant;
- those diagnosed since the start of the COVID-19 Pandemic; and
- those patients on non-HCL pumps would be transferred to HCL systems if the teams felt that this could be achieved with ease.

The NICE TA evidences that HCL is the most effective method for managing diabetes, resulting in reduced hospital admissions and complications. The TA also establishes a cost effectivity threshold that technology providers are being asked to meet. Alignment with the TA is being led pan Wales with local health boards developing business cases to support the move to HCL. Insulin used in the pumps and flash glucose monitoring (both able to be prescribed) are not managed via the all Wales Framework Agreement.

12. BCUHB Diabetes Workforce

A range of healthcare staff look after people with diabetes and help them manage their condition. In primary care this includes the GP, often the first point of contact, as well as the practice nurse and district nurse. Other primary care staff include the dentist, optometrist and community pharmacist. In secondary care, staff who look after diabetes patients include the consultant diabetologist, diabetes specialist nurse, pharmacist, ophthalmologist, podiatrist, dietician and psychologist. The table below shows staff in diabetes posts directly employed by BCUHB. This does not include those who work in primary care. (we need to discuss if/how this information could be identified)

Please refer to the full report for further details on the BCUHB workforce in diabetes departments across BCUHB IHCs, and for BCUHB teams that have diabetes in their title, but are sitting within specialities outside the diabetes department.

It is understood that recruitment to medical consultant posts has been particularly difficult (Lewis, J. 2023). There are some examples of where virement has been used to attract a broader MDT that can competently meet the level of clinical competence necessary.
Diabetes Specialist Nurses (DSN's) regularly lead clinical service delivery to ensure that Super Six activities continue, in the absence of medical consultant availability (Lewis, J. 2023). Every Band 7 DSN in BCUHB is a non-medical prescriber. It has been noted that is has been challenging for the Health Board to attract experienced DSNs (Lewis, J. 2023). Furthermore, a high proportion of the existing East and Central IHC DSN workforce are due to retire within the next three years. Training a DSN takes up to three years, but it has been noted that their impact is significant, once fully trained, in terms of supporting both the person with diabetes and the MDT (Lewis, J. 2023).

In BCUHB, there has been a proactive approach to support Master's level study as the role requires advanced specialist clinical competence at post graduate level, especially as DSN's are increasingly leading clinical services and practising as 'the clinical expert' in a range of settings (Lewis, J. 2023). However, career progression beyond Band 7 is generally not in place in BCUHB. It might be more attractive to pursue an advanced practice pathway for nurses who are seeking to progress their careers through a clinical route (Lewis, J. 2023).

Staff in diabetes posts (not including Primary Care), Betsi Cadwaladr UHB, as at 31st January, 2024

	Organisation Name	Staff Group	Position Title	Pay Band	FTE
Health Community: Centre	**Diabetes Snr Medical YGC E-R**	Medical and Dental	Consultant	M&D	1.00
	Diabetic Liasion Nurse	Additional Clinical Services	Diabetic Healthcare Technician	Band 3	2.50
		Nursing and Midwifery Registered	Nurse Consultant	Band 8c	0.60
			Specialist Nurse Practitioner	Band 6	2.29
				Band 7	5.68
				Band 8a	0.80
Centre Total					**12.9**

	Organisation Name	Staff Group	Position Title	Pay Band	FTE
Health Community: East	**Maelor Diabetes Medical**	Medical and Dental	Ad-Hoc Locum Consultant	M&D	1.00
			Consultant	M&D	4.00
			Locum Fixed Term Consultant	M&D	1.00
			Locum Foundation Year 1	M&D	1.00
			Locum Foundation Year 2	M&D	2.00
			Specialty Doctor (2021 contract)	M&D	0.60
			Specialty Registrar	M&D	2.00
	Maelor Mason Wd - Diabetic Nursing E-I	Additional Clinical Services	Senior Healthcare Assistant	Band 3	0.61
		Nursing and Midwifery Registered	Specialist Nurse Practitioner	Band 6	0.85
				Band 7	5.01
	Renal & Diabetic OP Nurses YWM	Additional Clinical Services	Healthcare Assistant	Band 2	2.55
		Nursing and Midwifery Registered	Registered Nurse	Band 5	1.43
East Total					**22.1**

	Organisation Name	Staff Group	Position Title	Pay Band	FTE
Health Community: West	**Diabetes Medical**	Add Prof Scientific and Technic	Physician Associate	Band 7	3.00
		Medical and Dental	Ad-Hoc Locum Consultant	M&D	1.00
			Consultant	M&D	2.00
	YG Diabetic Liaison Nursing E-R	Additional Clinical Services	Healthcare Assistant	Band 2	0.50
		Nursing and Midwifery Registered	Modern Matron	Band 8a	0.90
			Specialist Nurse Practitioner	Band 6	1.00
				Band 7	6.87
West Total					**15.3**

BCUHB Total	**50.2**

Source: Betsi Cadwaladr UHB

Staff sickness related to diabetes

A total of 637 calendar days were lost to diabetes related sickness in BCUHB staff over a 12-month period; the majority of sickness was due to insulin-dependent diabetes.

13. Patient Experience

The results of patient surveys for those using the Renal & Diabetic (Gladstone) Unit; Renal & Diabetic Unit; and Renal & Diabetic Outpatients services in Ysbyty Glan Clwyd and Wrexham Maelor was generally positive in terms of patient satisfaction. However, only 18.2% of respondents reported being able to speak to staff in Welsh, if they wanted to. The Ysbyty Gwynedd diabetes services are not mapped to the Civica feedback surveys and therefore there is no data available for this area.

Six complaints were made against BCUHB by a patient/family member between Quarter 2 and Quarter 4, 2023; the majority of the complaints were investigated under Putting Things Right regulations. The PALS system recorded 15 enquiries requesting assistance/information regarding diabetes over the same period.

14. Conclusions

It can be seen that both due to the aging of the population of North Wales and also the rise in obesity, the number of people registered as having diabetes in BCUHB has increased by 14,000 people (43%) between 2009/10 and 2021/22. The growth in Type 2 diabetes, in particular, is exceeding capacity to offer planned fundamentals of diabetes care within the current primary care approach (Lewis, J. 2023).

The prevalence of diabetes will continue to go up (by 32% between now and 2035) if we do not reverse the rising trend of obesity in our population. To do this we need to both increase physical activity levels, as well as increase the proportion of the population that follows a healthy and balanced diet. This needs to start early in the life-course before these patterns of behaviour become ingrained. There are a number of other risk factors for diabetes that need to be tackled such as tobacco smoking and alcohol. We also must urgently tackle health inequalities as the impact of diabetes, particularly on our more disadvantaged communities, is stark.

The vast majority of activity to prevent and manage diabetes lies in primary care and this should remain so. It is clear from the data presented in this report, for example the disappointingly low completion of the eight care processes, that there needs to be improvement in the way that diabetes is managed in primary care in North Wales. Furthermore, there needs to be an expansion in diabetes prevention programmes in North Wales, for example the All Wales Diabetes Prevention Programme, as well as a pan Health Board approach to offer remission programmes for people with Type 2 diabetes (Lewis, J. 2023).

There are many aspects of diabetes care in North Wales that are examples of good practice for example, the work to develop the Long-Term Conditions Hub, but there is a definite need to reduce variation and improve service consistency across the region. Much of the success so far has happened through building better relationships and increasing clinical trust – which, in many settings, transcend the contractual challenges, especially when the benefit to the patient is realised (Lewis, J. 2023).

Any improvements need to be owned and adopted at scale to have a whole system impact. There is also an urgent need to explore other more sustainable and effective system wide options to improve equity of access to improved diabetes care outside of the usual service models (Lewis, J. 2023). This could consider cluster-based approaches that improve access to DSN's and Diabetes dietitians working in community settings, by utilising funds that have historically been ring-fenced for enhanced primary care (diabetes) services (Lewis, J. 2023).

There needs to be greater update of current diabetes education programmes by patients. We need to support existing education programme to offer a virtual structured education programme for those newly diagnosed with Type 2 diabetes (Lewis, J. 2023). This will facilitate signposting based on the individual need to: weight management, self-management (X-pert / DSMEd / MyDesmond) and remission programmes (Lewis, J. 2023). Once accredited, this should satisfy QAIF for referral to a recognised diabetes self-management programme.

The longer-term benefit of prevention and remission strategies, plus uniform access to specialist practitioners in diabetes that are Cluster based, should have a positive impact upon the referral rate into and repatriation from specialist diabetes service (Lewis, J. 2023). This should enable more timely access for patients who need more advanced diabetes management support from a medical consultant led diabetes service with three dedicated diabetes inpatient MDTs. What it will not provide is sufficient resource to

manage the growth in demand for novel technologies; this will need detailed service modelling to create a case for investment (Lewis, J. 2023).

There needs to be a review of the contribution of the specialist workforce structure as a whole, in order to determine where the highest value contribution within a diverse MDT lies. A better model should attract external applicants to North Wales, encourage the growth of a sustainable MDT, as well as provide responsible career progression opportunities for those competent to advanced practice and consultant practitioner level (Lewis, J. 2023). Similarly, there is a case for change where non-registered health professionals can play an important contribution to the specialist MDT, with education; screening; nutrition support; and youth support work (Lewis, J. 2023).

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Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

BCUHB Diabetes Data & Service Profile – Summary of the key findings

V0a, 22/8/24

1. Purpose

The aim of this paper is to summarise the key messages and evidence from the full Profile report, in order to inform the development of the BCUHB Diabetes Transformation Project. It should be read in conjunction with the two other summary papers, namely 'Best Practice in Diabetes Services in Primary and Community Care', and 'Diabetes Technologies'. This paper is presented in the following sections:

- 2: Diabetes context
- 3: Epidemiology of diabetes
- 4: Risk factors for diabetes
- 5: Primary care diabetes activity and services
- 6: Secondary care diabetes activity and services
- 7: Complications of diabetes
- 8: Mortality
- 9: Medicines management
- 10: Finance
- 11: Procurement
- 12: BCUHB diabetes workforce
- 13: Patient experience
- 14: Conclusions

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2. Diabetes Context

Diabetes is a chronic and progressive disease, which if left uncontrolled can lead to severe illness such as heart disease, stroke, amputation, blindness and kidney failure. However, risks of complications are reduced if the condition is carefully managed and individuals have healthy lifestyles and good glucose control.

There are two main types of diabetes: Type 1 diabetes and Type 2 diabetes. In addition, gestational diabetes is diabetes that can develop during pregnancy. The condition is less common than Type 1 or Type 2 diabetes, but the prevalence has been increasing. In 2021/22, almost one in 12 people aged 17 years and over were diagnosed with Type 1 or Type 2 diabetes in Wales (8.0%). Between 2017-18 and 2021-22, there was a percentage increase of 18.7% in Type 2 diabetes among those aged under 40 compared to an increase of 11.3% in those aged between 40 and 79 years.

3. Epidemiology of Diabetes

In 2021/22, almost one in 12 people aged 17 years and over were diagnosed with Type 1 or Type 2 diabetes in Wales (8.0%), which is an increase of almost 60,000 people (40%) in the 12 years to 2021/22. Over the same time period, the number of people registered as having diabetes in BCUHB increased by 14,000 people (43%), which is mostly due to an increase in Type 2 diabetes. Diabetes prevalence is higher in the older population.

The percentage of adults registered by their GP as having diabetes in BCUHB (7.9%) is similar to the Wales average. The prevalence across BCUHB Primary Care Clusters, which range from 6.4% in Arfon to 9.3% in Meirionnydd. In terms of numbers, Isle of Anglesey and North Denbighshire Primary Care Clusters have the highest numbers of patients with diabetes. There is considerable variation in prevalence rates between them. It is important to note that QAIF data only provides recorded prevalence; it does not refer to or report on expected prevalence or estimated prevalence.

Recently published data from the Diabetes Insight & Variation Atlas provides the prevalence rate per 10,000 population.

Diabetes prevalence per 10,000 population, Betsi Cadwaladr UHB and Primary Care Clusters, 2022-23

	per 10,000 population
Betsi Cadwaladr UHB	791
Anglesey	899
Arfon	658
Dwyfor	1,259
Meirionnydd	525
Conwy East	899
Conwy West	756
North Denbighshire	905
Central & South Denbighshire	746
North East Flintshire	732
North West Flintshire	763
South Flintshire	764
North & West Wrexham	768
Central Wrexham	759
South Wrexham	763

Source: Diabetes Insight & Variation Atlas (NHS Wales Executive)

- Type 1 and Type 2 diabetes are more prevalent in males (53.7% Type 1 and 55.9% Type 2) compared to females (43.3% and 44.1%) in BCUHB.
- The prevalence of diabetes rises steeply with age: one in 20 people over the age of 65 in the UK has diabetes and in people over the age of 85 years this rises to one in five. The population of North Wales is aging which will increase the burden of diabetes.
- People from Black African, African Caribbean and South Asian backgrounds are at a higher risk of developing Type 2 diabetes from a younger age.
- People living in the most socio-economically disadvantaged communities have much higher rates of both Type 1 and Type 2 diabetes.
- There were 139,255 people with Type 2 diabetes under the age of 40 years, accounting for 4.8% of all Type 2 diabetes cases under the age of 80 in England and Wales. Between 2017-18 and 2021-22, there was a percentage increase of 18.7% in Type 2 diabetes among those aged under 40 (Figure 29 and Table 36) compared to an increase of 11.3% in those aged between 40 and 79 years.

3.1 Future prevalence of diabetes

The projected trends (medium projection scenario) of diabetes, based on patients registered with a GP in BCUHB, indicates that the number of diabetes registrations is predicted to rise from 46,994 in 2022/23 to 61,861 in 2035/36. This represents an increase of 31.6%, compared to 29.6% across Wales.

