

**Bundle BCU Planning, Population Health and Partnerships Committee 15**  
**January 2026**

1 SUPPORTING PAPERS

1.1 PP26.07 Supporting Papers for Director of Planning Report

PP26.07.1 FINAL - PPHP Development Session 24.09.25 - Prevention

PP26.07.2 PPHP Development Session Agenda Bundle 24.09.25 - Prevention



## Planning, Population Health & Partnerships Committee

### PPHP DEVELOPMENT SESSION - PREVENTION

<b>Date of Meeting</b>	24 September 2025
<b>Publication Status</b>	Open/ Public
	Not Applicable
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<b>Report Purpose</b>	For Noting
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#### Executive Summary

A dedicated PPHP Committee development session on 24<sup>th</sup> September 2025 explored how the Health Board can accelerate its long-standing ambition to shift focus and resources toward prevention and improved population health. Despite clear strategic intent over many years, the organisation has struggled to make a substantive reallocation of investment into prevention. The well attended session examined the systemic factors influencing population health, the interdependencies across wider determinants, lifestyle, wellbeing, long-term conditions, and the impact these collectively have on health service demand.

Discussions highlighted the need for deeper cross-sector collaboration to influence the wider determinants of health, the importance of early intervention on major long-term conditions, and the value of wellbeing and patient-defined outcomes in reducing pressure on services. Members emphasised the current mismatch between where funding is deployed and where it would have the greatest preventative impact, noting that many levers sit outside the direct control of the Health Board. Strengthening community partnerships, supporting social prescribing, engaging deprived and rural communities in ways that work for them, and leveraging the Health Board's role as an anchor institution were all identified as essential components of a long-term prevention strategy.



The group recognised the need for improved measurement of preventative impact, including short- and medium-term gains, and reflected that current Board and Committee metrics remain overly focused on acute, reactive indicators. Health and Wellbeing Hubs were viewed as a short-term opportunity to embed prevention within communities and accelerate multi-agency working. The outputs from the session are now being incorporated into the 2026–29 IMTP and the wider strategy development programme, with members recommending further development sessions throughout the year and a strengthened strategic focus in the Committee’s cycle of business.

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

<b>Committee / Group / Individuals</b>	<b>Date</b>	<b>Outcome, Evidence and Data</b>
N/A		

**Acronyms / Glossary of Terms**

PPHP	Planning, Population Health & Partnerships Committee
IMTP	Integrated Medium-Term Plan
CSP	Clinical Services Plan

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## PPHP DEVELOPMENT SESSION - PREVENTION

### 1. SITUATION

- 1.1 As part of the 'continuous planning' approach to developing the Health Board's longer-term strategies and plans, a development session of PPHP was held on 24<sup>th</sup> September 2025 to focus on Prevention and improving the health and wellbeing of the population. This report is a brief summary of the key points raised, that have been taken forward as part of the IMTP development for 2026-29 and will also contribute to the strategy development work.

### 2 BACKGROUND

- 2.1 The Health Board has had long-standing ambitions to increase the focus, emphasis and investment in prevention as part of its long-term strategies and plans to improve health and wellbeing but has not yet managed to make a significant shift in resources into this space. The PPHP development session held in Venue Cymru on 24<sup>th</sup> September 2025 was dedicated time for members to consider the challenges in achieving this and contribute to the strategic planning necessary to make this transition happen over the next few years.
- 2.2 The session was well attended by Clare Budden, Gareth Williams, Caroline Turner, Billy Nichols, Paolo Tardivel, Tehmeena Ajmal, Jane Moore, Stuart Keen, Pam Wenger, Helen Stevens-Jones, Alison Kemp, Faye Sheldon, Emma Lea, Philippa Peake-Jones, Laura Jones.

### 3 SPECIFIC MATTERS FOR CONSIDERATION

#### 3.1 PRE-READ MATERIAL

- 3.1.1 Prior to the session a set of pre-read material was circulated to ensure that members were sighted on some of the key considerations in this space ahead of the session. These will be provided alongside this report in the supporting papers of the PPHP meeting on 15<sup>th</sup> January 2026.
- 3.1.2 The material provided:
- A definition of Prevention covering primary, secondary and tertiary prevention.

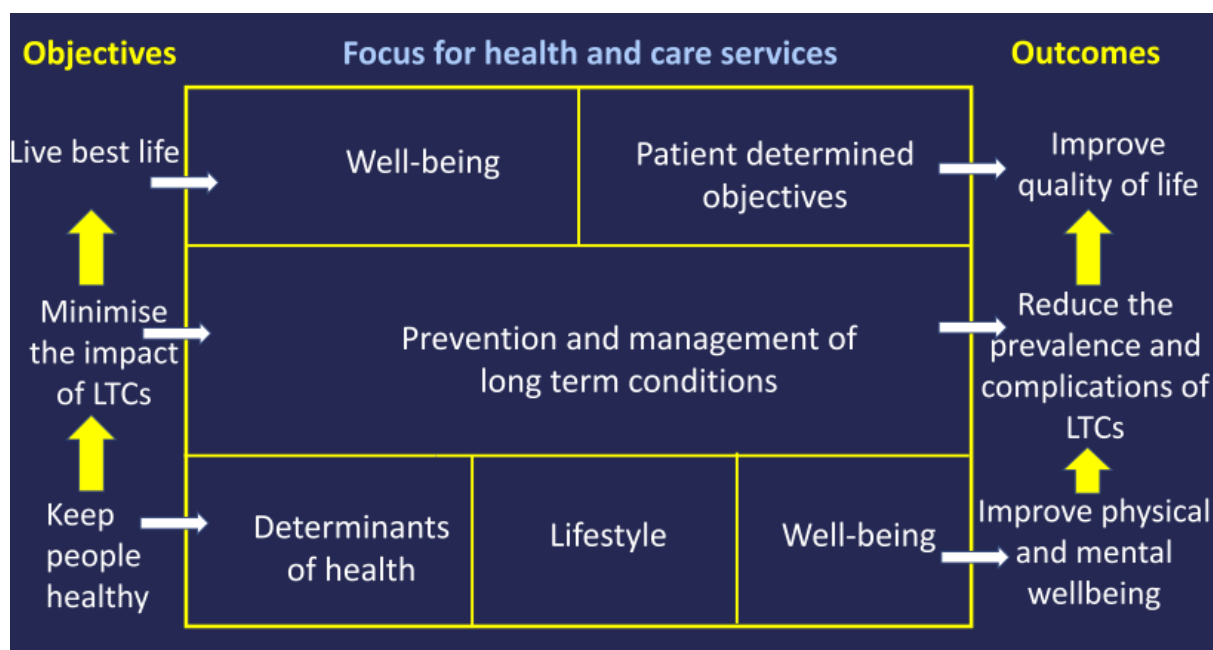
- The Focus for health and care services and the inter-relationships between the various contributory factors.
- The health needs, both now and in the future, covering aspects such as child poverty, overweight and obesity, mental health and wellbeing, long-term conditions and health inequality.
- The impact on health and care services including the NHS in 10+ years report, strategic framework for the six main major conditions in England and impact of health inequalities.
- Measurement of impact and whether the right things are being measured.
- An example of population health based planning in action through the Diabetes case for change.

## 3.2 MATERIAL PRESENTED ON THE DAY

3.2.1 The material used as the basis of discussion at the session started by highlighting the elements of the PPHP Committee's terms of reference that relate to this area:

- 2.1 Provide advice and assurance to the Board with regard to the development and oversight of the Health Board's long term planning, Integrated Medium Term Plan and Annual Operating Plan [ensuring that enabling strategies are aligned to these plans](#).
- 2.2 Ensure [effective partnership arrangements are in place to improve Population Health](#) (i.e primary care, public health and the social determinants of health) and [reduce health inequalities](#).
- 3.3 Providing advice, assurance and insight to the Board on the organisation's [ability to create and manage](#) strong planning, population health and partnership arrangements, including through [a robust data strategy](#).
- 3.4 Providing the Board with advice and insight on the development of the Health Board's Integrated Medium Term Plan (IMTP), and long term planning based on [robust business intelligence and modelling](#), and assuring the development of delivery plans within the scope of the Committee including their [alignment to the Population Health Needs assessment](#).

3.2.2 The majority of the conversation was centred around the various inter-relationships between the factors outlined in the graphic below:



3.2.3 The materials presented on the day are also part of the agenda bundle that will be provided alongside this report in the supporting papers of the PPHP meeting on 15<sup>th</sup> January 2026.

### 3.3 KEY DISCUSSION POINTS

3.3.1 The discussion started with an overview of how the diagram show in section 3.2.2 above should be interpreted. With the two objectives of the Health Board in mind of improving the health and wellbeing of the population as well as providing sustainable and effective health care services, the challenge is how to keep people healthy and how to deal with the real health impacts.

3.3.2 In order to keep people healthy, the wider determinants of health (e.g. housing, employment, education etc) need strong collaboration with partners, jointly prioritising and pooling resources to make a positive difference in these in key. These then relate to people's lifestyle, which aims to maximise the ability for people to be healthy. Poor wellbeing has a real impact on physical as well as mental health, impacting the ability for people to engage in society including things like employment. Improving both physical and mental wellbeing is one of the three key outcomes of this model.

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- 3.3.3 The next tier up in the diagram starts to introduce the risk factors or early signs of ill health. These are particularly important in relation to the six major long-term conditions of Cancer, Chronic Respiratory Disease, Cardiovascular Disease (including stroke and diabetes), Mental ill health, Musculoskeletal disorders and Dementia. The Department of Health in England reports that dealing with the complications of these diseases accounts for c.70% of health service activity. Prevention and early management of these long-term conditions and their risk factors (e.g. high blood pressure) is vital as the risk of getting another long-term condition once someone has one increases dramatically. When patients have multiple co-morbidities, there is a risk that medically improving one may have a negative impact on another. Reducing the prevalence and complications of long-term conditions then helps improve quality of life.
- 3.3.4 This then brings the top tier of the diagram into focus, where improving wellbeing and doing things like reducing social isolation is proven to be the equivalent of smoking fifteen cigarettes a day. When people report that they feel well, they are less likely to use other services. Linked to this is patient determined objectives, which is important as when people feel they have control and an ability to engage in how they manage their health and wellbeing, quality of life is improved. What is important to the patient e.g. being able to go to the hairdresser once a week, may not necessarily mean doing everything possible to improve physical outcomes, but enabling engagement in those things that the patient feels provide a good quality of life.
- 3.3.5 Following the overview above to orientate members around the model in the diagram there were a number of broader discussion points raised. The mismatch between where funding is currently allocated and spent compared to where it is most needed to drive this long-term agenda was called out. Areas such as leisure centres, schools, welfare systems being outside of the Health Board's control. Areas that do sit within health were cited as often being within the primary care contractors space and the Health Board doesn't have control over the levers in their contracts.
- 3.3.6 The importance of looking at the whole person, rather than dealing with one issue at a time was discussed and the importance of partner working in the community to undertake this type of work. There was consensus that there

is lots of work to do with communities and individuals themselves in this regard – community run initiatives like Park Run are important, but individuals need to find the motivation to take part. Social prescribing to this kind of thing in primary care was seen as a good enabler. Influencing people from a young age to build healthy habits, in both diet and exercise is key. It was reflected upon that the health system spends a lot of money on people in their last years of life, often to little effect, and relatively little on people early on in their life. This links well to the directives in the Wellbeing of Future Generations Act.

- 3.3.7 There was a discussion about the ‘what matters conversation’ in the Health and Wellbeing act, that plays into patient choice and what is most important to them – linked back to the point of quality of life.
- 3.3.8 Engagement and collaboration with local partners to develop community infrastructure opportunities was raised. There is potential to work with local planning authorities and local development frameworks on this, tying the need to invest in these types of areas when housing developments come through the planning system.
- 3.3.9 The leadership role the Health Board needs to take as an anchor institution (e.g. active work place programme) was referenced both in terms of the c.20,000 employees, but also their ability to influence friends, families and their communities. The Third Sector is already a key partner and are embedded in communities across North Wales, providing a real opportunity to accelerate this work. It was reflected upon that often things get slowed down and end solutions are not popular when they are created by large public sector organisations. It’s been proven to work elsewhere (e.g. Coventry) when a framework is set on ‘what’ needs to happen, but decisions on ‘how’ interventions are designed and delivered are devolved to communities.
- 3.3.10 There was a discussion about people that live in areas of deprivation and them having fewer options but having to make more choices. It’s important that these communities are engaged with in a place and in a way that works for them and not for public sector organisations. This feeds into the health inequalities work and there was some discussion about whether investment should be biased towards these areas and not purely on a ‘fair share’ population basis. Rural communities were also discussed in this regard.

3.3.11 Being able to identify, articulate and monitor the impact of this type of work over the short, medium and long term was discussed. It's a bit of a misconception that all types of prevention work only demonstrate impact over the long-term. Addressing hyper-tension as an example has an immediate measurable impact. There was a reflection that the key metrics covered in Executive, Committee and Board agendas do not represent enough of this type of important work and are heavily skewed towards the 'here and now'. The worry being the adage 'what gets measured gets managed'.

3.3.12 The developing portfolio of Health and Wellbeing Hubs were pointed to as a current opportunity to start to move the dial in this space – both embedding services in communities, but also collaboration with partners on the wider determinants of health.

#### 3.4 **NEXT STEPS**

3.4.1 It was felt that this session had been valuable and that more of these development sessions should be planned on key topics throughout the year. A focus on Primary and Community care next was suggested.

3.4.2 In relation to the PPHP Committee itself, there was a suggestion that the cycle of business should contain a different strategic focus in each meeting.

3.4.3 The output from this session is to be included in both the IMTP and Strategy development work, ensuring that the relationship with the Well North Wales work is considered.

#### **4 KEY RISKS / MATTERS FOR ESCALATION**

4.1 None

#### **5 RECOMMENDATIONS**

5.1 The Committee is asked to:

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



ASSESSMENT	
<b>Link to Strategic Priorities</b>	
	2. Developing strategy and long-lasting change If more than one applies, please list below:
<b>Design Principles</b>	Simplify, Standardise, and Adopt Best Practices If more than one applies, please list below:
<b>Corporate Risks and Board Assurance Framework</b>	<ul style="list-style-type: none"> <li>▪ BAF24-01 - Not Fully Building an Effective and Accountable Organisation</li> <li>▪ BAF24-02 - Not Delivering Strategic Development and Digital Transformation</li> <li>▪ BAF24-03 - Not Achieving Long Term Financial Sustainability</li> <li>▪ BAF24-04 - Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability</li> <li>▪ BAF24-05 - Not Engaging with Citizens, Partners and Communities</li> <li>▪ BAF24-06 - Not Delivering the Required Improvements to Transform Care and Enhance Outcomes</li> <li>▪ BAF24-07 - Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk</li> <li>▪ BAF24-08 - Not Implementing Evidenced Based Improvement and Innovation</li> </ul>
<b><u>Wellbeing of Future Generations Act – Wellbeing Goals</u></b>	A Healthier Wales
	If more than one applies, please list below:

IMPACT ASSESSMENTS		
<b>Equality</b> <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	
	If no, please include rationale:	



<b>Socio-Economic Impact Assessment</b> <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	
	If no, please include rationale:	
<b>Quality</b> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	<b>Enablers of Quality</b> All Apply	<b>Domains of Quality</b> All Apply
	If more than one applies, please list below:	If more than one applies, please list below:
<b>Wellbeing of Future Generations Act – Wellbeing Goals</b>	A Healthier Wales	

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

**Bundle BCU Planning, Population Health and Partnerships Committee 24  
September 2025**

- 1 13:30 - DEVELOPMENT SESSION
- 1.1 13:30 - Welcome and Apologies
- 1.2 13:30 - Development Session: Focus for Health and Care Services  
1.2 PPHP Committee Development Session Slide Pack
- 2 15:30 - Pre-Reading Material  
2 PPHP Development Session Pre-Reading



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NHS  
WALES

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Betsi Cadwaladr  
University Health Board