4. Risk factors for diabetes

Type 1 diabetes is caused by an absolute insulin deficiency, which usually results from autoimmune destruction of the insulin producing beta cells in the pancreas (NICE, 2024a). Risk factors include genetic and environmental factors.

As well as increasing age, the key risk factors for Type 2 diabetes include (NICE, 2024b) are summarised below.

4.1 Healthy Weight

Obesity accounts for 80-85% of the risk in developing Type 2 diabetes and is the predominant risk factor. Adults reporting to be obese (BMI of 30 or more) are more than twice as likely to have diabetes as those who do not (Public Health Wales Observatory, 2023).

4.1.1 Low birthweight

There is some evidence that preterm birth before 35 weeks of gestation is associated with an increased risk for Type 2 diabetes in later life. The proportion of low birth weight births in North Wales is similar to that of the Welsh average, and is decreasing over time. There is a strong link between low birth weight and socio-economic disadvantage, where the rate of low birth weight births in the most deprived quintile in Wales is 58% higher than in the least deprived quintile of the population (statistically significant difference). The key risk factor for low birthweight is maternal smoking and maternal exposure to environmental tobacco smoke.

4.1.2 Children and young people overweight and obesity

According to the most recent Childhood Measurement Programme report (2022/23), the proportion of children categorised as 'overweight not obese' in BCUHB was 13.8% (Wales average 13.4%), which was slightly lower compared with the 14.4% observed for BCUHB in 2021/22, and statistically significantly lower than the pre-pandemic 2018/19 report of 15.9%. The proportion of boys and of girls categorised as 'overweight not obese' was similar.

The proportion of children categorised as having obesity was 12.1% (higher than the Welsh average of 11.4%). This result was slightly lower than the 13.2% reported last year for BCUHB and the 12.8% reported in 2018/19. The proportion with obesity was higher for boys compared with girls at 13.1% versus 11.2%, respectively

There was a statistically significantly higher proportion categorised as having obesity in the most deprived quintile (13.9%) compared to the least deprived (9.3%) in North Wales. Children living in the most deprived quintile of deprivation were at a 50% higher risk of being obese than those living in the least deprived quintile, similar to the data for 2021/22.

4.1.3 Adult overweight and obesity

The percentage of adults reporting to be overweight and obese in BCUHB (58.9%) is below the average for Wales (61.8%); at unitary authority level, percentages range from 54.3% in Denbighshire to 62.7% in Conwy. The percentage of adults who report being obese in BCUHB (23.4%) is lower than the Wales average (25.4%) and ranges from 17.1% in Denbighshire to 29.8% in Gwynedd. The trend for adults with obesity in Wales is increasing over time, and will likely contribute to a subsequent increase in Type 2 diabetes.

4.1.4 Maternal overweight and obesity

Almost a third of women are defined as obese at their initial pregnancy assessment, and this seems to be increasing over time in line with the data for the general adult

population. Approximately 31.1% of women had a BMI 30+ (obese) at their initial assessment in 2022 both in BCUHB and at an all-Wales level.

4.1.5 Older people overweight and obesity

Obesity is also an issue in older adults, who are more likely to have Type 2 diabetes. The proportion of older people (aged 65+) in BCUHB (40.6%) is slightly higher than the Welsh average (39.6%). In North Wales, the lowest proportion of older adults of healthy weight are in Conwy UA (33.4%) and the highest proportion are in Flintshire (48.9%). Females are more likely to be of healthy weight compared to males.

4.2 Nutrition

4.2.1 Fruit and Vegetables

The proportion of adults in BCUHB (25.3%) who report eating the recommended portions of fruit and vegetables in 2021-23 is lower than the average for Wales (29.1%), with proportions ranging from 15.9% on the Isle of Anglesey to 29.2% in Flintshire.

4.2.2 Infant Feeding

Breastfeeding has both health benefits for babies and mothers. Breast milk provides a baby with optimal nutrition and supports healthy growth and development. There are inequalities in breastfeeding initiation and continuation rates, whereby mothers from disadvantaged communities are least likely to breastfeed.

Across BCUHB, 35.1% of babies are breastfed at 10 days, which is just below the average for Wales (36.2%). Across North Wales, breastfeeding at 10 days ranges from 30.7% in Denbighshire to 39.1% in Gwynedd. At Cluster level, percentages range from 25% in North West Flintshire to 48.4% in Meirionnydd.

Similar to other risk factor data presented in this paper, there are stark inequalities in breastfeeding rates based on socio-economic deprivation, where 26.8% of babies are breastfed at 10 days in the most deprived quintile in Wales, compared with 47.3% in the least deprived.

4.3 Physical Activity

People who have a physically active lifestyle have approximately 50% lower risk of developing Type 2 diabetes mellitus compared to those who have a sedentary lifestyle (Public Health Wales, 2016).

People in North Wales are becoming less active. Fewer than half of all adults (45.8%) meet the physical activity guidelines in 2022/23, which is lower than the proportion in 2020/21 (57.6%) and 2021/22 (52.6%), and significantly lower than the Welsh average (55.4%). In addition, 35% of adults in North Wales reported being inactive (doing less than 30 minutes a week of physical activity), which compares to 30% for the whole of Wales. Children and young people aged 11-16 years are also becoming less active, with just under 17 percent in North Wales achieving the recommended 60 minutes of physical activity that increases heart rate, per day.

4.4 Smoking

Tobacco smoking is a major cause of premature death and one in two long-term smokers will die of smoking related diseases (BCUHB, 2015). There is evidence that people who smoke cigarettes are 30% to 40% more likely to develop Type 2 diabetes than people who do not smoke.

In BCUHB, just under 11% of adults reported smoking in 2022/23 compared to almost 13% across Wales. At a local level, smoking ranges from 7.7% in Conwy to 14.9% in Gwynedd. There are stark differences in smoking prevalence between different socio-economic groups, with 21.8% of adults reporting to smoke in the most deprived areas of Wales compared to 7.1% in the least deprived areas.

Across BCUHB, 3.6% of 11 to 16 year olds report smoking weekly, which is just above the average for Wales (3.0%). Across the region, percentages range from 2.5% in Denbighshire to 4.3% on the Isle of Anglesey.

4.5 Alcohol

Alcohol is a significant risk factor for the major causes of premature death and a direct cause of 5% of all deaths in Wales (BCUHB, 2015). It is thought that excess alcohol intake is associated with an increased risk of Type 2 diabetes.

In BCUHB, 16% of adults report drinking alcohol above the weekly recommended guidelines in 2022/23, compared to 17.2% across Wales. Across the region figures range from 9.9% in Denbighshire UA to 20.4% in Flintshire. Drinking alcohol above recommended guidelines is significantly higher among adults in the least deprived areas (21.3%) compared to the most deprived areas of Wales (14.6%).

4.6 Family History

People with a parent, brother, sister or child with diabetes have a higher risk of developing diabetes.

4.7 Ethnicity

Black, Asian and Minority Ethnic (BAME) groups have a higher risk of diabetes. BCUHB has a lower percentage of non-white residents compared to the average for Wales. At UA level, Wrexham has the highest proportion of people who are Black, Asian and Minority Ethnic (4.5%), and lowest in Anglesey and Conwy (2.2%).

4.8 History of gestational diabetes

Women with a history of gestational diabetes have a seven-fold increased risk for developing type 2 diabetes in later life.

4.9 Drug treatments

Statins, corticosteroids and combined treatment with a thiazide diuretic and a beta-blocker can increase the risk of developing Type 2 diabetes.

4.10 Females with polycystic ovaries

Polycystic ovary syndrome (PCOS) is one of the most common endocrine disorders affecting women of reproductive age. The prevalence ranges from 2.2–26% (depending on the criteria used and the population studied) with many affected women undiagnosed (NICE; Prevalence | Background information | Polycystic ovary syndrome | CKS | NICE).

The cardio metabolic profile is adversely altered in PCOS, and many cardiovascular disease (CVD) risk factors (such as body mass index, dyslipidaemia, hypertension, insulin resistance, metabolic syndrome, and deficiencies in insulin secretion) are increased. Insulin resistance is present in around 65–80% of women with PCOS. This is independent of obesity but is further exacerbated by excess weight.

Insulin resistance has been shown to worsen reproductive and metabolic features and type 2 diabetes in PCOS. The prevalence of impaired glucose tolerance and type 2 diabetes (5-fold in Asia, 4-fold in the Americas, and 3-fold in Europe) are significantly increased in PCOS, regardless of the age of the person. This is independent of obesity but is further exacerbated by excess weight. About 20–40% of obese women with PCOS have glucose intolerance or type 2 diabetes by the end of their fourth decade.

4.11 Metabolic Syndrome

Insulin resistance is commonly associated with metabolic syndrome, which is a combination of high blood pressure, dyslipaemia, fatty liver disease, obesity and a tendency to develop thrombosis.

The risk of Type 2 diabetes is increased if a persons have ever had hypertension (Diabetes UK n.d.). In BCUHB in 2021/22, over 120,900 patients (17.0%) were registered by their GP as having high blood pressure, which is higher than the Welsh average of 15.7%, and ranged from 18.7% in the Dwyfor Cluster to 13.8% in Arfon. However, this could be an underestimate of the true number of residents with high blood pressure.

4.12 Inequality & Deprivation

Deprivation is strongly associated with reduced life expectancy and healthy life expectancy, as well as health care use. It is also associated with increased risk of Type 2 diabetes.

BCUHB has some of the most disadvantaged areas in Wales, particularly along the North Wales coastline. Rhyl West 2 and Rhyl West 1 are the first and second most deprived LSOAs in Wales. Denbighshire UA has the highest percentage of LSOAs in the most deprived 10% LSOAs in Wales also the greatest number of LSOAs in the most deprived 10%.

4.13 Other risk factors include mental health conditions such as schizophrenia, bipolar disorder and depression (Diabetes UK, n.d.).

The Primary Care Quality Assurance and Improvement Framework (QAIF) records the percentage of patients with Schizophrenia, Bipolar affective disorder and other psychoses who have a record of blood pressure, BMI, smoking status and alcohol consumption in the preceding 15 months and in addition to those aged 40 or over, a record of blood glucose or HbA1c in the preceding 15 months (Welsh Government, 2022).

The percentage of patients registered with GP practices who have been recorded as having a mental health condition ranges from 0.8% in South Flintshire to 1.4% in Central Wrexham.

5. Primary Care Diabetes Activity and Services

The vast majority of diabetes care takes place in Primary Care as planned contractual activity in chronic conditions (Lewis, J. 2023). For diabetes, this will include the annual review, interim review, completion of essential care processes and referral to national programmes such as Diabetes Eye Screening for Wales (DESW). This also comprises signposting to Health Board 'system wide' services (where they exist), such as prevention, remission, weight management and recognised self-care programmes (Lewis, J. 2023).

Data from the National Diabetes Audit (NDA) provides a picture of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards, which are (Primary Care Information Portal n.d.):

- Care processes;
- treatment targets; and
- structured education (most recent data is not available due to changes in data collection).

Outcomes from the NDA provide useful comparative information at Cluster level. While data is collected at GP Practice level, Digital Health and Care Wales is not able to share data at that level with Health Boards.

5.1 Care processes

A vital component for the effective prevention of diabetes complications is the Annual Review (Lewis, J. 2023), which consists of nine essential care processes, eight of which are the responsibility of GP Practices. These important elements of planned care identify treatable risks, reduce exacerbations and optimise effective care (Lewis, J. 2023). In addition, they provide important signposting to self-management programmes. The eight care processes NICE recommend are undertaken once a year are:

NICE care processes

1.	HbA1c – blood test for glucose control.
2.	Blood pressure – measurement of cardiovascular risk.
3.	Serum Cholesterol – blood test for cardiovascular risk.
4.	Serum Creatinine – blood test for kidney function.
5.	Urine Albumin/Creatinine Ratio – urine test for kidney function.
6.	Foot risk surveillance – foot examination for foot ulcer risk.
7.	Body mass index – measurement for cardiovascular risk.
8.	Smoking history – question for cardiovascular risk.

- In 2021-22, only 29% of people with diabetes received all eight care processes in BCUHB
- At an individual care process level (see Table below), the highest percentages are approximately 85% for serum creatine and 84% for HbA1c; the lowest were for Urine Albumin (46%) and Foot surveillance (50%).
- At Primary Care Cluster level, the percentage achieving all eight care processes range from 10% in Conwy East to almost 38% in North and West Wrexham. Although the latest data appears to show an improvement in percentages of care processes achieved between 2020-21 and 2021-22, they are not as high as pre-pandemic levels; this is similar across the whole of Wales (National Diabetes Audit, 2022).

Care processes, all diabetes, Betsi Cadwaladr UHB

Care Process	2019-20	2020-21	2021-22
Blood Pressure	90.32	72.74 ↓	79.94 ↑
BMI	78.40	60.97 ↓	69.02 ↑
Cholesterol	81.19	68.32 ↓	73.77 ↑
Foot Surveillence	67.08	37.87 ↓	49.57 ↑
HbA1c	89.81	79.18 ↓	83.71 ↑
Serum Creatinine	90.56	80.80 ↓	84.91 ↑
Smoking	88.46	77.81 ↓	79.90 ↑
Urine Albumin	53.33	38.97 ↓	46.43 ↑
All Eight Care Processes	40.97	20.61 ↓	29.03 ↑

Source: National Diabetes Audit; Primary Care Portal

For people with Type 1 diabetes, factors associated with reduced likelihood of receiving all eight care processes were younger age and people living in more deprived areas. The likelihood of receiving all eight care processes was increased in older people; people of Asian, Black or Mixed Ethnicity; people living in a less deprived area; and diabetes duration of one to four years and five to nine years (when compared with reference group of those with diabetes for 15 years and over) (National Diabetes Audit, 2022). For people with Type 2 diabetes, factors associated with achieving all eight care process were similar to those with Type 1. Reduced likelihood was also associated with females and diabetes duration of less than one year (National Diabetes Audit, 2022).