# PPHP Committee Development Session

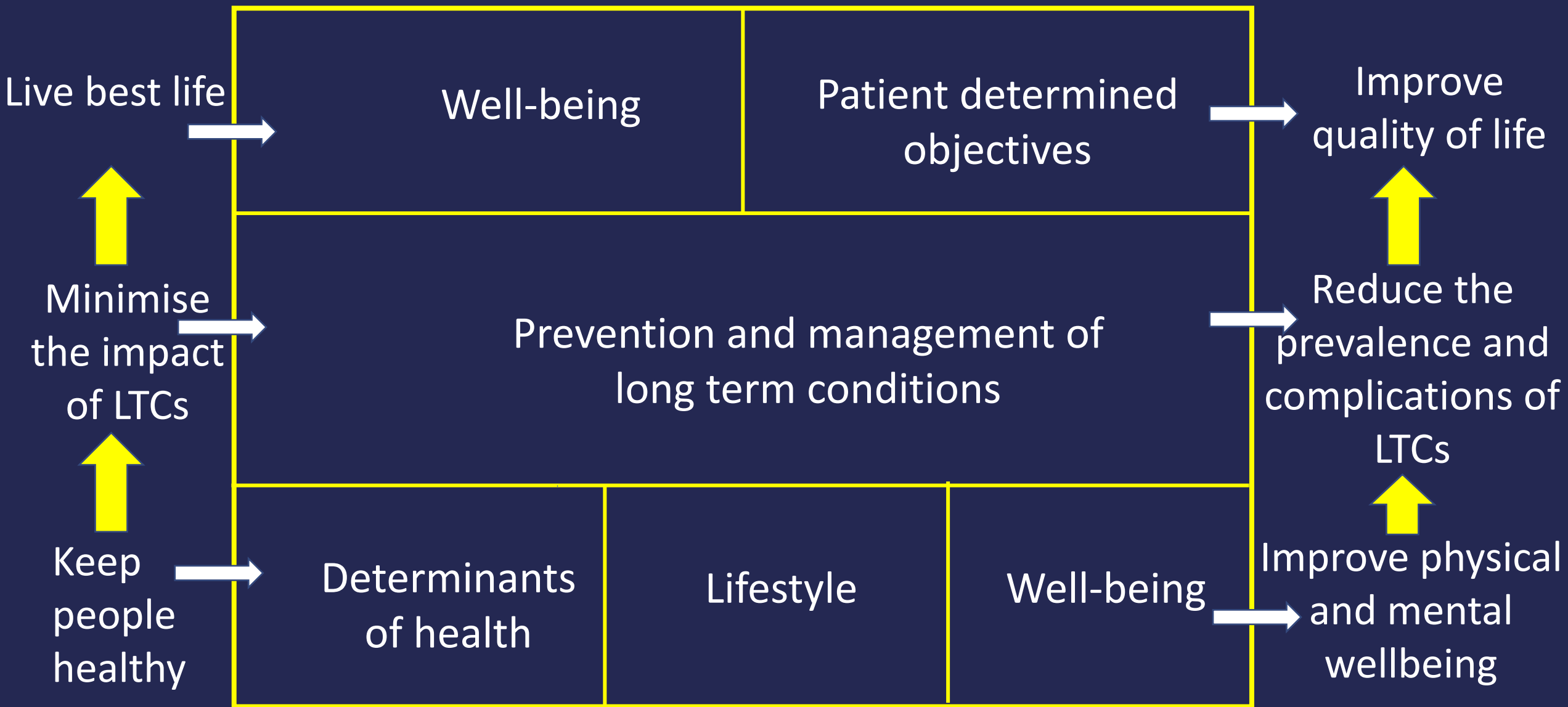
## Session Slides



# Objectives

# Focus for health and care services

# Outcomes



- 2.1 Provide advice and assurance to the Board with regard to the development and oversight of the Health Board's long term planning, Integrated Medium Term Plan and Annual Operating Plan **ensuring that enabling strategies are aligned to these plans.**
- 2.2 Ensure **effective partnership arrangements are in place to improve Population Health** (i.e primary care, public health and the social determinants of health) **and reduce health inequalities.**

*Extract – PPHP ToR, Purpose*

- 3.3 Providing advice, assurance and insight to the Board on the organisation's **ability to create and manage** strong planning, population health and partnership arrangements, including through **a robust data strategy**.
- 3.4 Providing the Board with advice and insight on the development of the Health Board's Integrated Medium Term Plan (IMTP), and long term planning based on **robust business intelligence and modelling**, and assuring the development of delivery plans within the scope of the Committee including their **alignment to the Population Health Needs assessment**.

# Discussion

- What do we want impact to look like in North Wales?
  - What does good look like and where is it seen and by whom?
- What should the focus be for PPHP in order to deliver its purpose?
  - What are the enabling strategies which most influence plan development?
  - Who are the key people / partners – how are they represented? What should they be reporting to the committee and have they got what they need to do this?
- How do we shift to integrated models of care?
  - What are the intended and unintended consequences of changes?
- When – short / medium / long – how should this be represented in our plans
  - Which measures of impact will we use?
  - How do we know we've succeeded?

# Enablers and Barriers to this agenda

- Prioritisation (national / local / conflicting) and political landscape
- Partnership and whole system approaches – prioritisation, engagement, structures
- Population Health Data and Intel
- Resources (shared, existing, new, re-design, allocation)
- Finance (shared, re-allocation, investment, opportunity costs)



GIG  
CYMRU  
NHS  
WALES

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University Health Board

# PPHP Committee

## Development Session

### Prevention & Population Health

### Pre-session reading



# Pre-read overview

*This pack provides background materials to support discussion at the session.*

- Prevention - health & care role
- Health needs – now and projected
- Impact on health & care services
- Measuring impact (and what are the right measures?)
- Examples – Population Health based planning in action

Prevention- health & care

# Prevention

## The definition of prevention

As agreed by Welsh Government and the Office of the Future Generations Commissioner for Wales

### Primary prevention:

Building resilience – creating the conditions in which problems do not arise in the future. A universal approach.

### Secondary prevention:

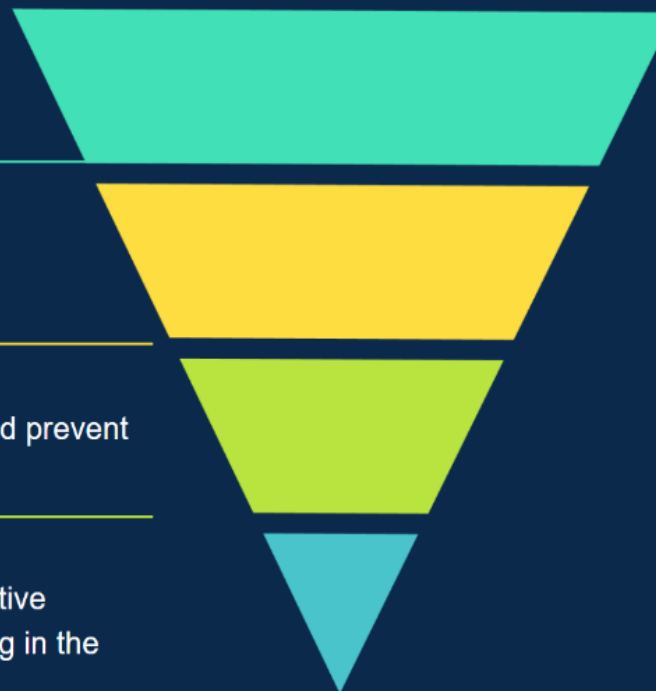
Targeting action towards areas where there is a high risk of a problem occurring. A targeted approach, which cements the principles of progressive universalism.

### Tertiary prevention:

Intervening once there is a problem, to stop it getting worse and prevent it reoccurring in the future. An intervention approach.

### Acute spending:

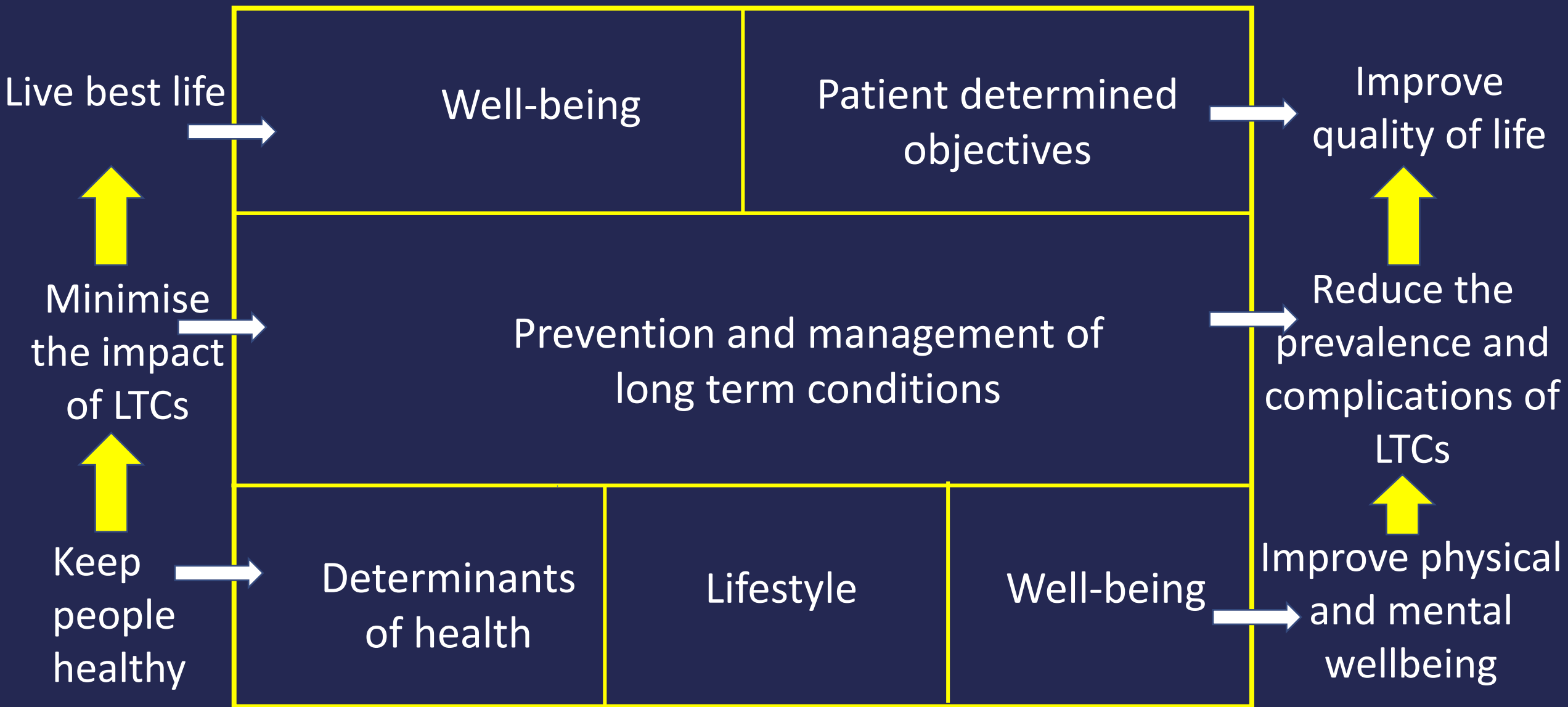
Spending, which acts to manage the impact of a strongly negative situation but does little or nothing to prevent problems occurring in the future. A remedial approach.



# Objectives

# Focus for health and care services

# Outcomes

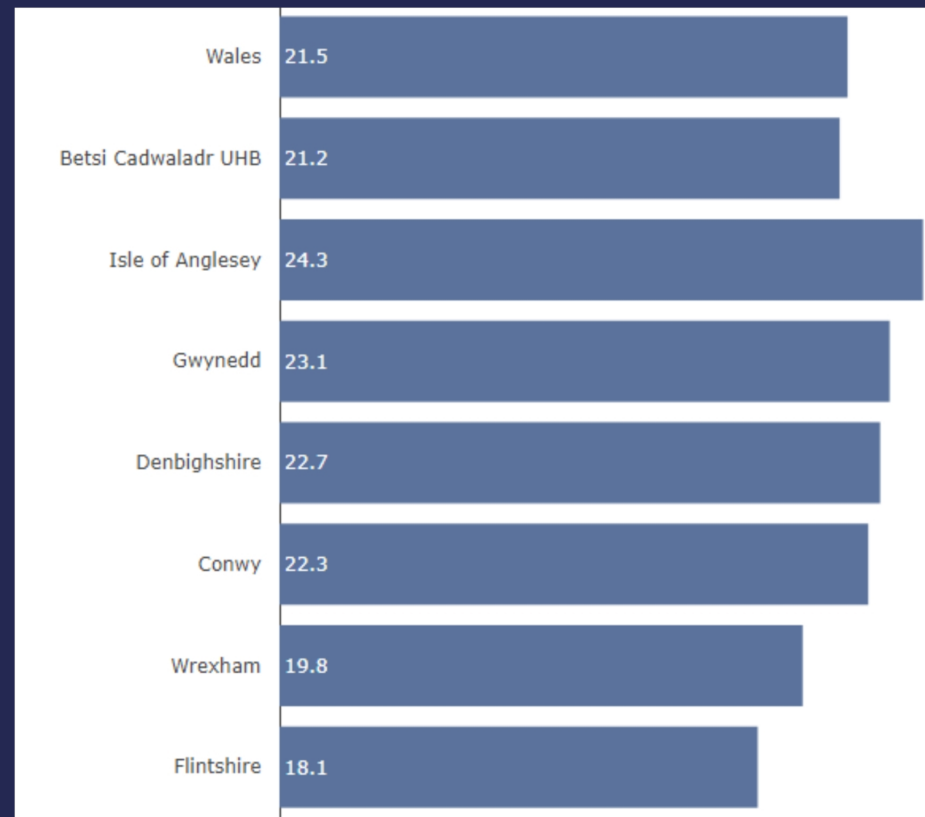


# Health Needs – now and projected

# Child Poverty

## Percentage of children living in poverty, Wales, BCUHB and unitary authorities, 2022/23

Produced by Public Health Wales, using the Registration and Population Interaction Database (RAPID), Department for Work and Pensions (DWP) and HM Revenue and Customs (HMRC)



- In 2022/23, just over **21.2%** children aged 0-15 years in BCUHB were living in poverty
- Children are one of the population groups whose health and well-being are **most affected by the cost-of-living crisis**, both directly and indirectly.
- Direct impacts of the cost-of-living crisis on children's health include a **higher risk of asthma** and other health conditions as a result of living in a cold home, and a **greater risk of obesity** as a result of missing out on nutritious food.
- Indirect impacts include being at **higher risk of exposure to adverse childhood experiences (ACEs)**, such as abuse, **increased risk of chronic illnesses** in adulthood and **poorer employment prospects** due to **lower educational attainment**.

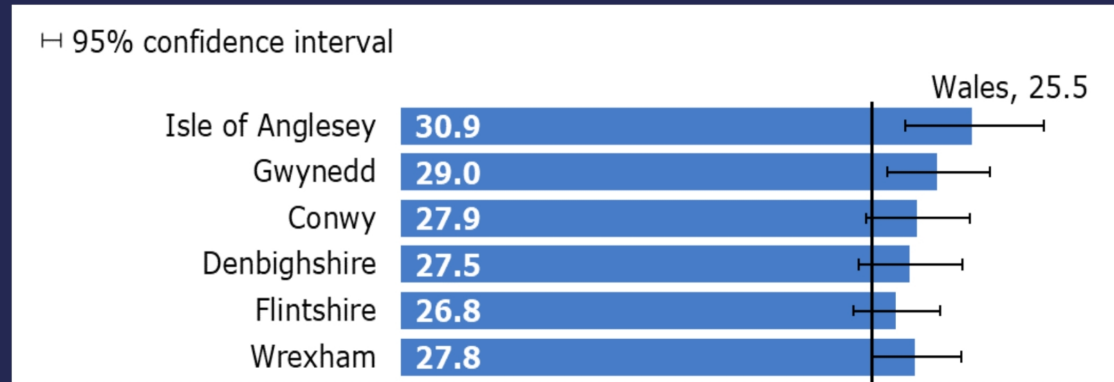
# Overweight and Obesity

- Among adults aged 16 and over, **58.9% report to be living with overweight and obesity**
- Over **84,400 BCUHB patients** are registered by their GP as having obesity; this is almost **14% of the population**.
- **28% of 4 and 5 year olds in BCUHB are overweight/obese**. This is statistically significantly higher than Wales (25.5%).
- **32.4%** of 4 and 5 year olds in the **most deprived areas** are overweight or obese, compared to **24.2% in the least deprived areas**

## Percentage of children aged 4 to 5 years who are overweight or obese, Child Measurement Programme, Wales and North Wales unitary authorities, 2023/24

Produced by Public Health Wales, using CMP data (DHCW)

### Overweight/Obese



## Percentage of children aged 4 to 5 years with overweight or obesity, difference between most and least deprived within Wales and BCUHB, 2023/24 (health board deprivation fifths)

Produced by Public Health Wales, using CMP (DHCW) and WIMD 2019 (WG)



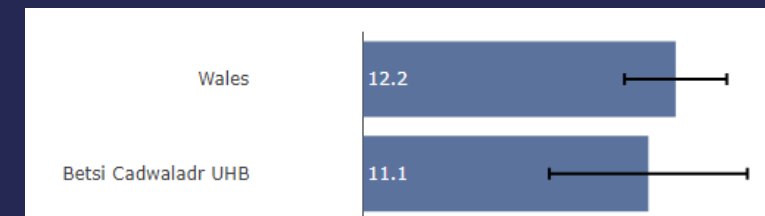
# Mental Health and Wellbeing

- In 2023, **emergency hospital admissions for mental and behavioural disorders in BCUHB (249 per 100,000 population)** were statistically significantly higher than Wales (225 per 100,000 population).
- The rate of **emergency hospital admissions due to self-harm in young people aged 10 to 24 years in BCUHB (375 per 100,000 population)** is **statistically significantly higher than Wales (239 per 100,000)**.
- People with **long-term conditions are 2-3 times more likely to experience poor mental health** compared to those without (*Welsh Government, 2025*).
- **Low wellbeing associated with higher smoking prevalence (PHE, 2021)**
  - People with Mental Health conditions are more likely to smoke than general public and smoking rates increase with severity of illness
  - Smokers >15/day more likely to experience a common MH disorder than those who smoke <15 or none
- **Self-reported mental health and wellbeing among students is statistically significantly lower** in Conwy (76.1%) and Flintshire (78.8%) than the Wales average (80.0%) (*SHRN survey*)
- Mental ill health is the **most common cause of work-limiting conditions** in those aged 44 or younger (The Health Foundation, 2023).
- The percentage **gap in the employment rate for those with a long-term health condition compared to those without is 11.1% in BCUHB and 12.2% for Wales as a whole.**



**Gap in employment rate for those with a long-term health condition, percentage, persons, Wales, Betsi Cadwaladr UHB, 2023**

Produced by Public Health Wales using APS (ONS)