More broadly, increasing prevalence of diabetes, losing experienced staff and resulting recruitment difficulties, changes in systems of care delivery, diabetes indicators being

removed from QoF, and different perceptions of what constitutes 'primary care diabetes' have all contributed to worryingly low completion of care processes (Lewis, J. 2023).

A Diabetes Specification (DS) has existed in Wales as an additional Directed Fund to support practices to improve completion of the requirements for planned diabetes care (Lewis, J. 2023). However, it is understood that this specification has not had the anticipated impact (Lewis, J. 2023).

The attainment of all eight care processes for Type 1 diabetes in BCUHB (13.1%) should be of concern for people living with Type 1 as they may not be offered a recall for annual review in primary care, perceiving that this activity would form part of a secondary care appointment. A clearer pathway to support an improvement in eight care process completion in Type 1 diabetes is very much needed (Lewis, J. 2023).

5.2 Treatment Targets

Better management of diabetes is delivered through attainment of the treatment targets. The role of primary care in overall admissions avoidance through attainment of all three treatment targets is important (Admissions avoidance and diabetes, 2013), including through:
- structured and on-going patient education
- risk stratification
- delivery of the eight care processes
- a care planning approach to agreeing goals
- informing people with diabetes about how to prevent emergencies

The three treatment targets pertaining to diabetes that NICE recommend are:

NICE treatment targets

1.	HBA1c ≤ 58 mmol/mol
2.	Blood Pressure ≤ 140/80
3.	Statins for combined* prevention of CVD

** Combined prevention of CVD: The percentage of people with diabetes that fall into either of the primary or secondary prevention groups during the audit period:*
- *Primary prevention of CVD: The percentage of people with diabetes aged 40 to 80 years with no history of heart disease that received statins during the audit period;*
- *Secondary prevention of CVD: The percentage of people with diabetes (any age) with a history of heart disease that received statins during the audit period.*

In 2021-22, just over 27% of patients with diabetes in BCUHB received all three treatments recommended by NICE, compared to just over 31% in 2019-20, which is again disappointing. At Cluster level, the 2021-22 figure ranges from 21% in Conwy East to almost 29% in Central and South Denbighshire.

Across England and Wales, the achievement of all three treatment targets has improved for Type 1 diabetes (National Diabetes Audit, 2022). For Type 2 diabetes, there is a downward trend across England and Wales in blood pressure and HbA1c treatment (National Diabetes Audit, 2022); across BCUHB the picture is slightly different for HbA1c which has increased since 2019-2020.

5.3 Immunisations

Primary care provides vaccination services for patients with diabetes. Influenza immunisation uptake in people aged under 65 years with diabetes for the 23/24 Flu Season (data 23rd April 2024) in North Wales was 53.5%, compared to the Welsh

average of 51.4%. This ranged from 62.2% in Anglesey to 49.2% in Denbighshire; the target is 75%.

Pneumococcal vaccine coverage for those in the at-risk group with diabetes is above the Wales average across BCUHB as a whole (51.2% vs 41.1%), and at unitary authority level.

5.4 Primary Care Enhanced Services

The Negotiated Enhanced Services (NES) within the Diabetes Specification (DS) provides an opportunity for GP practices to improve the services they provide for patients with diabetes to include initiation and monitoring of diabetes injectable therapies, as well as encouraging repatriation from specialist outpatient services back to primary care (Lewis, J. 2023). It has been noted that the NES in its current state is increasing variation and inequity of access for people living with diabetes as it confuses the remit for contributing services by fixing service delivery within traditional models that are finding it difficult to cope with the increasing demand (Lewis, J. 2023).

Approximately 20 to 30% of people living with Type 2 diabetes will require insulin at some point in their patient journey, either as a temporary or permanent feature of their treatment plan. It has been argued that it is very difficult for a finite specialist resource in North Wales to cope with the influx of referrals of varying clinical indication, coupled with a rapid increase in demand upon specialist diabetes services due to NICE guidance position on glucose sensor technology in both Type 1 and insulin treated Type 2 diabetes (Lewis, J. 2023). Moving forward the new NICE Technology Appraisal for Hybrid Closed Loop systems in Type 1 diabetes will occupy a significant proportion of specialist diabetes activity.
The table below summarises how many (and %) of the 96 BCUHB GP Practices (that were outlined in the source data) provide the five types of enhanced services for diabetes. Further detail by individual Cluster is provided in the main Diabetes Profiled document.

Diabetes Gateway Module DES	**Injectable Incretin Mimetics Monitoring (Module 1) NES**	**Injectable Incretin Mimetics Initiation**	**Insulin Monitoring (Module 3) NES**	**Insulin Initiation (Module 4) NES**
77 (80%)	53 (55%)	54 (56%)	43 (45%)	42 (44%)

5.5 Locality/Cluster Based Diabetes MDT Service

Non-medical, locality-based, diabetes MDT posts (Diabetic Specialist Nurse (DSN)/ Dietitian and Healthcare technicians) were promoted through Programme Management Office (PMO) initiatives, and subsequently resourced via Primary Care funding and also Cluster funded in some areas (Lewis, J. 2023). Furthermore, by working jointly with primary care providers, care establishments and community nursing, it has been possible to create a more resilient diabetes service offer within the area served with a relatively modest investment (Lewis, J. 2023). This has facilitated integration, innovation, and timely access to specialist nursing support, weight loss, remission and prevention programmes (Lewis, J. 2023)

This service currently exists in eight out of fourteen Clusters, comprising of approximately 6.9 WTE Diabetes Specialist Nurses, 2.9 WTE Diabetes Dietitian, and 1 WTE Diabetes Healthcare Assistant. Funding for these posts is not uniform (Lewis, J. 2023). It has been noted that, if this type of approach was available across BCUHB, we would be in a stronger position to manage the majority of Type 2 diabetes services outside of the hospital outpatient setting (Lewis, J. 2023). This would, in turn, allow the hospital-based diabetes teams to focus on delivering the 'Super Six' diabetes services.

5.6 Cluster-based Long Term Conditions Hub (The North Denbighshire Transformation Project)

This Cluster based initiative, funded through Transformation in September 2021, involved the creation of a one-stop diabetes hub. The model completes all eight essential care processes in diabetes annual reviews and uses the clinical assessments and Point of Care Testing (POCT) results to develop a negotiated care plan with the person who has diabetes in one practice visit. It further addresses the cardiovascular, renal and metabolic risk reduction and provides signposting to self-management resources.

For individuals who attended the 'hub' model, between 74.9% and 91% achieved completion of all eight care processes, which compares favourably with the BCUHB average of 29% in 2021-22 (for both Type 1 and Type 2 diabetes). The service has potential to expand for people living with other chronic conditions (Lewis, J. 2023).

Patients have valued the opportunity of completing all their care processes, receiving their results during their appointment and consulting with a diabetes expert to re-negotiate an agreed care plan in a single visit (Lewis, J. 2023). There is a service evaluation and BCUHB have also just had a successful bid for a med-tech accelerated evaluation for the next (last 12 months) of the project.

CMC/North Denbighshire LTC Hub, July – November 2022

	Number	Percentage attendance
Patients invited	522	
Patients attended	460	88

	Number	Percentage completion
BP recorded	442	96.0
HbA1c	430	93.4
Lipids	367	79.7
Foot checks	391	85.0
Creatinine	343	74.5
Albumin	338	73.4
BMI	443	96.0
Smoking status	433	94.0
8 Care process completion average		87.0

Data based on 2 clinic days per week utilising branch practice clinic site (Ty Elan).

5.7 All Wales Diabetes Prevention Programme

The All-Wales Diabetes Prevention Programme (AWDPP), developed nationally by Public Health Wales, offers targeted dietary and physical activity support to individuals who are at increased risk of Type 2 diabetes. This brief intervention is cost effective to deliver, as demonstrated by economic analysis from Swansea University (Lewis, J. 2023). In BCUHB, the AWDPP is currently delivered at two pilot sites in the West, namely Meirionnydd (Dolgellau, Tywyn and Bala Surgeries) and Anglesey (Biwmaris, Llanfairpwll). Many other Health Boards in Wales have widened this service beyond the initial Public Health Wales financed pilots and now incorporate it as a core funded service across their Health Boards (Lewis, J. 2023). Key findings following the initial 12 month review include:

- 31% of patients have been referred for National Exercise Referral Scheme (NERS) and 36% for weight management services; however, it is unclear if they have engaged with services
- There appears to be a higher percentage of patients improving their HbA1c when they have attended the diabetes prevention program than not; however, at present this data is currently based on a small number of patients and further data is being collected.

5.8 Psychology services for diabetes

There is strong evidence that people living with diabetes experience higher levels of psychological distressed compared to people without diabetes (Diabetes UK, 2019). The All Wales Diabetes Implementation Group state that psychological care for people living with diabetes should be integrated, accessible and flexible and with a stepped-model of care approach.

Examples of good practice include:

- SEREN Connect: an education programme for young people with diabetes moving from paediatric to adult diabetes services that integrates psychological knowledge throughout.
- Talking Type 1: a book range developed to meet some of the unmet psychological need for people living with diabetes.

5.9 Remission and weight loss treatment of Type 2 Diabetes

The Public Health Wales Counterweight project is offered to people diagnosed with Type 2 diabetes (less than six years duration) in Gwynedd and Anglesey, and utilises weight loss as an effective treatment (do we have more data on this?) for Type 2 diabetes (Lewis, J. 2023).

In addition, funding from Strategic Planning for Primary Care (SPPC) has enabled the development of a digital virtual group low calorie programme. This investment followed on from work undertaken by the East diabetes team collaborating with primary care diabetes services to offer supported weight loss as an effective treatment for type 2 diabetes (Lewis, J. 2023).

5.10 Dental Services

People with poorly controlled diabetes have a higher risk of tooth and gum problems. People with diabetes access their dental care through NHS dentists or privately. NICE guidance recommends that periodontitis is discussed as part of the plan of care for patients with diabetes and gum inflammation. There is no specific data available on dental patients with diabetes.

5.11 Optometry services

Diabetic eye screening comes through the national screening programme run by Public Health Wales, and is therefore relatively 'light touch' with primary care Optometry. All patients with diabetes are, however, entitled to a free NHS eye examination (WGOS1 appointment) and Optometrists are well placed to identify diabetic retinopathy/maculopathy or other signs of concern. The new Optometry contract incorporates a greater focus on prevention and well-being, so diabetes has now been raised in a number of Optometry collaboratives/clusters as priority.

Outside of the national contract, BCUHB has a localised data capture pathway with 11 primary care practices to support secondary care with patients under their care for diabetic retinopathy. Under this pathway, a number of patients are seen for their 'in-person' assessment by a primary care Optometrist who captures the necessary data and scans/images before sending back to secondary care for medic review. This has proven very successful (Can we be more specific? Outcomes? Experience?) over the past 12 months or more. The new Optometry contract allows for more autonomous pathways in primary care, utilising Optometrists with higher qualifications. There are plans to work with BCUHB medical retina colleagues in secondary care to identify a safe cohort of patients that can be managed in primary care and this will very likely include a number of patients with diabetic retinopathy.

5.12 Diabetic Eye Screening

Diabetic eye screening is available for everyone aged 12 years and over with a diagnosis of Type 1 or Type 2 diabetes. Coverage across BCUHB (36.1%) (coverage still feels low given the risk/impact – do we know why? Access? Awareness?) is above the average for Wales (31.5%); at UA level, coverage ranges from 30.2% in Conwy to 42.1% in Flintshire.

During 2021/22, there were 10,135 results reported (some individuals may have been screened more than once in a year), with 5,436 records of no retinopathy and 3,737 records of any retinopathy.

5.13 Structured Education

Structured education (SE) is an important NICE recommended intervention to enable people with diabetes to manage their condition. A suite of education options is available via the Self Care team in BCUHB for patients living with diabetes or pre-diabetes, which include:

- Diabetes Self-Management Programme (DSMP): course to help adults living with type 2 diabetes to maintain and improve their quality of life through self-management.
- Diabetes Self-Management Programme (DSMP) & STANCE: A seven week programme covering the diabetes self-management programme and the STANCE diabetes foot education.
- X-pert Diabetes: Course for adults living with Type 2 diabetes, including those newly diagnosed following on from their attendance at the dietician group session.
- X-pert Insulin programme: Designed to help people living with type 2 diabetes and using insulin to self-manage their condition, health and quality of life.
- X-pert Weight: Course to help people to manage their weight in a healthy way.

- X-Pert Diabetes Education Apps: Some of the diabetes education programmes are now available in an App format, to enable access to the programmes at a convenient time of day and week. The eligibility for each of the programmes still applies.
- New to Type 2 Education: Dietetic led intervention seeks to ensure all people newly diagnosed with Type 2 diabetes have access to a reputable standard of education and signposting to further (accredited) self-management programmes.

DG comment: There is a lot of service activity data provided for each of the above, including the average completion rates, but it would be helpful to understand if the following is also available to in order to provide a better picture of the impact (and cost-effectiveness) of attending these courses:
- outcomes e.g. did people who attended have better clinical outcomes either pre-post intervention, or as a whole cohort compared to control groups i.e. those who did not attend the courses?
- do we have robust measures of the value of attending for patients (qualitative evidence)? Case studies?
- Do we know why people DNA/DNC?
- Do we know the number/% patients referred on to lifestyle support e.g. NERS?
- the offered/attended rates for Wales and BCUHB seem low – in particular for Type 1. Do we know why?

5.14 District Nursing

There are on average 2,650 diabetes related DN visits per week across the region (Feb 2023 – Jan 2024), equating to 138,000 visits for the 12 month period, with the vast majority relating to insulin care. The largest number of visits made are to patients aged 76 to 85 years, which accounted for just under 40% of visits.