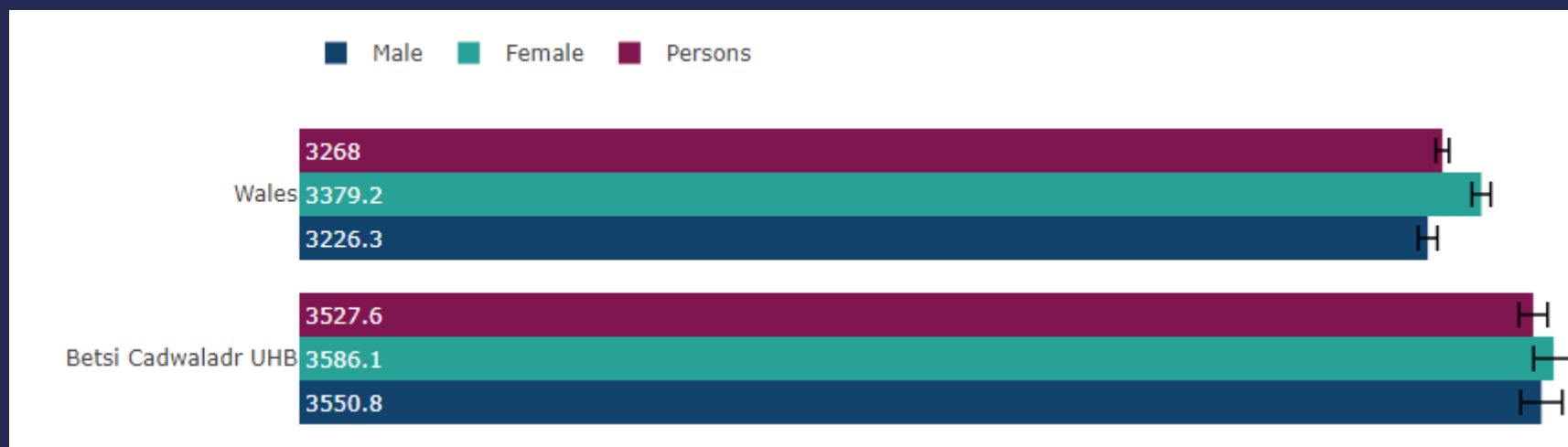


# Long Term Conditions: Cancer

- The rate of cancer in patients registered with a GP in BCUHB is **3,527.6 per 100,000 persons**, which is **statistically significantly higher compared to the all-Wales rate (3,268 per 100,000)**.
- If current trends continue, **the number of cancer cases is projected to increase by 11% from 2025 to 2035, largely driven by an ageing population** (Source: [Public Health Wales](#)).

**Cancer disease register, EASR per 100,000, persons, males and females, Wales & BCUHB, 2023**

Produced by Public Health Wales using Audit+, DHCW



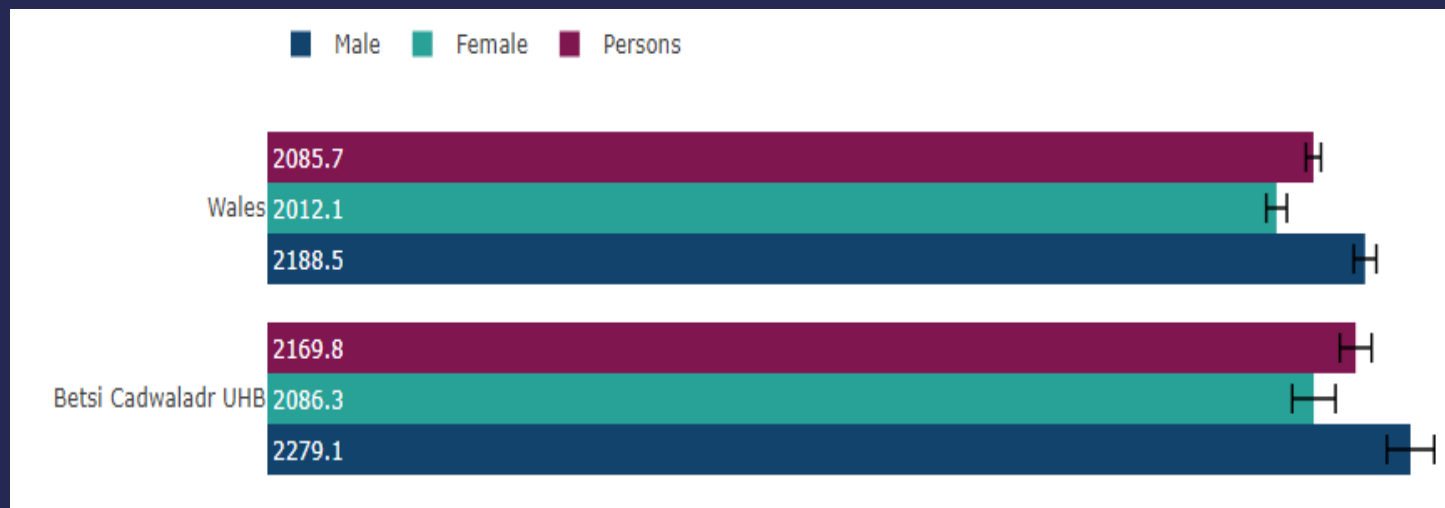
Note: data from QAIF do not necessarily equate to prevalence as defined by epidemiologists. Recorded prevalence figures based on QAIF registers may differ from prevalence figures from other sources because of coding or definitional issues. QAIF only provides recorded prevalence; it does not refer to or report on expected prevalence or estimated prevalence.

# Long Term Conditions: Respiratory Disease

- There are **18,327 (2.6%) patients registered by their GP as having COPD** in BCUHB.
- The BCUHB rate (2,169.8 per 100,000 persons) is **statistically significantly higher than the all-Wales rate** (2,085.7 per 100,000).
- Projections indicate **increasing numbers of patients on GP respiratory disease registers**

Chronic Obstructive Pulmonary Disease Register, EASR per 100,000, persons, males and females, Wales and BCUHB, 2023

Produced by Public Health Wales using Audit+, DHCW



Note:

It should be noted that data from QAIF do not necessarily equate to prevalence as defined by epidemiologists. Recorded prevalence figures based on QAIF registers may differ from prevalence figures from other sources because of coding or definitional issues. QAIF only provides recorded prevalence; it does not refer to or report on expected prevalence or estimated prevalence.

Projected change in the number of patients on GP respiratory disease registers, Wales, 2023/24 to 2033/24

Condition	Projected count in 2033/34	Percentage increase
Asthma	7.4%	7.2%
COPD	2.4%	2.3%

Notes:

Increase is predicted as the population is increasing, as well as the proportion of older people in the population. The reduced prevalence of smoking, de-industrialisation of Wales and introduction of more stringent workplace health legislation will influence future prevalence of COPD.

(Source: [Respiratory disease prevalence – trends, risk factors, and 10-year projections - Public Health Wales \(nhs.wales\)](#)).

# Long Term Conditions: CVD

- The number of patients on GP disease registers for **cardiovascular diseases and cardiovascular risk factors** has **increased** across Wales over the last 13 years (*Public Health Wales*)\*
- **17.1%** of BCUHB patients are registered by their GP as having **hypertension**, compared to 15.8% across Wales.
- The number of people on the **hypertension register** across Wales has **increased by 11%** between 2009/10 and 2023/24. Numbers are expected to increase by a further 7% between 2023/24 and 2033/24, which is just **over 1 in 6 people**.

## Patients registered by GP with a cardiovascular condition, 2023

Source: Public Health Wales Primary Care Cluster Dashboard

Condition	Number on register	Percentage on register		Rate per 100,000 persons	
		BCUHB	Wales	BCUHB	Wales
Heart failure	8,779	1.2	1.2	1,025.9	1,140.9
Stroke & TIA	15,903	2.2	2.2	1,868.6	2,005.3
Hypertension	122,616	17.1	15.8	14,818.4	14,814.5
Atrial fibrillation	18,878	2.6	2.5	2,182.2	2,301.9

Note: data from QAIF do not necessarily equate to prevalence as defined by epidemiologists. Recorded prevalence figures based on QAIF registers may differ from prevalence figures from other sources because of coding or definitional issues. QAIF only provides recorded prevalence; it does not refer to or report on expected prevalence or estimated prevalence.

## Projected change of the number of patients on GP cardiovascular disease registers, Wales, 2023/24 to 2033/34

Source: [Public Health Wales](#)

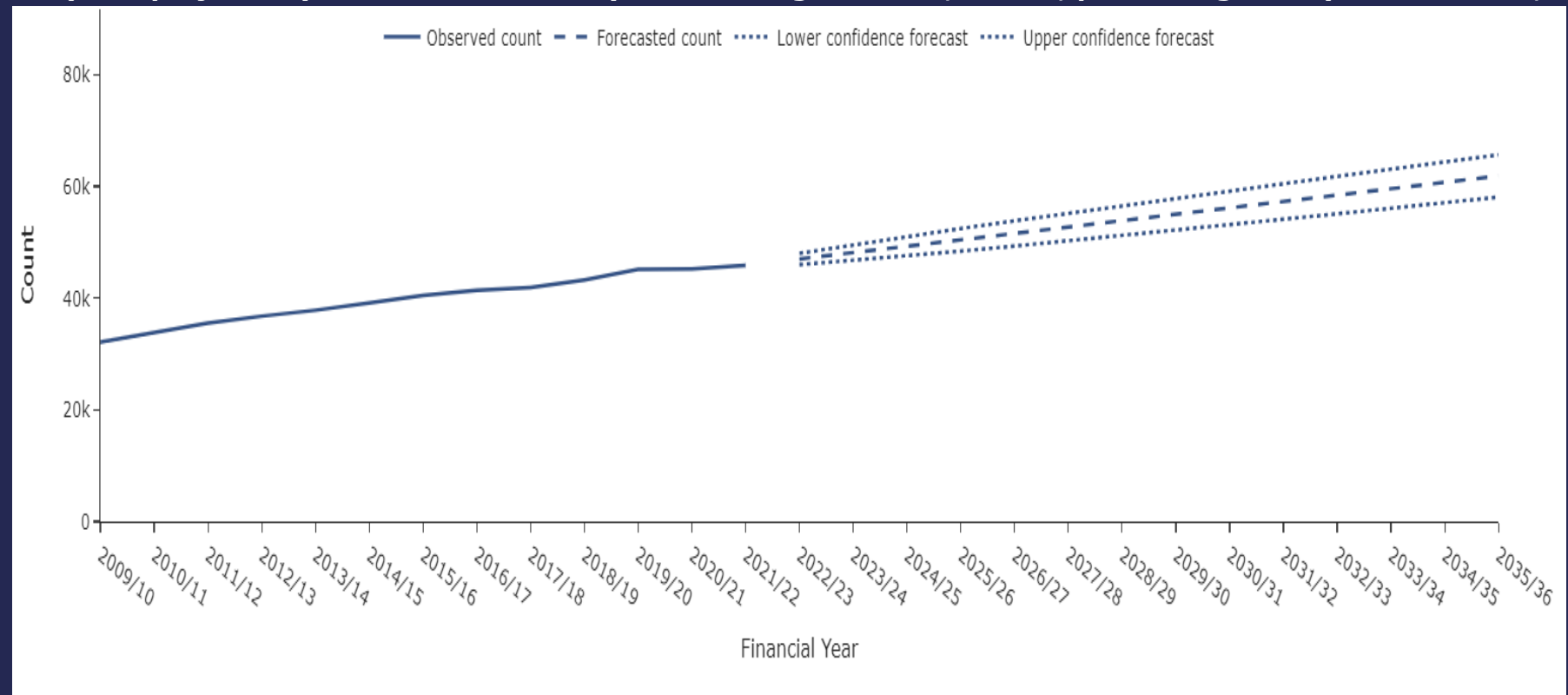
Measure	Condition	Percentage increase
Cardiovascular disease	Heart failure	46%
Cardiovascular disease	Stroke/Transient Ischaemic attack (TIA)	8%
Clinical risk factor	Hypertension	7%
Clinical risk factor	Atrial fibrillation	26%

# Long Term Conditions: Diabetes

- There are just over 47,000 (8%) patients registered by their GP as having diabetes.
- While the BCUHB rate (7,100 per 100,000 persons) is statistically significantly below the all-Wales rate (7,694 per 100,000), projections suggest **number of diabetes registrations in BCUHB is predicted to rise from 46,994 in 2022/23 to 61,861 in 2035/36**, an increase of 31.6% compared to an increase of 29.6% across Wales as a whole.

**Observed (2009/10 to 2021/22) and projected (2022/23 to 2035/36) diabetes registrations, counts, persons aged 17 years and over, Betsi Cadwaladr UHB**

Source: Public Health Wales Observatory



# What is Health Inequality?

Health Inequalities are differences in people's health across the population and between specific population groups, that are **systematic, avoidable and unfair**.

The term is used in many different ways and can refer to differences in :



Health Status



Access to Care



Quality and experience of care



Health-related behaviours



Wider determinants of health

Health Inequalities- Public Health Network Cymru

Equal access in healthcare has long been a goal, but more recently the focus has turned to equity.



The Difference Between Health Equity and Equality - Johns Hopkins ACG<sup>®</sup> System

## Life expectancy

The Gap between **least and most deprived** for Men in North Wales is



**7.2**  
**years**

The Gap in **healthy life expectancy** for Men in North Wales is

**12.2**  
**years**

The Gap between **least and most deprived** for Women in North Wales is



**5.7**  
**years**

The Gap in **healthy life expectancy** for Women in North Wales is

**10.9**  
**years**

Source: Produced by Public Health Wales Observatory using PHM, MYE (ONS) & WIMD 2019 (WG)

ANGLESEY



Traws Cymru  
train route

Life expectancy across North Wales differs from stop to stop.



WREXHAM

## Health Inequality in North Wales

There are Lower Super Output Areas in BCUHB. **423**

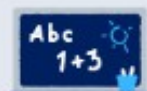
**48** are in the 20% most deprived LSOAs in Wales.

Below is the number LSOA's within the 20% most deprived for each domain within the Welsh Index of Multiple Deprivation (WIMD). Source: wimd.gov.wales



**50**

Health



**63**

Education



**115**

Access to Services



**80**

Community Safety



**88**

Housing



**45**

Employment



**54**

Income

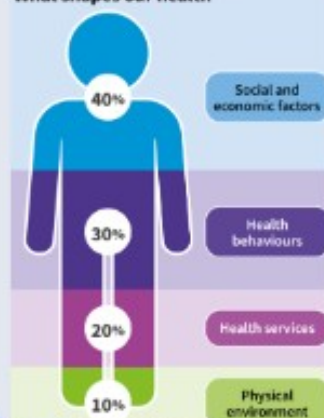


**12**

Physical Environment

## Social Determinants of Health

What shapes our health



Source: Health Inequalities and the social determinants of health - CHEX

## BCUHB adult health behaviours data



**10.6%** who smoke



**16.0%** drink above guidelines



**45.8%** meeting physical activity guidelines of active 150 mins per week



**37.4%** of a healthy weight (working age 16-64)

adults living in the most deprived areas are less likely to follow healthy lifestyle behaviours due to factors influenced by the social determinants of health.

Source: Produced By Public Health Wales using NSFW (WG)

## BCUHB Housing and Education data

### Homelessness

FIGURE 6: Households assessed as homeless between April 2024 and March 2025 - Rate per 10,000 households



Source: www.gov.wales/homelessness

**1707**

Households accommodated temporarily (end of quarter, Jan-Mar 2024-25)

Source: StatsWales

**29.6%**

Low income households (households below 60% GB median (= <£23,572)), 2024

**14.6%**

Young people not in education, employment or training (NEET), 2024

Source: Gov. Wales - Young people not in education, employment or training (NEET), 2024

Source: North Wales Regional Innovation Coordination Hub, December 2024 using GIG PayCheck, 2024