6. Secondary Care Diabetes Activity & Services

Secondary care services are usually based in a hospital or clinic, though some services may be community based. They may include planned operations, specialist clinics, or rehabilitation services such as physiotherapy. There are three main acute hospitals in North Wales with Emergency Departments – Ysbyty Gwynedd, Ysbyty Glan Clwyd and Wrexham Maelor, plus a number of community hospitals, such as Llandudno.

The Super Six Specialist Diabetes Services describe the fundamental functions of an expected 'Specialist' diabetes MDT service offer (Lewis J, 2023).

The hospital-based specialist services in Ysbyty Gwynedd work towards this model for their outpatient activity only (Lewis, J. 2023). In order to manage the workflow, much of the diabetes patients outside of Super Six priorities in Ysbyty Gwynedd are either actively repatriated to primary care post-intervention (if the referral is outside of super six, but deemed clinically appropriate for specialist intervention), or are seen sooner and managed by the DSNs in joint primary care clinics (Lewis, J. 2023). Therefore, referrals are less likely from Anglesey and Arfon.

Posts supporting and working jointly in primary and community care settings have increased access to training, education and clinical support for people living with diabetes, as well as health professionals (Lewis, J. 2023). However, although the Ysbyty Gwynedd Diabetes team have not resolved the demand for outpatient diabetes activity, there is learning that can be shared to help improve the workflow between specialist and primary care health providers (Lewis, J. 2023). In contrast, Glan Clwyd and Wrexham Maelor are unable to move to this model due to the demand from non-Super Six outpatient activity (Lewis, J. 2023).

8.1 Emergency Department Attendances

The Emergency Department may well be a first point of call for someone with diabetes who suffers urgent complications. During the period 1st April 2021 to 22nd November 2023 the number of Emergency Department (ED) attendances with a principal diagnosis of diabetes, including those outside BCUHB (OBCU), have been 2,338; the largest number of attendances has been in Wrexham Maelor Hospital. The small numbers for Ysbyty Glan Clwyd in 2021-22 reflect the transition to the Symphony 'go live' at the end of 2022. At Primary Cluster level, the highest number of attendances were from patients from outside BCUHB followed by those registered with a North Denbighshire GP Practice. ED attendances with a principal diagnosis of diabetes account for around 0.7% to 1.2% of all ED attendances (excluding maternity and mental health).

8.2 Hospital Admissions, Wales

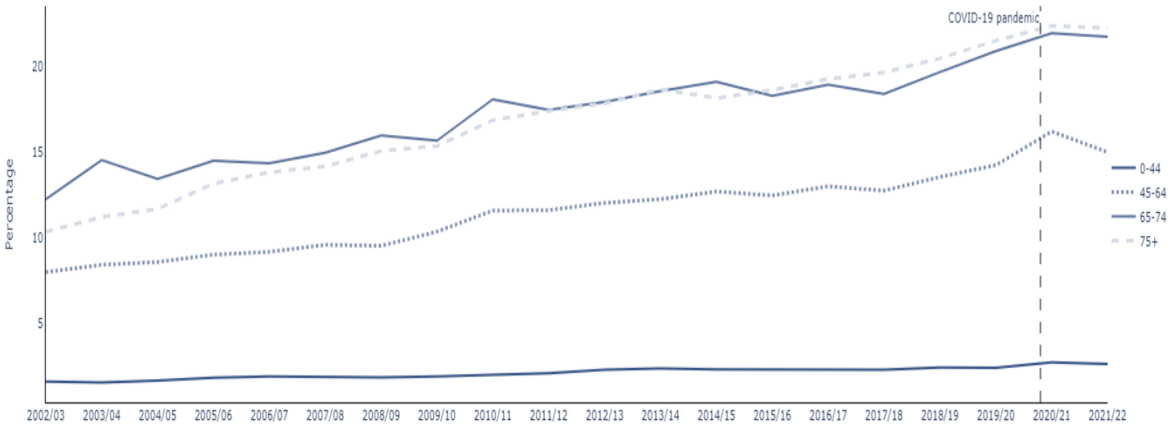
In 2021/22, more than one in ten inpatient admissions (11%) across Wales were to patients with diabetes (any mention). In 2019/20, more than one in five of all hospital admissions for people aged 65 years or older included diabetes as a primary or

secondary diagnosis (Public Health Wales Observatory, 2023). Diabetes-related hospital spells across Wales were estimated to cost £428 million in 2021/22.

6.3 Hospital Admissions, Betsi Cadwaladr UHB

The figure below shows a steady increase in the percentage of total inpatient admissions with any mention of diabetes in BCUHB since 2002/03.

Percentage of total inpatient admissions with any mention of diabetes (E10-E14), by age group, persons all ages, Wales, 2002/03 to 2021/22
Source: Public Health Wales Observatory



In BCUHB in 2021/22, there were over 17,000 diabetes related spells (excluding amputations), with an emergency, elective or transfer admission method; the average cost is around £5,200 per spell.

The Central IHC has the highest number and proportion of total admissions (41%) of patients with a primary diagnosis of diabetes, admitted into a BCUHB hospital by IHC and per 1,000 head of resident population; the East IHC has the lowest numbers. However, there will be more admissions to non-BCUHB hospitals for this group of patients, which are not included in these figures. The Central IHC also has the highest rates of admissions for Type 1 and Type 2 diabetes.

In 2022/23, over 25,800 residents of BCUHB were treated as inpatients with a diagnosis of diabetes in any position in a hospital within or outside BCUHB.

6.4 Emergency Admissions

The highest number of emergency admissions with diabetes mentioned in any position, from April 2021/22 to July 2023/24, was in the Central IHC. At Primary Care Cluster level, the highest numbers were on the Isle of Anglesey and in North Denbighshire.

6.5 Hospital admissions by diagnosis and age group

Type 2 diabetes accounts for the vast majority of diabetes emergency admissions. The highest number of admissions were among those aged 80 years and over, and were higher for males compared to females.

6.6 Bed days

Occupied bed days are the sum of the number of occupied beds for each day of the period by patients. Diabetes as a primary diagnosis accounted for just over 9,000 beds days (an average of 25 beds per day) across BCUHB in 2022-23 compared to over 13,000 in 2021-22. Wrexham Maelor hospital has the highest number of bed days.

6.7 Length of Stay

The average length of stay is the average number of days that a patient spends in hospital. It is generally measured by dividing the total number of days stayed in hospital by all inpatients during the period by the number of discharges. The average length of stay for emergency admissions for diabetes in all diagnosis positions in BCUHB during 2021/2023 ranges between approximately 8-11 days. Endocrinology has the longest length of stay followed by general medicine.

6.8 Hospital admissions by deprivation

In Wales and BCUHB, the percentage of total inpatients with any mention of diabetes is higher for residents from the most disadvantaged areas compared to the least deprived.

6.9 Paediatrics hospital admissions

There were 55 Children's Ward admissions in BCUHB between 1st January 2023 and 27th February 2024.

6.10 Outpatient Activity

The endocrinology specialty includes diabetes and the following conditions:

- thyroid disease
- lipid disorders
- endocrine disorders of the reproductive system, such as polycystic ovary syndrome
- adrenal disease
- bone and calcium disorders
- pituitary disease
- endocrine late effects of cancer treatment

New outpatient attendances are increasing year on year. The largest number of endocrinology outpatient attendances are by people in the 50 to 59 and 60 to 69 year old age groups, and is higher among females compared to males.

In 2023/24, there were just over 5,900 endocrinology outpatient referrals in BCUHB. The highest number of referrals were made by a General Medical Practitioner, followed by a Consultant or Independent nurse other than in an A&E Department. The East has the highest number of urgent referrals across the health board and they have been consistently higher than their routine referrals since 2019/20. The highest endocrinology appointments DNAs are in the 18 to 29 year old age group and amongst female patients.

6.11 Dietetics

All referrals to dietetic diabetes services in BCUHB are entered onto an electronic records system (Therapy Manager) and added to a waiting list for triage. The average number of patients referred to the service in 2022 and 2023 were 940 in the West IHC, 1,156 in the Central IHC, and 1,095 in the East IHC. Differences in numbers may reflect the differences in population size and age, coding and recording practices, different services and skill mixes, and varying levels of complexities of conditions in each Area. Further details of the dietetic diabetes services in each IHC are provided in the full report.

6.12 Bariatric Surgery

Bariatric/obesity surgery in Wales is commissioned by the Welsh Health Specialised Services Committee (WHSSC) from two providers. The Welsh Institute of Metabolic and Obesity Surgery (WIMOS) in Swansea Bay University Health Board provides services for patients in South Wales, and services for patients from North Wales and Powys are provided by the Salford Royal Hospital. The WIMOS is the larger of the two providers and is commissioned to deliver 100 procedures per annum, comprising a mix of new interventions and revisions; the Salford Royal Hospital has historically been funded to deliver as many procedures as is required, which is helped by the low number of referrals from North Wales.

Over the course of the last year, the Salford Royal Hospital has struggled to return to their pre-Covid position (a situation which the hospital has indicated is unlikely to improve); over the same period, the number of referrals from BCUHB's maturing Level 3 service has grown notably. The result has been low activity levels (only a handful of procedures delivered per year) and growing referrals combining to deliver a worsening waiting list position and regional inequity. Work to explore whether WIMOS – where longstanding performance issues have been addressed over the course of the last 18 months – can temporality provide capacity for BCUHB and North Powys is ongoing, although there has been no decision thus far; WHSSC will also be investigating whether there is scope for an alternative English provider.

6.13 Welsh Ambulance Service Trust activity

Diabetes related 999 calls

The 999 call data related to diabetes for BCUHB (January 2022 – February 2024) show that a total of 1,405 emergency calls were made, with the highest proportion from Gwynedd (22%) and the lowest from Anglesey (10.2%). People aged 65 years and over account for 42% of all diabetes related 999 calls. 34% of all 999 calls related to diabetes were cancelled prior to arrival of an ambulance and 24% of individuals were taken to hospital.

Diabetes related 111 calls

919 diabetes-related calls were made to 111 during January 2022–February 2024, with the majority (76%) relating to diabetes concerns. Almost 42% of calls were

concerning people aged 65 years and over. Almost 16% of calls were streamed to A&E and 14% were streamed to Primary Care Out-Of-Hours services within one hour. Just under 8% of calls resulted in an emergency ambulance being arranged.

9. Complications of diabetes

Diabetes can cause other health problems if it is not managed properly, including eye and sight problems, nerve damage, heart and circulatory diseases, and diabetic ketoacidosis, which mostly affects people with Type 1 diabetes (British Heart Foundation, n.d). Securing consistent delivery of all three NICE treatment targets is key to avoiding such complications, and will result in both financial savings and improved patient outcomes.

The latest data for BCUHB (2020) shows that heart failure admissions were the largest complication from all diabetes. Were Type 1 and Type 2 is specified, chronic kidney disease is recorded as the largest complication.

7.1 Amputations

In 2022/23, diabetes related hospital spells in Betsi Cadwaladr UHB that required an amputation (total of 129 spells) cost over £14,000 per spell and averaged 20 days in hospital. Recently published trend data (April 2016 to November 2023) from the NHS Wales Executive for shows that there were 809 admissions for amputation procedures with diabetes in any diagnosis position in BCUHB, which accounted for 69% of all amputations across BCUHB with any diagnosis.

Trend data from 2009 to 2020 from the National Diabetes Audit dashboard shows the number of major amputations have been increasing in males with Type 2 diabetes and females with Type 1 diabetes.

7.2 Diabetic Foot

Diabetes may lead to poor circulation and reduced sensation in the feet and legs. It is estimated that around 2,000 people with diabetes in Wales have foot ulcers at any given time with around 330 amputations carried out each year (Diabetes UK, n.d). Podiatry for people with diabetes is one of the most overlooked aspects of diabetes management. Data from the National Diabetes Footcare Dashboard shows that 62.2% of people with diabetes have the first expert assessment by the specialist footcare service within 0 to 13 days, compared to 68.6% across Wales (National Diabetes Footcare Audit Dashboard, 2023). The percentage has declined in BCUHB from 80% in 2018/19 to just over 62% in 2022/23.

7.3 Kidney disease

Almost one in five people with diabetes will require treatment for diabetic nephropathy (Diabetes UK, n.d.). Kidney disease counts for 21% of deaths in Type 1 diabetes and 11% of deaths in Type 2 diabetes (Kidney Research UK, 2018). The number of chronic kidney related cases for people with Type 1 and Type 2 diabetes in BCUHB has increased significantly between 2009 and 2020, with numbers consistently higher for females than

males. This increase over time reflects the increase in prevalence of Type 2 diabetes in the population.

10. Mortality

Diabetes related mortality is increasing across Wales; since July 2021, the observed age-standardised rate has been consistently higher than the comparator rate, which is the mean value for the previous five years excluding 2020. As these are age-standardised rates, the rising mortality cannot be attributed to the aging population (Public Health Wales Observatory, 2023).

In most months since the beginning of 2020, the age-standardised mortality rate with any mention of diabetes, but excluding Covid-19, has been higher than the average value of the previous five years, excluding 2020. BCUHB has the second lowest European Age-standardised Rate (EASR) in Wales and has been consistently below the Welsh average since 2014-16.

The diabetes mortality EASR difference between the most and least deprived fifths of the Welsh population has more than doubled, from 37 per 100,000 in 2002, to 87 per 100,000 in 2022 (Public Health Wales Observatory, 2023). The picture is similar in BCUHB, where mortality with any mention of diabetes is higher in the most deprived fifth than the least deprived fifth. This inequality gap has generally increased over time which is concerning.

Inpatient mortality for people with diabetes is considerably higher than for people who do not have diabetes.

10. Medicines Management Information

Wales
During the period 2014/15 to 2022/23, the number of items prescribed to treat and manage diabetes in Wales rose by around one third; the net cost of drugs prescribed to treat and manage diabetes almost doubled to £105 million during this period.