# Impact on Health & Care services



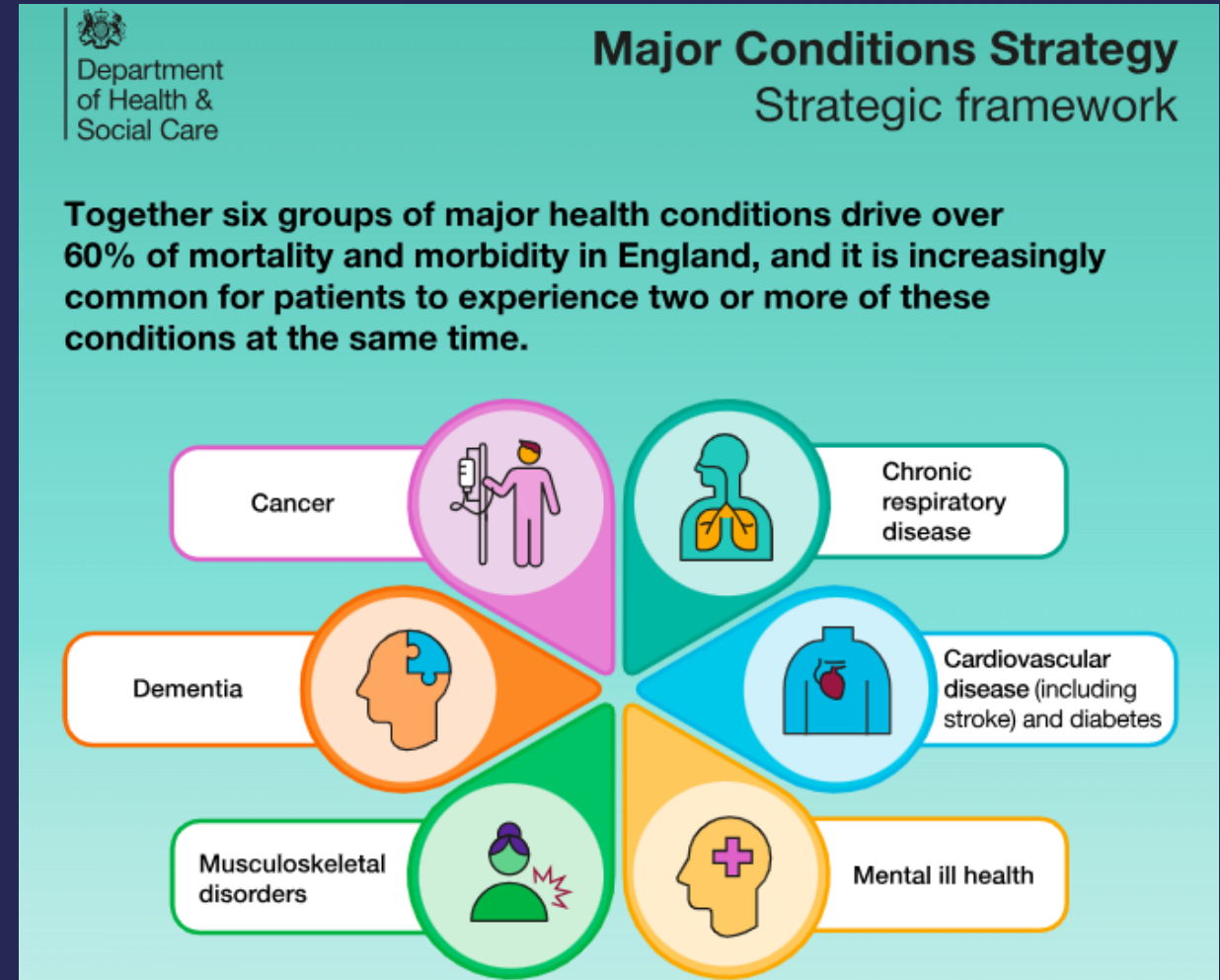
Llywodraeth Cymru  
Welsh Government

# NHS in 10+ Years

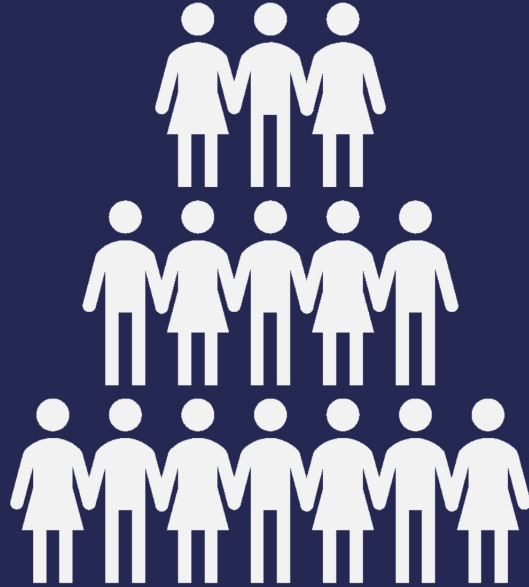
Population Projections	Long-Term Conditions (LTCs)	Risk Factors	Supply: NHS staff, beds, social care	Economic Considerations	New Technology, Genomics and Artificial Intelligence (AI)
Ageing population: 1 in 5 age 70+ by 2038	Ageing population means a higher proportion living with LTCs	21% of people in Wales living in relative income poverty	Reductions in time spent in hospital expected	NHS Wales under significant pressure from growing patient needs and restricted capacity	Advanced tech will likely increase self-management of some LTCs
UK life expectancy growing slower than similar countries	People living with 4+ LTCs to almost double by 2035	Cost of living crisis likely to deepen existing health inequalities	Significant increase in NHS staffing needs*	Funding gap in Wales – spending per person is like England, but less than EU-14 **	Increased use of digital and tech will likely improve health surveillance
Stark differences in life expectancy between least and most deprived groups	The majority of people with 4+ LTCs will have mental ill-health by 2035	Rates of obesity are expected to rise until 2031-37	Impacts may be mitigated by changes in technology and workforce composition	UK spends 55% less on Capital Health spending than EU-14** (eg, buildings and equipment)	Improvements to medicine and public health through new genetic and genomic technologies
Potential causes: widening health inequalities, slow economic growth	More cancer cases in people aged 70+ by 2040	Adult smoking trends have been decreasing over time	Burden on GPs and community/ social care is likely to increase	Population health impacts individual and national prosperity	Adoption of AI and supporting Research and Development will drive innovation in healthcare
	Diabetes prevalence to rise, a 22% increase by 2035-36	Modifiable behaviours are risk factors for many LTCs	Number of 65+ requiring unpaid care is growing	Poor physical and mental health is associated with drop in earnings	AI needs to be regulated, ethical and transparent

# Major Conditions Strategy (DHSC, 2023)

- 6 major condition groups driving >60% of disease burden and significantly impacting NHS capacity/workforce productivity in England



# Impact of Health Inequalities



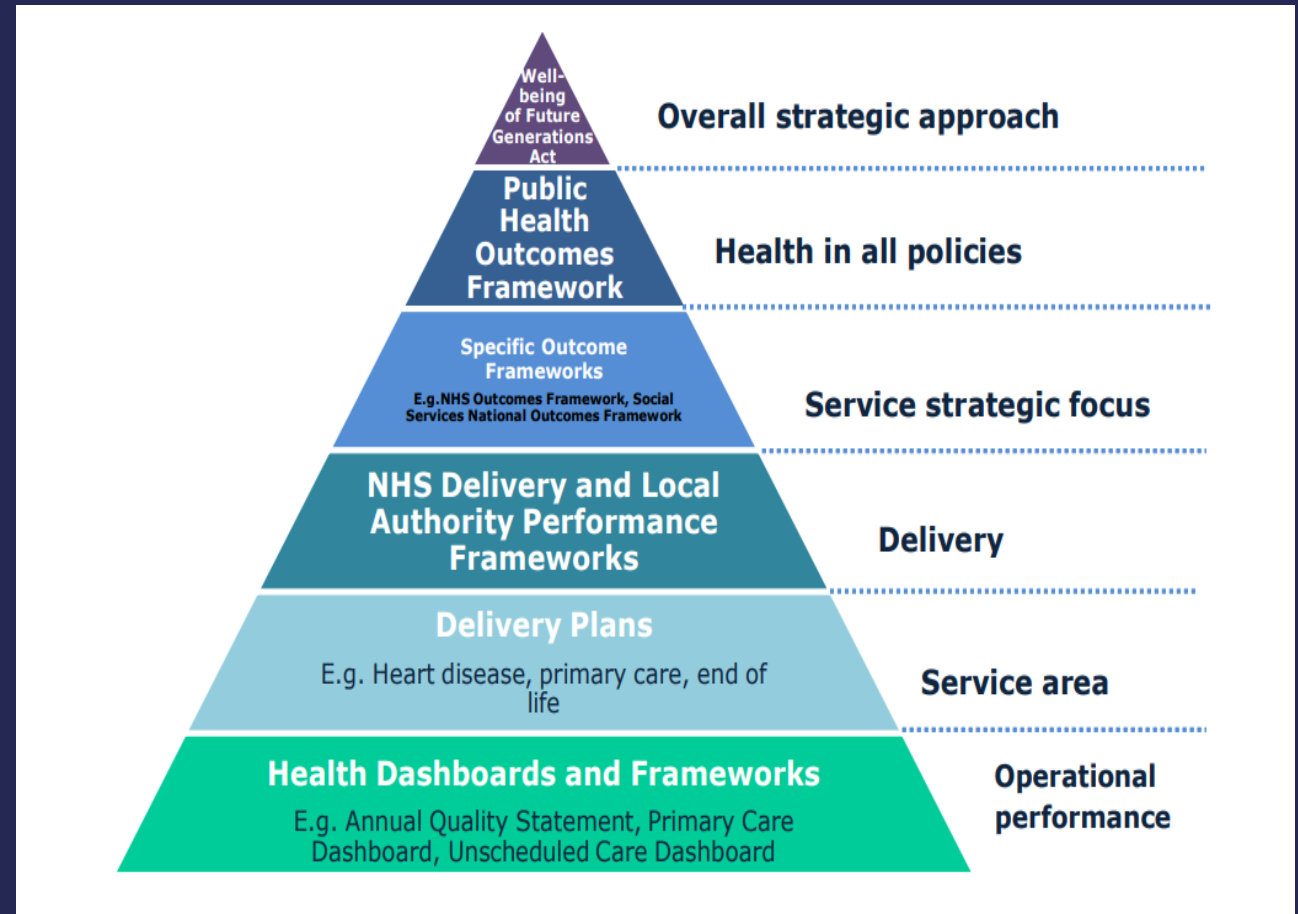
- Targeted efforts to reduce health inequalities are needed to help drive improvements in healthcare **efficiency** and **outcomes**
- Reducing health inequalities requires addressing **social determinants of health** and **enabling equitable healthcare access**

*“The gap between the least and most deprived areas in Wales, for premature deaths from non-communicable diseases, has been increasing in recent years, and is now almost two and half times greater in the most derived areas, compared to the least.” (Public Health Wales 2023)*

Measuring Impact – (and are we measuring  
the right things?)