Betsi Cadwaladr UHB
During the period 2014/15 to 2022/23, the number of items prescribed to treat and manage diabetes in BCUHB increased from just over 677,900 to almost 892,000; the net cost of drugs prescribed to treat and manage diabetes rose from £12.5 million to £20.4 million over the same period, an increase of around 63%.

The cost of treating the complications of diabetes is much higher than the cost of treating the disease, with estimates suggesting that for every £1 spent on diabetic medicines, £2 will be spent on non-diabetic medicines for diabetic patients. (Diabetes.co.uk, 2023). The cost of supplying diabetic and non-diabetic medicines to diabetic patients will therefore be in the region of £60 million, which exceeds 40% of the total primary care prescribing spend. With no access to disaggregated prescribing data within NHS Wales, it not possible to accurately quantify this figure.

The data on Primary Care Cluster diabetes related prescribing costs per 10,000 population shows that North Denbighshire has the highest costs across the health board

region (£929,000) and Arfon the lowest (£502,500); the BCUHB average was £659,600. Insulin accounts for the highest costs and the second highest number of items prescribed by General Practice in 2022/23. Metformin hydrochloride is the largest item prescribed and accounts for 6% of annual costs of diabetes medications, the third lowest item.

Community Pharmacies in North Wales do not currently collect data on specific diabetes services.

14. Finance

It is widely recognised that approximately 10% of NHS expenditure goes on treating diabetes and the complications of diabetes (NHS England, n.d). BCUHB's expenditure for the 2022/23 financial year was £2 billion. Treating diabetes in its broadest sense could therefore be costing the health board circa £200m per annum.

14.1 Programme budgeting

Programme budgeting is a financial method that health boards in Wales use to identify all health and social care expenditure, including primary care services, to programmes of care based on medical condition, including diabetes.

While programme budgeting supports cross-organisation comparison, the method does not capture the true cost of treating a condition. The data below identifies a figure of £33m which has been directly attributed to diabetes. While useful for comparison purposes this will be significantly below the true cost of diabetes care incurred by the health board.

The total expenditure for diabetes and the percentage of total BCUHB expenditure on diabetes amounted to over £32 million in 2022/23, and 1.63% respectively. In 2019-20, expenditure was just under £26.9 million and the percentage of total expenditure 1.67%. Primary care expenditure dwarfs secondary care by a factor of about 3:1.

The average cost per diabetic patient resident in BCUHB are based on the 2021/22 number of patients aged 17 years and over registered by their GP practice as having diabetes, plus an estimated figure of 450 patients aged under 17 years. The cost in 2022-3 has been calculated as just over £700. Again, this is likely to be a large underestimation. Elsewhere in the literature, a range of costs have been estimated from around £3,000 per diabetes patient per year (NHS England, 2016) and US $5,859.30 (International Diabetes Federation, 2021).

There has been an overall increase in expenditure per BCUHB resident for diabetes in since 2019-20. However, BCUHB spending per head is lower than the average for Wales and all other health board regions, and has been consistently lower than Wales since 2019-20.

14.2 Diabetes expenditure

Finance data from the recently published by the NHS Executive show costs per spell for diabetes compared with non-diabetes inpatients at Primary Care Cluster level. The average costs per spell of diabetes-related inpatient care in 2022/23 in BCUHB was £4,746, compared to £2,750 non-diabetes inpatients. Variation across Primary Care Clusters can be explained by factors such as the age profile of the population and local practice.

The longest lengths of stay across BCUHB are for patients with Type 2 peripheral circulatory problems. The overall cost of hospital admissions with primary diagnosis of diabetes is £4.3 million during 2022/23. The highest percentage cost seems to be Type 2: peripheral circulatory problems. The average length of stay for the East Area will be higher, reflecting the inclusion of the two rehabilitations wards in Wrexham.

Further details on the costs of diabetic care in secondary care are provided in the full report.

15. Procurement

An all-Wales Framework Agreement is in place to manage the procurement of Diabetes Technology (NHS Wales Shared Services Partnership-Procurement Services, 2021). A number of technology providers are managed on this Framework to enable patient choice and clinical recommendations.

In accordance with NICE Guidelines, patients have the right to choose the technology provider in respect of their Insulin Pump. In December 2023, a NICE Technology Appraisal (TA) mandated hybrid closed looping (HCL) which comprises of three elements: a pump; continuous glucose monitor (CGM); and an app which enables these two elements to communicate. NHS Wales are currently embedding a five-year implementation plan to align with the TA. The priority groups are:

- children and young people;
- people planning pregnancy and those already pregnant;
- those diagnosed since the start of the COVID-19 Pandemic; and
- those patients on non-HCL pumps would be transferred to HCL systems if the teams felt that this could be achieved with ease.

The NICE TA evidences that HCL is the most effective method for managing diabetes, resulting in reduced hospital admissions and complications. The TA also establishes a cost effectivity threshold that technology providers are being asked to meet. Alignment with the TA is being led pan Wales with local health boards developing business cases to support the move to HCL. Insulin used in the pumps and flash glucose monitoring (both able to be prescribed) are not managed via the all Wales Framework Agreement.

16. BCUHB Diabetes Workforce

A range of healthcare staff look after people with diabetes and help them manage their condition. In primary care this includes the GP, often the first point of contact, as well as the practice nurse and district nurse. Other primary care staff include the dentist, optometrist and community pharmacist. In secondary care, staff who look after diabetes patients include the consultant diabetologist, diabetes specialist nurse, pharmacist, ophthalmologist, podiatrist, dietician and psychologist. The table below shows staff in diabetes posts directly employed by BCUHB. This does not include those who work in primary care. (we need to discuss if/how this information could be identified)

Please refer to the full report for further details on the BCUHB workforce in diabetes departments across BCUHB IHCs, and for BCUHB teams that have diabetes in their title, but are sitting within specialities outside the diabetes department.

It is understood that recruitment to medical consultant posts has been particularly difficult (Lewis, J. 2023). There are some examples of where virement has been used

to attract a broader MDT that can competently meet the level of clinical competence necessary.
Diabetes Specialist Nurses (DSN's) regularly lead clinical service delivery to ensure that Super Six activities continue, in the absence of medical consultant availability (Lewis, J. 2023). Every Band 7 DSN in BCUHB is a non-medical prescriber. It has been noted that is has been challenging for the Health Board to attract experienced DSNs (Lewis, J. 2023). Furthermore, a high proportion of the existing East and Central IHC DSN workforce are due to retire within the next three years. Training a DSN takes up to three years, but it has been noted that their impact is significant, once fully trained, in terms of supporting both the person with diabetes and the MDT (Lewis, J. 2023).

In BCUHB, there has been a proactive approach to support Master's level study as the role requires advanced specialist clinical competence at post graduate level, especially as DSN's are increasingly leading clinical services and practising as 'the clinical expert' in a range of settings (Lewis, J. 2023). However, career progression beyond Band 7 is generally not in place in BCUHB. It might be more attractive to pursue an advanced practice pathway for nurses who are seeking to progress their careers through a clinical route (Lewis, J. 2023).

Staff in diabetes posts (not including Primary Care), Betsi Cadwaladr UHB, as at 31st January, 2024

	Organisation Name	Staff Group	Position Title	Pay Band	FTE
Health Community: Centre	**Diabetes Snr Medical YGC E-R**	Medical and Dental	Consultant	M&D	1.00
	Diabetic Liasion Nurse	Additional Clinical Services	Diabetic Healthcare Technician	Band 3	2.50
		Nursing and Midwifery Registered	Nurse Consultant	Band 8c	0.60
			Specialist Nurse Practitioner	Band 6	2.29
				Band 7	5.68
				Band 8a	0.80
Centre Total					**12.9**

	Organisation Name	Staff Group	Position Title	Pay Band	FTE
Health Community: East	**Maelor Diabetes Medical**	Medical and Dental	Ad-Hoc Locum Consultant	M&D	1.00
			Consultant	M&D	4.00
			Locum Fixed Term Consultant	M&D	1.00
			Locum Foundation Year 1	M&D	1.00
			Locum Foundation Year 2	M&D	2.00
			Specialty Doctor (2021 contract)	M&D	0.60
			Specialty Registrar	M&D	2.00
	Maelor Mason Wd - Diabetic Nursing E-I	Additional Clinical Services	Senior Healthcare Assistant	Band 3	0.61
		Nursing and Midwifery Registered	Specialist Nurse Practitioner	Band 6	0.85
				Band 7	5.01
	Renal & Diabetic OP Nurses YWM	Additional Clinical Services	Healthcare Assistant	Band 2	2.55
		Nursing and Midwifery Registered	Registered Nurse	Band 5	1.43
East Total					**22.1**

	Organisation Name	Staff Group	Position Title	Pay Band	FTE
Health Community: West	**Diabetes Medical**	Add Prof Scientific and Technic	Physician Associate	Band 7	3.00
		Medical and Dental	Ad-Hoc Locum Consultant	M&D	1.00
			Consultant	M&D	2.00
	YG Diabetic Liaison Nursing E-R	Additional Clinical Services	Healthcare Assistant	Band 2	0.50
		Nursing and Midwifery Registered	Modern Matron	Band 8a	0.90
			Specialist Nurse Practitioner	Band 6	1.00
				Band 7	6.87
West Total					**15.3**

BCUHB Total	**50.2**

Source: Betsi Cadwaladr UHB

Staff sickness related to diabetes

A total of 637 calendar days were lost to diabetes related sickness in BCUHB staff over a 12-month period; the majority of sickness was due to insulin-dependent diabetes.

17. Patient Experience

The results of patient surveys for those using the Renal & Diabetic (Gladstone) Unit; Renal & Diabetic Unit; and Renal & Diabetic Outpatients services in Ysbyty Glan Clwyd and Wrexham Maelor was generally positive in terms of patient satisfaction. However, only 18.2% of respondents reported being able to speak to staff in Welsh, if they wanted to. The Ysbyty Gwynedd diabetes services are not mapped to the Civica feedback surveys and therefore there is no data available for this area.

Six complaints were made against BCUHB by a patient/family member between Quarter 2 and Quarter 4, 2023; the majority of the complaints were investigated under Putting Things Right regulations. The PALS system recorded 15 enquiries requesting assistance/information regarding diabetes over the same period.

14. Conclusions

It can be seen that both due to the aging of the population of North Wales and also the rise in obesity, the number of people registered as having diabetes in BCUHB has increased by 14,000 people (43%) between 2009/10 and 2021/22. The growth in Type 2 diabetes, in particular, is exceeding capacity to offer planned fundamentals of diabetes care within the current primary care approach (Lewis, J. 2023).

The prevalence of diabetes will continue to go up (by 32% between now and 2035) if we do not reverse the rising trend of obesity in our population. To do this we need to both increase physical activity levels, as well as increase the proportion of the population that follows a healthy and balanced diet. This needs to start early in the life-course before these patterns of behaviour become ingrained. There are a number of other risk factors for diabetes that need to be tackled such as tobacco smoking and alcohol. We also must urgently tackle health inequalities as the impact of diabetes, particularly on our more disadvantaged communities, is stark.

The vast majority of activity to prevent and manage diabetes lies in primary care and this should remain so. It is clear from the data presented in this report, for example the disappointingly low completion of the eight care processes, that there needs to be improvement in the way that diabetes is managed in primary care in North Wales. Furthermore, there needs to be an expansion in diabetes prevention programmes in North Wales, for example the All Wales Diabetes Prevention Programme, as well as a pan Health Board approach to offer remission programmes for people with Type 2 diabetes (Lewis, J. 2023).

There are many aspects of diabetes care in North Wales that are examples of good practice for example, the work to develop the Long-Term Conditions Hub, but there is a definite need to reduce variation and improve service consistency across the region. Much of the success so far has happened through building better relationships and increasing clinical trust – which, in many settings, transcend the contractual challenges, especially when the benefit to the patient is realised (Lewis, J. 2023).

Any improvements need to be owned and adopted at scale to have a whole system impact. There is also an urgent need to explore other more sustainable and effective system wide options to improve equity of access to improved diabetes care outside of the usual service models (Lewis, J. 2023). This could consider cluster-based approaches that improve access to DSN's and Diabetes dietitians working in community settings, by utilising funds that have historically been ring-fenced for enhanced primary care (diabetes) services (Lewis, J. 2023).

There needs to be greater update of current diabetes education programmes by patients. We need to support existing education programme to offer a virtual structured education programme for those newly diagnosed with Type 2 diabetes (Lewis, J. 2023). This will facilitate signposting based on the individual need to: weight management, self-management (X-pert / DSMEd / MyDesmond) and remission programmes (Lewis, J. 2023). Once accredited, this should satisfy QAIF for referral to a recognised diabetes self-management programme.

The longer-term benefit of prevention and remission strategies, plus uniform access to specialist practitioners in diabetes that are Cluster based, should have a positive impact upon the referral rate into and repatriation from specialist diabetes service (Lewis, J. 2023). This should enable more timely access for patients who need more advanced diabetes management support from a medical consultant led diabetes service with three dedicated diabetes inpatient MDTs. What it will not provide is sufficient resource to manage the growth in demand for novel technologies; this will need detailed service modelling to create a case for investment (Lewis, J. 2023).

There needs to be a review of the contribution of the specialist workforce structure as a whole, in order to determine where the highest value contribution within a diverse MDT lies. A better model should attract external applicants to North Wales, encourage

the growth of a sustainable MDT, as well as provide responsible career progression opportunities for those competent to advanced practice and consultant practitioner level (Lewis, J. 2023). Similarly, there is a case for change where non-registered health professionals can play an important contribution to the specialist MDT, with education; screening; nutrition support; and youth support work (Lewis, J. 2023).

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Appendix 5: Diabetes Transformation Consensus Event – Day 1 Programme

Rhaglen Trawsnewid Diabetes BIPBC
BCUHB Diabetes Transformation Programme
Digwyddiad Rhanddeiliaid 22ain Dachwedd 2024, Canolfan Busnes Conwy
Stakeholder Event 22nd November 2024, Conwy Business Centre
Agenda

Cefndir	**Background**
Dyma'r cyntaf mewn cyfres o dri digwyddiad a gynlluniwyd i greu cyd-ddealltwriaeth o'r heriau presennol ym maes gofal Diabetes ar draws Gogledd Cymru, ac i gydgynhyrchu model gofal a ffefrir i'w ddatblygu.	This is the first in a series of three events designed to create a collective understanding of the current challenges in Diabetes prevention and care across North Wales, and to co-produce a preferred model of care to take forward.
Nodau'r Rhaglen Trawsnewid Diabetes yw lleihau nifer yr achosion o ddiabetes ym mhoblogaeth Gogledd Cymru trwy ganolbwyntio mwy ar atal ac ymyrraeth gynnar, a gwella iechyd a lles pobl sy'n byw gyda diabetes.	The aims of the Diabetes Transformation Programme are to reduce the prevalence of diabetes in the North Wales population through a greater focus on prevention and early intervention, and to improve the health and wellbeing of people living with diabetes.
Dros y tri gweithdy byddwn yn gweithio gyda'n gilydd i: 1. Datblygu dealltwriaeth gyffredin o gyflwr presennol atal a gofal Diabetes yng Ngogledd Cymru a chytuno ar set o egwyddorion ar gyfer y gwaith wrth symud ymlaen. 2. Nodi atebion posibl i'r heriau a wynebir a datblygu modelau gofal hyfyw (yn unol â'r egwyddorion y cytunwyd arnynt ar Ddiwrnod 1) y gellid eu datblygu. 3. Cytuno ar fodel gofal a ffafrir a'r camau sydd eu hangen i gyrraedd yno. Bydd adroddiad yn cael ei gynhyrchu yn dilyn pob digwyddiad a fydd yn crynhoi'r trafodaethau a'r camau gweithredu y cytunwyd arnynt, a fydd yn helpu i lywio digwyddiadau dilynol.	Over the three workshops, we will work together to: 1.Develop a shared understanding of the current state of Diabetes prevention and care in North Wales and agree a set of principles for the work moving forward. 2.Identify potential solutions to the challenges faced and develop viable models of care (aligned to the principles agreed on Day 1) that could be taken forward. 3.Agree a preferred model of care and the steps required to get there. A report will be produced following each event that will summarise the discussions and agreed actions, which will help to inform subsequent events.
Rydym yn gwerthfawrogi eich cyfranogiad a brwdfrydedd yn ein sesiynau. Er mwyn sicrhau profiad cynhyrchiol a chydlynol, gofynnwn yn garedig i chi aros yn eich grwpiau penodedig trwy gydol y digwyddiad. Bydd hyn yn hwyluso gwell cydweithio ac yn caniatáu ar gyfer trafodaethau mwy effeithiol. Diolch am eich cydweithrediad a'ch dealltwriaeth, ac edrychwn ymlaen at weithio gyda chi ar y Rhaglen bwysig hon.	We appreciate your participation and enthusiasm in our sessions. To ensure a productive and cohesive experience, we kindly ask that you remain in your assigned groups throughout the duration of the event. This will facilitate better collaboration and allow for more effective discussions. Thank you for your cooperation and understanding, and we look forward to working with you on this important Programme.

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Agenda

22ain Dachwedd 2024 / 22nd November 2024 **Sut olwg sydd ar ofal Diabetes nawr? What does Diabetes care look like now?** **Canolfan Busnes Conwy / Conwy Business Centre**

AMSER / TIME	YSTAFELL / ROOM	GWEITHGAREDD / ACTIVITY
09:00-10:00	Brenig	Cyrraedd a chofrestru / Arrival and registration Darperir lluniaeth / Refreshments will be provided
10:00-10:05	Geirionydd	Croeso a chyflwyniad i'r diwrnod / Welcome and introduction to the day *Dr Jane Moore and Julie Lewis*
10:05-10:15	Geirionydd	Gweithgaredd egniol – rhwydweithio cyflym / Energiser activity – speed networking *Lucy Hawkins and Natasha Stephenson*
10:15-11:00	Geirionydd	Cyflwyniadau: / Presentations: • Data a phroffil gwasanaeth – sut olwg sydd ar ein poblogaeth? / Data and service profile – what does our population look like? *Rob Atenstaedt and Kathryn Lang* • Penawdau o dystiolaeth ar arfer gorau/ Headlines from evidence on best practice *Dafydd Gwynne* • Themâu o'r Asesiad Effaith ar Gydraddoldeb / Themes from the Equality Impact Assessment *Dafydd Gwynne* • Canlyniadau'r model “gwneud dim” / Results of the “do nothing” modelling *Uned Gwyddor Data Iechyd Cyhoeddus Cymru Public Health Wales Data Science Unit*
11:00-11:30	Geirionydd	Myfyrdodau a thrafodaeth – Caffi Sgwrsio / Reflections and discussion – Conversation Café
11:30-11:45	Brenig	Egwyl / Break
11:45 – 12:15	Geirionydd	Cyflwyniadau: / Presentations: • Beth mae ein clinigwyr yn ei ddweud wrthym am y model gofal diabetes presennol? / What are our clinicians telling us about the current diabetes model of care? *Dr Eilir Hughes, Julie Lewis and Frances Baverstock* • Beth mae ein defnyddwyr gwasanaeth yn ei ddweud wrthym am eu profiad? / What are our service users telling us about their experience? *Helen Stevens-Jones*
12:15-12:45	Geirionydd / Ogwen	Myfyrdodau a thrafodaeth – Caffi Sgwrsio / Reflections and discussion – Conversation Café
12:45-13:30	Brenig	Cinio / Lunch

22ain Dachwedd 2024 / 22nd November 2024 – Sut olwg sydd ar ofal Diabetes nawr? What does Diabetes care look like now? Canolfan Busnes Conwy / Conwy Business Centre		
AMSER / TIME	**YSTAFELL / ROOM**	**GWEITHGAREDD / ACTIVITY**
13:30-14:15	Geironydd / Ogwen	Gweithgaredd cyn-mortem: Deall y senario waethaf Pre-Mortem activity: Understanding the worst-case scenario *Lucy Hawkins and Natasha Stephenson*
14:15-14:30	Brenig	Break
14:30-15:30	Geirionydd / Ogwen	Cytuno ar set gyffredin o egwyddorion ar gyfer ein gwaith wrth symud ymlaen: Gwaith grŵp wedi'i hwyluso Agreeing a shared set of principles for our work moving forward: Facilitated group work *Lucy Hawkins and Natasha Stephenson*

15:30-16:00	Geirionydd	Cytuno ar gamau gweithredu a pharatoi ar gyfer Diwrnod 2 (13 Rhagfyr) / Agreeing actions and preparation for Day 2 (13th December)

Cyflwynwyr / Presenters:

Lucy Hawkins, Natasha Stephenson	Yr Uned Strategaeth	The Strategy Unit
Jane Moore	Cyfarwyddwr Gweithredol Dros Dro Iechyd y Cyhoedd	Acting Executive Director of Public Health
Julie Lewis	Ymgynghorydd Nyrsio / Arweinydd Clinigol Diabetes	Nurse Consultant / Diabetes Clinical Lead
Robert Atenstaedt	Ymgynghorydd Iechyd Cyhoeddus	Public Health Consultant
Kathryn Lang	Cyfarwyddwr Cynorthwyol, Data, Cudd-wybodaeth a Mewnwelediad	Assistant Director, Data, Intelligence and Insight
Rosemary Walmsley	Gwyddonydd Data Iechyd Cyhoeddus Cymru	Public Health Wales Data Scientist
Dafydd Gwynne	Prif Ymarferydd Iechyd Cyhoeddus	Principal Public Health Practitioner
Eilir Hughes	Arweinydd Clwstwr Ardal Dwyfor a Gogledd / Cyfarwyddwr Meddygol Gofal Cychwynnol, Gorllewin *BIPBC*	Cluster Lead for Dwyfor and North Meirionnydd */ Primary Care Medical Director, West BCUHB*
Frances Baverstock	Nyrs Arweiniol Gofal Sylfaenol	Lead Nurse Primary Care

Teitl adroddiad: ***Report title:***	Corporate Risk Register Report & Board Assurance Framework.			
Adrodd i: ***Report to:***	Planning, Population Health & Partnership Committee (PPHP)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 10 December 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this standing agenda item is to provide an update position of the Corporate Risk Register (CRR) and present the first iteration of the Board Assurance Framework risk (private) to which PPHP has oversight. • CRR24-18 'Operational Planning for Transmittable Diseases and Outbreaks' proposed reduction in current risk score from 20 to 16 (likelihood reduced from 5 to 4), resulting in the risk score now within the risk appetite.			
Argymhellion: ***Recommendations:***	The Committee is asked to **receive assurance** for the four (1 private) corporate risks to which the Committee has overall accountability. The Committee is asked to note the contents of the BAF (private). The Audit committee will be asked to provide feedback on the development of the first iteration before being presented to the January Board Meeting.			
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance			
Awdur yr Adroddiad: ***Report Author:***	Anthony Hughes, Risk Assurance Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Links to the BAF detailed in respective CRR reports
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Health Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Not applicable for this report
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	Not applicable for this report
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Links to the BAF detailed in respective CRR reports
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Individual Executive Sign off of CRR reports, Review at next Risk Management Group and subsequent Executive Team Meeting.

Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	See the individual risks for details of the related links to the Board Assurance Framework.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable for this report
Camau Nesaf: ***Next Steps:*** 1. Further scrutiny of all corporate risks by Executive Team as per normal reporting cycle. 2. Submission of Board Assurance Framework to Board	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – Risk Dashboard, Planning, Population Health & Partnership Committee Appendix 2 – Corporate Risk Register Report Appendix 3 – Board Assurance Framework Risks BAF24-02, BAF24-05, BAF24-06, BAF24-08.	

Corporate Risk Register Report

1) Introduction and Background

1.1 There are 3 Corporate Risks for Planning, Population Health & Partnership Committee oversight and assurance. The full details of those risks are highlighted in Appendix 2 and include evidence of controls in place, assurances on those controls, additional controls required and actions with due dates.

- CRR24-07 – Availability and Integrity of Patient Information
- CRR24-08 – Population Health
- CRR24-18 – Operational Planning for Transmittable Diseases and Outbreaks.

1) Key Highlights

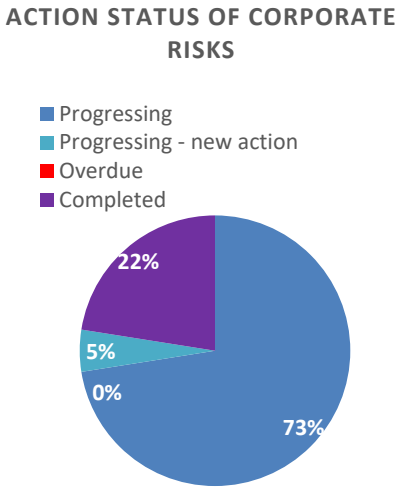
Corporate Risks Dashboard (Appendix 1) below provides a list of the 3 corporate risks to which the committee is accountable.

This paper presents all risks to which Planning, Population Health & Partnership Committee has oversight, with details (Appendix 2) of those risks.

The Committee is asked to note and receive assurance, following review of the risks:

- **CRR24-18** 'Operational Planning for Transmittable Diseases and Outbreaks' – The Head of Public Health Assurance & Development presented a deep dive on the Population Health Corporate Risk during the November 2024 Risk Scrutiny Group. Assurance was given to the group in relation to the mitigations, controls and long term outcomes. Proposed reduction in current risk score from 20 to 16, resulting in the risk score now within the risk appetite.

Out of the 3 corporate risks, 29 actions have been developed to mitigate the risks. 9 actions have been completed, 18 actions are progressing and on track and 2 new actions have been identified and progressing.



Next steps

1. Continued scrutiny of the actions, controls and progress of all corporate risks by Executive Team.
2. Submission of Corporate Risks to Board.

Appendix 1 - Corporate Risk Register Dashboard - Planning, Population Health & Partnership Committee

Lead	Ref	Risk Title	Current Score (Likelihood x Impact)	Risk Target Score	Appetite Main Risk Type / Appetite Level	Lead Board Committee	Risk Management Commentary
CDIO	CRR24-07	Fragmented Patient Care Record	4 x 4 = 16 ⟷	12	Quality / Open 15-19	Planning, Population Health & Partnership Committee	Opened Dec 23, 11 actions identified, 3 completed, 8 progressing. Reduction in current risk score from 20 to 16 – September 2024.
EDoPH	CRR24-08	Delivering a population health approach to health and wellbeing	4 x 4 = 16 ⟷	12	Quality / Open 15-19	Planning, Population Health & Partnership Committee	Opened Nov 2023. 11 actions identified, 4 completed, 5 progressing, with 2 new actions identified. Risk title and content updated to highlight operational aspect of the risk. Reduction in current risk score from 20 to 16 – September 2024.
EDoPH	CRR24-18	Operational Planning for Transmittable Diseases and Outbreaks	4 x 4= 16 ↓	12	Quality / Open 15-19	Planning, Population Health & Partnership Committee	Opened June 24. 7 actions identified, 5 actions progressing, 2 actions completed. Following review and deep dive of the risk at the November Risk Scrutiny Group, proposed reduction in current risk score from 20 to 16.

Key:

Executive	
Chief Digital Information Officer	CDIO
Executive Director of Public Health	EDoPH

Appendix 2 – Corporate Risk Register Report - Planning, Population Health & Partnership Committee

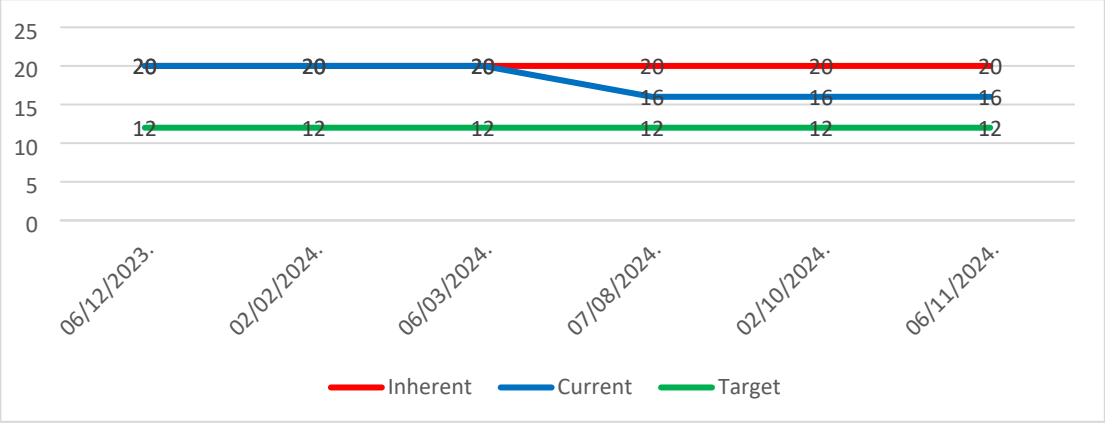
CRR 24-07	**Risk Title:** A Fragmented Patient Care Record		**Date Opened:** 06/12/2023
	Assuring Committee: Partnerships, People and Population Health Committee		**Date Last Committee Review:** 20/08/2024
Date Last Reviewed: 06/11/2024	**Director Lead:** Chief Digital and Information Officer	**Link to BAF**:	**Target Risk Date:** 31/03/2029
There is a risk that patient harm will be caused due to the lack of a joined up longitudinal Electronic Healthcare Record system that digitalises clinical workflow, alerts, hand overs and scheduling under a single patient identifier, which could lead to deaths and harm.			

Mitigations/Controls in place	Additional Controls required
1. Current paper file identified as the Master Copy of the full record. 2. Access to current clinical systems to print clinical information ready to store in the Master File. 3. CITO Contract in place to house scanned document as a repository. 4. Mandate process in place to control the adoption of new functionality within existing systems to capture patient data. 5. Current system training and standard operating procedures around searching for and registering new patients to prevent the creating of duplicate records in place. 6. Dashboard in place which flags any new duplicate patient record created to allow immediate record merge. 7. Standard operating procedures involving searching for and storing patient information to prevent harm in cases where duplicate records exist is in place within Patient Administration System. 8. Optimisation Programme in place for the four main patient administration systems to review usage and reduce duplication across the systems. This will also support the removal of obsolete systems. 9. Assistant Director of Patient Records now member of Clinical Effectiveness Group and Patient Safety and Quality Group to ensure harms associated with patient records are addressed. 10. The work underway with the Mental Health Electronic Health Record Programme is the first part of the future Electronic Health Record journey with the governance route agreed.	1. Lack of current system capabilities to integrate into the fuller Electronic Health Record. Optimisation programme underway with a focus on EPOC, EPRO and WCP to review current systems interoperability and functionality. CITO has been agreed as the Electronic Document Management System for the Health Record. 2. Availability of current paper records within digital environment. The Electronic Health Record outline business case will analyse resource requirements to consider scanning or dual processing of records. Scanning Strategy currently in development. 3. Standard practice registration across the three acute sites. Proposal developed including resource funding required based on the East Health Records service coverage. Awaiting outcome of the cost pressure resource allocation. 4. No agreement to fund additional Health Records staff to address backlog of duplicate patient records / identifiers. Standardised procedures in place to prevent re-occurrence. 5. The Clinical Design Authority is being established first meeting 1st December 2024 to ensure that the design and use of digital systems does not compromise the safety, quality, or effectiveness of care, and that it enhances the patient experience and outcomes. 6. Lack of quality within the content of current patient records. Office of the Medical Director accepted ownership and will consider as part of professional standards. 7. Continued delay in confirmation of membership at the Patient Safety and Quality Group. Progress chasing monthly in place. 8. Correct use of current clinical systems. Current review underway to establish usage with a future plan including training on the use and capability of all systems.

Actions	Due Date	Progression Analysis
Assessment to be undertaken of what is required for the development of an Outline Business Case for an Electronic Health Record (EHR) Development of the Outline Business Case is now underway and a Programme Board has been established for governance. The Outline Business Case is due to be completed by March 2025. Proposal to close action as assessment undertaken.	31/03/2025	Completed

Seeking approval and funding for the Strategic outline case for Electronic Health Record	31/12/2024	Completed
Establish the cost and resource requirements to back scan all live records This forms part of the Scanning Strategy, with current procurement underway for additional external support to develop this requirement.	31/01/2025	Progressing
Develop a Health Board Scanning Strategy Continuing to progress with funding secured and working with procurement to commission external support.	31/03/2025	Progressing
Standardise the way in which using existing systems (paper and electronic) as part of the DDaT optimisation workstreams Optimisation, Support and Training Team in place. Delivery of Therapy Manager, Post Take System (EAS) and replacement of STREAM Ward Board system are progressing very well. The Optimisation Team is currently being formed following the agreement on staff movement across Digital, Data, and Technology. The work plan is under development and is expected to be completed by the end of November 2024. The new team will begin implementing the work plan in December 2024.	31/03/2025	Progressing
Undertake a review of all current systems to ensure these can be integrated into an Electronic Health Record As part of the EHR Programme a Technical and Data Workstream has been established to consider and explore the integration considerations for the fuller Electronic Health Record.	30/04/2025	Progressing
Accelerating the business case, approvals, procurement and implementation of an Electronic Patient Record for Mental Health (minimum 2-year project) Pre-engagement preparation underway with Invitations To Tender (ITT) draft documents currently being finalised prior to pre-engagement with the market. It is expected that this will be live week beginning 11th November 2024 with potential bidder sessions planned for week beginning 25th November 24. Once the bidder sessions have been completed the draft ITT documentation will be finalised and the tender will go live. Specialist procurement support has been used to ensure a compliant, value for money procurement.	30/04/2025	Progressing
Recruitment of additional health records staff to standardise the registration practice across three acute sites. No change to current position as still awaiting outcome from cost pressure funding. Cost Pressure meeting with Finance on 14th November to discuss.	30/11/2024	Progressing
Engage with the Estates Rationalisation Programme to secure the future of "fit for purpose" file libraries for legacy paper records. Meeting arranged for 7th November 2024 with Corporate Risk Lead Officer to discuss. .	30/06/2025	Progressing
Following completion of the Baseline assessment of the location of all records, a review and recommendations will be developed and presented Planning, Population Health and Partnerships Committee. Continuing to progress with increase in audits being undertaken.	31/08/2025	Progressing

A new all encompassing Patient Electronic Health Record Programme is established that pulls all streams of work under one overall governance arrangement. EHR Programme Board now established and has met twice and will continue to meet on a monthly basis. Proposal to close the action as this has now been established and governance arrangements are in place.	31/03/2029	Completed



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

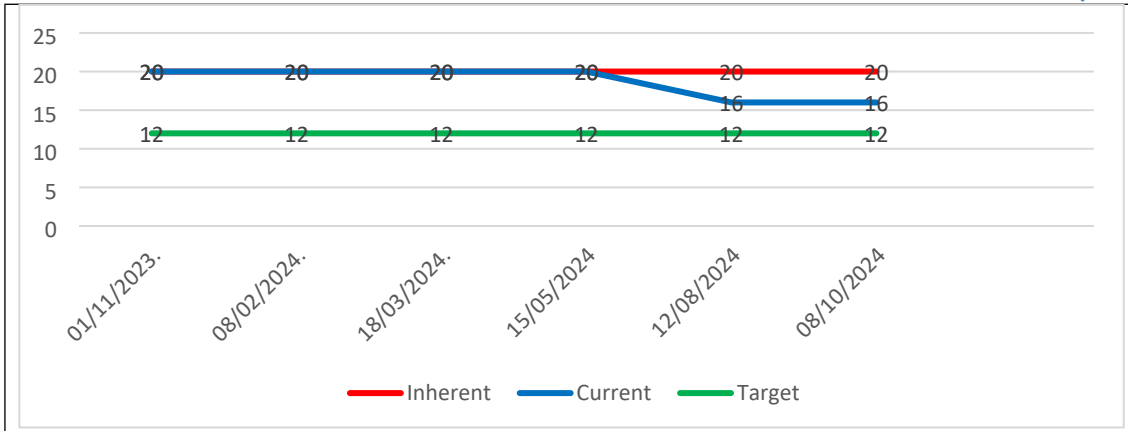
Organisational wide risk based on potential patient safety and negative impact if the risk were to materialise. In addition the financial and resource requirement to implement the controls and mitigations required are significant.

CRR 24-08	**Risk Title:** Delivering a population health approach to health and wellbeing		**Date Opened:** 01/11/2023
	Assuring Committee: Partnerships, People and Population Health Committee		**Date Last Committee Review:** 20/08/2024
Date Last Reviewed: 8/10/2024	**Director Lead:** Executive Director of Public Health	**Link to BAF**:	**Target Risk Date:** 31/03/2025

There is a risk that the Health Board fails to consider and implement prevention and early intervention models in order to reduce health inequalities and improve long term population health and wellbeing. This may be caused by a lack of prioritisation, planning and delivery in relation to the prevention of ill health and early intervention.
This may lead to continuation and increases in largely preventable non-communicable diseases including Type 2 Diabetes, Respiratory conditions, Cardiovascular disease, Cancer, Musculoskeletal conditions, mental health and wellbeing and multiple co-morbidities. It may also lead to to increasing rates of infectious disease. Failure to address the risk could potentially lead to avoidable morbidity and mortality within the population of North Wales

Mitigations/Controls in place	Additional Controls required
1. Population Health Executive Delivery Group provides strategic direction. 2. Annual development of IHC data packs and headline report support Health Board planning to reflect current and emerging need. 3. Consultants in Public Health are linked to delivery of key programmes of work, Public Health Wales and with IHC areas, providing expertise and guidance. 4. Funding associated with Healthy Weight Healthy Wales which was formerly non-recurrent grants has now been added recurrently to the Health Board core budget. 5. Prevention and health inequalities form key part of the Health Board Integrated plan 24-27. 6. Interviews have taken place for the Executive Director of Public Health during August. 7. Interviews have taken place for 2 x vacant Consultant in Public Health posts and appointed to. 8. Board Awareness session regarding the 'shift to Prevention' focus has taken place in July 24 9. DDAT and Public Health Team are meeting to progress data requirements and address gaps 10. Quarter 1 Prevention deliverables within the Health Board Plan 24/25-26/27 have been achieved. 11. Receipt of the evaluation report for the Inverse Care Law activity. 12. Review / refresh of IHC Data packs to inform planning 13. Population Health Executive Delivery Group – Workshop 'Prevention – Priorities, Planning and Delivery' to inform direction and planning has taken place. 14. Quarter 2 Prevention deliverables in the Health Board Plan 24/25-26/27 have been achieved 15. Well North Wales Paper received by Board, outlining the direction for this integral programme approved (Oct 24). 16. Strategic Arts in Health Plan received by Board, approved (Oct 24) 17. PPHP Committee received delivery update by Health Protection Team (Aug 24)	1. Response to the demographic profile and the current and forecast prevalence of chronic conditions and their effect on demand. 2. There is no secured long term funding to support implementation and growth of the whole system approach across North Wales at scale. 3. The availability of data and intelligence to support strategic focus at the local level and subsequent planning is not available. 4. The Deputy Director of Public Health post is currently vacant as the post holder is Acting Executive Director of Public Health. 5. Appointment to current Senior Practitioner vacancies 6. Prevention and early intervention actions and deliverables embedded within service and IHC plans and monitored routinely as part of performance monitoring 7. Staff training – Make Every Contact Count 8. Impact of preventative services is captured and understood

Actions			Due Date	Progression Analysis
Public Health team and DPH to meet with DDaT to discuss data and intel gaps to inform planning to support strategic focus for Public Health			31/07/2024	Completed
IHC Data packs and headline reports are completed and circulated			19/09/2024	Completed
Population Health Executive Delivery Group – Workshop 'Prevention – Priorities, Planning and Delivery' to inform direction and planning			19/09/2024	Completed
Recruitment to 2 x Consultant in Public Health (East and West)			31/10/2024	Completed
Recruitment to vacant Senior Practitioner posts Jobs are now advertised			31/11/2024	Progressing
IHC Plans (as part of the Health Board 3 year plan) 25/26-27/28 evidence response to the IHC Population Health data packs and deliverables BCU Planning Framework has now been approved. Draft BCUHB Plan due December. MECC (Make Every Contact Count) training for staff is identified as an area for consideration in IHC Plans.			30/11/2024	Progressing
Recruitment to the post of Executive Director of Public Health Interviews are completed.			31/12/2024	Progressing
A review of the impact of preventative services has commenced This action will continue into 25/26. It is anticipated it will form part of the Health Board Delivery plan 25/26-27/28			31/03/2025	Progressing
Health Board Annual Plan / 3 year milestones and associated activity The Health Board plan approved for 24-27 reflects prevention priorities and deliverables. BCU Planning Framework has now been approved. Draft BCUHB Plan due December			31/03/2025	Progressing
Executive Director of Public Health will agree the Prevention Priorities and Prevention Deliverables as part of the BCUHB Plan development 25-28, as the identified Exec lead – which contribute to delivery of the Health Board 5 Strategic Objectives.			31/03/2025	New Action
The Public Health Team will carry out a review of existing programmes of work and agree Directorate priorities 25/26			31/03/2025	New Action
		Impact	Likelihood	Score



Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

The population health of North Wales is worsening and 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 through loss of involvement. Worsening health outcomes, increasing ill health and widening inequalities directly affects the Health Board ability to deliver excellent healthcare services meaning the Health Board purpose must retain clear focus on improving the health and wellbeing of the population

CRR24-18	**Risk Title:** Operational Planning for Transmittable Diseases and Outbreaks - Health Protection		**Date Opened:** 03/04/2024
	Assuring Committee: Planning, Population Health and Partnerships Committee		**Date Last Committee Review:** 22/10/2024
Date Last Reviewed: 29/11/2024	**Director Lead:** Executive Director of Public Health	**Link to BAF**:	**Target Risk Date:** 31/01/2025

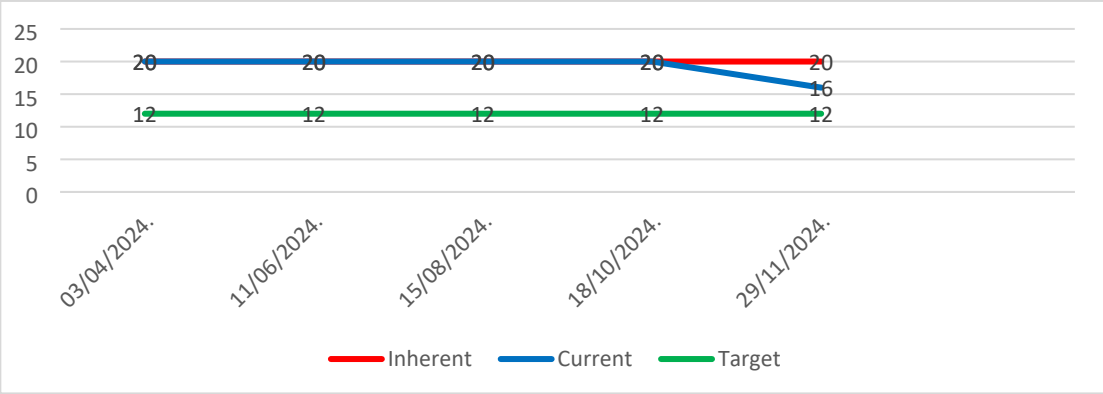
There is a risk that the Health Board does not plan adequately for outbreaks and incidents of communicable disease such as (but not solely) Measles, M.Pox, COVID-19, Pertussis etc.. This may be caused by the unpredictability of when the disease may first occur, the varierty of new and emerging threats, the variations in the nature of the required response to specific diseases, the availability and cost of associated resources (e.g. pharmaceutical products, workforce, estate, contact tracing, sampling, vaccination, communications), the scale of potential outbreaks, the difficulties in protecting specific vulnerable groups and members of staff in a timely way. This could lead to greater exposure of the public and staff members to communicable diseases causing an increase in cases, further transmission, interuption of health board services and in some cases death.

Mitigations/Controls in place	Additional Controls required
1. Health Protection Service established within BCUHB with a clear remit for enhancing the response to incidents and outbreaks in North Wales in accordance with the Communicable Disease Outbreak Control Plan for Wales. 2. Standard Operating Procedures relating to community sampling for specific diseases, including Measles, M pox, Avian Influenza, COVID-19 (although some remain to be developed) 3. Pathways established for response measures to specific diseases, for example, HNIG pathway and vaccination outbreak response for measles. 4. Health Protection Service responsible for the management of COVID-19 incidents in closed settings in North Wales 5. Strong links with Health Protection Partners including Public Health Wales and each of the 6 Local Authority Environmental Health teams. 6. Strong links with the Communicable Disease Surveillance Service to support the monitoring of trends in communicable diseases 7. Multi-agency simulation exercise undertaken in September 2023 in North Wales to test preparedness measures for specific outbreaks. 8. Access to and use of the national Case and Incident Management System: Tarian 9. Significant lessons identified from preparedness activities associated with national increase in Measles cases, leading to the development of tools, assets and pathways that could be adapted for use with other communicable diseases 10. IHC engagement with outbreak planning and preparedness activities highlighted in the IHC packs 24/25 11. Appointment of an EPRR Lead who is able to support with the development of an outbreak plan for the Health Board	1. No approved comprehensive procedure/plan in place for the management of communicable disease outbreaks (in and out-of-hours) within BCUHB. (this point deleted as this is an aspect of a comprehensive outbreak plan)

12. Additional focus placed on staff (occupational health) vaccinations, with additional support provided for staff influenza and MMR uptake from the Health Protection Service 13. Strategic group established within the Health Board to lead on the development of plans and pathways for the management of suspected and confirmed cases of High Consequence Infectious Diseases (particular focus on Mpox Clade I). Preparedness activities to date include the testing of 'green routes' with the WAST Epi-Shuttle on each acute site, the preparation and testing of IPC guidance and sampling plans, confirmation of appropriate isolation areas on each acute site. and the initiation of preparedness activities within each IHC for the management of suspected and confirmed HCID cases. 14. National multi-agency simulation event to test local preparedness plans and processes for HCID Mpox Clade I – 'Fad Felen' 15. Contributions made to the development of national action cards for HCID cases. 16. NHS Executive audit of BCUHB HCID preparedness measures due early 2025.	

Actions	**Due Date**	**Progression Analysis**
Establish the link with EPRR lead to scope arrangements for a communicable disease outbreak management plan.	1 October 2024	Complete
Production of a draft outline of a communicable disease outbreak management plan	1 October 2024	Complete
To establish an operational group within BCUHB for the developing and shaping a communicable disease outbreak management plan (full list of members can be provided if required here) Action point is progressing – the operational group is currently engaged in activities to ensure preparedness measures are in place within the Health Board for identifying and managing suspected and confirmed cases of High Consequence Infectious Disease (HCID), notably Mpox Clade I. The group has representation from IHC's, Primary and Secondary care, Health Protection, EPRR, PHW, WAST, Health at Work and communications. The current need is to ensure that appropriate operational plans are in place to manage HCID cases.	1 March 2025	Progressing (revised date from 1 October 2024)
To prepare a draft copy of a communicable disease outbreak management plan An extension to the due date is anticipated as a result of current focus on HCID.	1 December 2024	Progressing
To run a simulation exercise across the Health Board to test the functionality and contents of the communicable disease outbreak management plan	1 February 2025	Progressing
Further revision of the plan following simulation exercises	14 February 2025	Progressing
Approval and agreement of the communicable disease outbreak management plan with an agreed schedule of simulation events.	31 March 2025	Progressing

		Impact	Likelihood	Score



N.B. Inherent and Current score lines stacked as both are 20.

Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

There are a number of unpredictable situations that could arise and would have a potentially significant impact on the population. The likelihood is seen as 5 due to the history of outbreaks over the last decade or more.

Planning, Population Health & Partnerships Committee – Non-Routine Committee Business Workplan

(1 April 2024 – 31 March 2025)

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
20.08.24	Action from August Meeting PP24/50.3	PPHP Committee	Update on becoming an intelligence led organisation	DR and team to provide an update to the Committee on Becoming an intelligence led organisation on a bi-annual basis making reference to progress in relation to the spider diagram and progress on the link to the cultural change programme. Does this need to include a private item on ICT Failure & Cyber (linking to the PPHP risk or has this been covered by Board Dev?)	Kathryn Lang	Dylan Roberts	18.02.25	
20.08.24	Action from August Meeting PP24/52.2	PPHP Committee	Review of Well Being Objectives (See email from WH 07.11.24)	Revised paper to the October meeting once work has progressed further including a timetable for the implementation plan.	Chris Stockport	Chris Stockport	18.02.25	Paper went to Oct meeting, requested put forward for Feb meeting
04.11.24	Email from Gwyneth Page re: PH Forward Plan	Public Health Team	Population Health Delivery Report	For Assurance	Gwyneth Page	Jane Moore	18.02.25	
04.11.24	Email from Gwyneth Page re: PH Forward Plan	Public Health Team	Prevention and Early Years Grant Funding update	For Assurance	Gwyneth Page	Jane Moore	18.02.25	
25.11.24	Discussion at PPHP	PPHP Committee	Feedback from SRG	The impact of the SRG from 2023/24 and Mike Parry to join the meeting (see email from HSJ 25.11.24)	Helen Stevens-Jones	Helen Stevens-Jones	18.02.25	
18.11.24	Action from Board 24/191	Health Board	Well North Wales	Consider role of SRG and PPHP Committee in relation to the Well North Wales work.	Jane Moore	Jane Moore	18.02.25	
02.08.24	Request from Helen Stevens-Jones	Helen Stevens-Jones	Market Shaping with the Third Sector on Social Prescribing	Paper from Brian Laing re: models for working with the third sector in relation to social prescribing. The paper will go to the RPB in September before PPHP in Oct	Helen Stevens-Jones	Brian Laing	18.02.25	HSJ to confirm if needed for Feb meeting
21.11.24	Action PP24/78.1 and discussion with Pam	PPHP Committee	EPRR Risks	Include a substantive item on the agenda for the February meeting focussing on the EPRR Risks.	Sharon Scott	Jane Moore	18.02.25	
21.11.24	Action from Oct Meeting PP24/74.1	PPHP Committee	Llais Annual Report / Experience Paper	Llais Annual Report / Experience Paper to be reported to PPHP (and QSE) annually	Geoff Ryall-Harvey	Geoff Ryall-Harvey	April / May 2025	
14.05.24	Actions from April & August Meetings PP24/11.3 & PP24/49.7	PPHP Committee	Partnership Working (strategic approach to working with the third sector)	HSJ confirmed that an update and discussion on next steps will go to ET and come to PPHP in June 25 (see email from HSJ 03.12.24)	Helen Stevens-Jones	Helen Stevens-Jones	June 2025	

20.08.214	Action from August Meeting PP24/55.1	PPHP Committee	Health Protection Service	Update on the progress made within the Health Protection Service.	Sam Lauder	Jane Moore	Aug 2025	
25.10.24	Email from Hannah Lloyd, Public Health	Pam Wenger	Active Workplace Bundle	Item going to ET in Oct / Nov, Hannah Lloyd linking with Glesni re: the process on policy development, Board being asked to sign up to the NW Healthy Travel Charter.	Pam Wenger	Pam Wenger	20.12.24	**CLOSED** Went to Comm 10.12.24
08.10.24	Item from PPHP CoB	Chris Stockport	Primary Care and Community Care & Clusters	Paper not ready for October meeting so being put forward for December meeting.	Ffion Johnstone	Chris Stockport	10.12.24	**CLOSED** Went to Comm 10.12.24
09.08.24	Corporate Planning Update paper to PPHP 20.08.24	Chris Stockport Paper	Draft BCU Plan	Shaping and testing of draft BCU Plan with PPHP (see presentation in paper PP24/58)	Chris Stockport	Chris Stockport	10.12.24	**CLOSED** Went to Comm 10.12.24 in private
14.05.24	Original PPHP CoB (Links to 5A in ADP)	Laura Jones via Nick Lyons	North Wales Medical School Update	High level update on progress on the development of the school & main risks	Lea Marsden	Jim / McGuigan Nick Lyons	22.10.24	**CLOSED** Went to Comm 22.10.24
18.06.24	Action from June Meeting PP24/33.8	PPHP Committee	Progress against the Weight Management Programme	A delivery plan to be presented to the Committee to provide assurance. Also a review of risks that relate to the programme. A delivery and risk plan will form part of the Public Health Report	Lydia Orford Hannah Lloyd	Jane Moore	22.10.24 / 10.12.24	**CLOSED** Covered in Public Health Delivery Report to Comm 22.10.24
05.08.24	Request from Helen Stevens-Jones	Helen Stevens-Jones	Partnerships, engagement and communications update	Request from HS-J for discussion.	Helen Stevens-Jones	Helen Stevens-Jones	22.10.24	**CLOSED** Went to Comm 22.10.24
20.08.24	Action from August Meeting PP24/54.2	PPHP Committee	Flu Vaccinations	Include an update in the report to next meeting in October in relation to the low level of uptake from staff for the flu vaccine and how to maximise the use of GPs to encourage flu vaccine uptake.	Jane Moore	Jane Moore	22.10.24	**CLOSED** Went to Comm 22.10.24
08.08.24	Request from Rob Atenstaedt via Rhian Baker	Rob Atenstaedt	Health & Wellbeing	Health & Wellbeing Profile of the North Wales Population	Rob Atenstaedt	Jane Moore	22.10.24	**CLOSED** Went to Comm 22.10.24
23.04.24	Action from April Meeting PP24/12.2	PPHP Committee	Emergency Preparedness, Resilience and Response (EPRR)	An interim report to the Committee in October highlighting the findings from the initial review, the testing that has been completed and the plans that have been put in place.	Sharon Scott	Jane Moore	22.10.24	**CLOSED** Went to Comm 22.10.24
23.04.24	Action from April Meeting PP24/10.4	PPHP Committee	Deep dive into data issues and opportunities	Deep dive to take place after a Board Development session on “Being an Intelligence Led Organisation”	Dylan Roberts	Dylan Roberts	20.08.24	**CLOSED** Went to Comm 20.08.24
23.04.24	Action from April Meeting PP24/10.2	PPHP Committee	The role of DHCW	Discussion around whether we are able to influence DHCW in terms of our priorities as a HB	Dylan Roberts	Dylan Roberts	20.08.24	**CLOSED** Went to Comm 20.08.24

08.05.24	Email from Natalie Morris-Evans	Natalie Morris-Evans	NHS Wales Decarbonisation Strategic Delivery Plan 2021-2030	Decarbonisation Programme Board to feed into PPHP (Action from AC for PPHP to consider – reference to Internal Audit Report – email 18.03.24 from CB)	Russell Caldicott	Russell Caldicott	20.08.24	**CLOSED** Went to Comm 20.08.24
15.05.24	Original PPHP CoB	Laura Jones via Suzanne Didcote	Well Being of Future Generations Act (Audit Wales)	This came from the original PPHP CoB and has also been queried by Pam W	Kamala Williams / Wendy Hooson	Chris Stockport	20.08.24	**CLOSED** Went to Comm 20.08.24