# Measuring impact (current):

- Quadruple Aim 1 – performance measures
- Specific measures – are result focused rather than focused on component parts or causal components
- Public Health Outcomes Framework
- Development of dashboards
- 29 indicators are directly attributed to achieving 'A Healthier Wales'



Measuring the Health and wellbeing of a Nation, 2016

# Measuring the right thing

The following measures can support a shift from intervention to well-being focused plans:

- Data gathered from Patient Determined Outcomes (inc PROMs, PREMs)
- Wellbeing Outcomes
- QALYs DALYs
- Reduction (over time) Poverty, Unemployment – Wider Determinants
- Health Impact Assessment trends
- Population Needs Assessment trends
- PHOF
- Prevention and management of LTCs shift towards integrated models of P&CC (access numbers, change in patient / public behaviour, impact on demand elsewhere in Health system and non Health care services eg Social Prescribing)

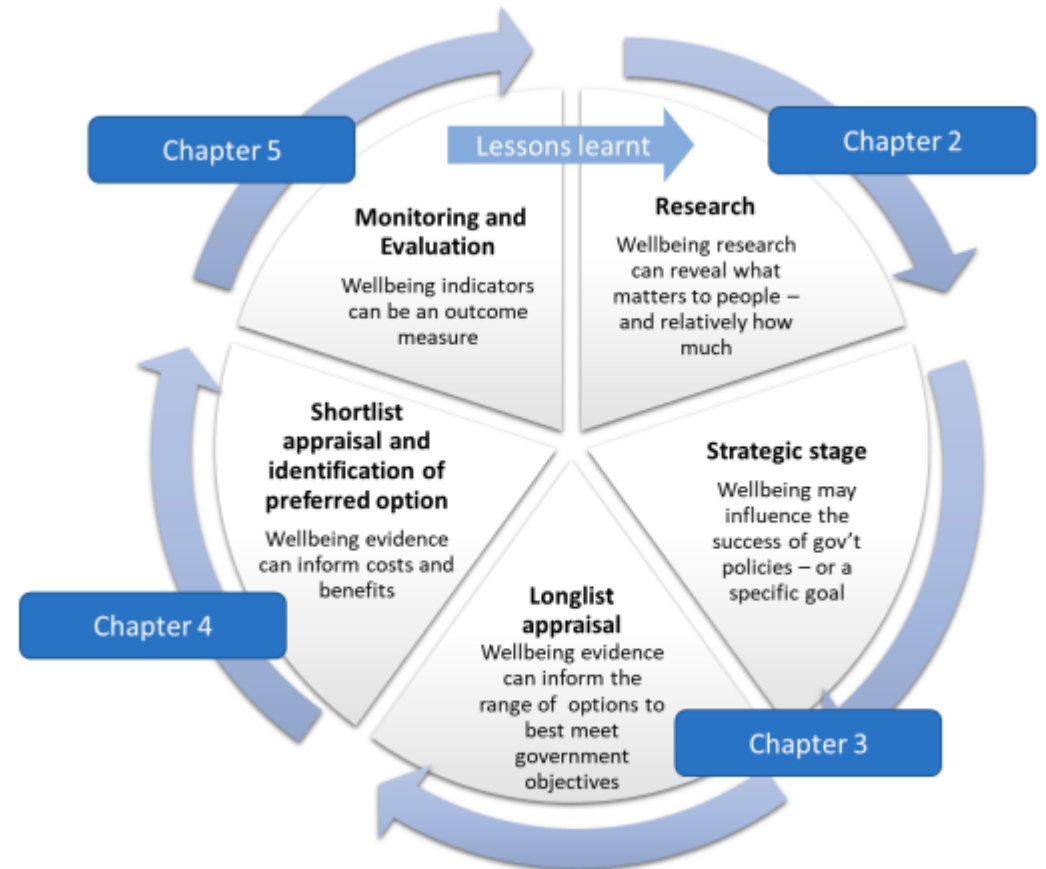
# Measuring Wellbeing (*UK Gov Green Book Supplementary Guidance: Wellbeing*)

UK Government Green Book Guidance supports the **inclusion of wellbeing impacts in public sector appraisals**

## Why It Matters:

- Wellbeing is a **part of public value and policy development**
- **Wellbeing indicators can attempt to measure societal development and quality of life**

Figure 1: Wellbeing in policy development



Source: *Outline of Key Appraisal Steps from The Green Book (HM Treasury, 2020, Box 2 page 6)*, amended to add wellbeing considerations and background research stage

# Wellbeing as a tool to address Inequalities

- **Approaches focused on wellbeing** can reveal underlying health, income, and social inequalities, and can provide solutions to addressing them
- **Place based interventions and community-centred approaches** can reduce inequalities and support inclusive community-centred policies to improve wellbeing outcomes for all





# Patient determined objectives

- Enabling people to be **in control** and **feel involved** in decision making can lead to better outcomes
- **Personalised care** is of the 5 changes outlined in the NHS Long Term Plan
- 3 Primary Care Network (PCN) multidisciplinary roles support delivery of personalised care in England
  - Care Coordinators
  - Health and Wellbeing Coaches
  - Social Prescribing Link Workers
- **ARRS roles** are helping to provide proactive, personalised care from an MDT to help people to **stay well for longer**

[NHS England » Expanding our workforce](#)

# Examples – Population Health based planning in action

# How are we tackling health inequalities and shifting to prevention?

## Well North Wales

RPB-led whole system approach to improving wellbeing and reducing health inequalities through addressing the wider determinants of health and enabling community-led approaches.



## Place-based approach to Physical Activity



We have, worked with Actif North Wales and partners to pilot a place based approach to physical activity to understand what matters most to residents about how they use places and spaces to keep active and well, and mobilise community assets.

Communities are becoming more engaged in local decision making, increased partnership working and more opportunities be active have been created.

## Whole Systems approach to Healthy Weight



Message sent to Lydia  
9/9/2

Laura messaged should  
have it tomorrow  
11/9/2025

## Help Me Quit



BCUHB has the highest number of smoking rates for pregnant women in Wales. HMQ piloted an incentive scheme across North Wales to support pregnant smokers to quit smoking.

Improved outcomes were reported for the incentive cohort during the pilot period compared to usual care and to those achieved in previous year.

Message sent to Chloe for explanation of outcome improvement 11/9/2

HOLYHEAD



WREXHAM

## What are we doing next?

### Prevention Framework

Working with regional partners to develop a regional prevention/wellbeing framework to reduce inequalities through the wider determinants.

### Anchor Framework

Supporting the development of the regional Anchor framework to improve health outcomes for the population through opportunities, employment, assets, and staff wellbeing.

### Inclusion Health

Developing our strategic case for tackling health inequalities through an inclusion health offer.

## How this work can be supported?

### Embed equity in decision making

Apply a health inequalities lens when approving policies or strategies and ensure Equality Impact Assessments are used consistently.

### Target resources proportionately

Take a 'proportionate universalism' approach to ensure universal services are available for all, but are scaled and targeted according to need.

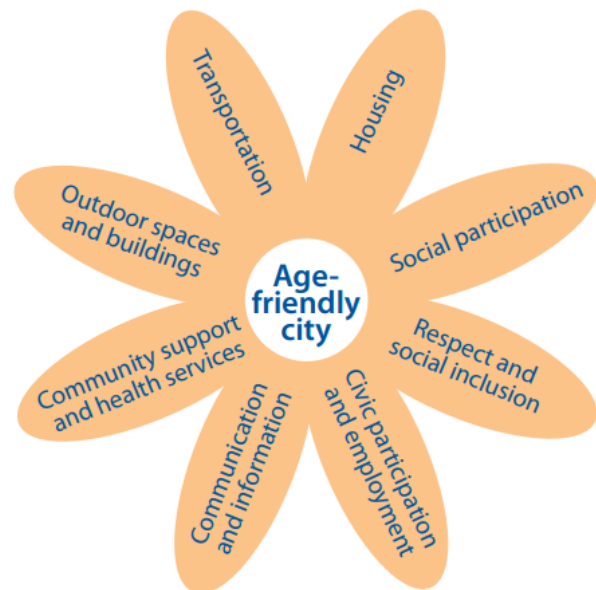
### Improve data and accountability

Ensure regular reporting on health inequalities in access, outcomes and experience by deprivation, geography and protected characteristics and hold services accountable for reducing gaps.

# Improving wellbeing – Places, Spaces and Social Connection

- WHO’s “age friendly cities framework” identifies 8 domains to identify and address barriers to wellbeing and participation of older people, to support **active ageing** and **enhance quality of life for older people**.

Figure 6. Age-friendly city topic areas



- There are a menu of possible wellbeing interventions linked to positive outcomes – including **neighbourhood design, green and blue space, placemaking** and **urban regeneration**
- **Community hubs** and **community development** improve social relations, individual mental health and wellbeing, and community wellbeing e.g. through new informal community support networks, creation of skills
- **Green space** interventions improve **community** and **individual** wellbeing e.g. opportunities for social activities and volunteering, community empowerment



» [Places, spaces and social connection: five years of new learning](#)

[community-hubs-green-space-April2021.pdf](#)



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

# Population Health based planning in action – to drive service improvement and delivery to meet the needs of North Wales Example – Diabetes Case for Change



# Case for change – informing future plans

- The following slides provide an example of a population based prevention model applied to Diabetes and how it informs changes within a future health delivery system
- This model could equally support the development and planning for prevention models for other long term conditions
- This model could support approaches to address the wider determinants of health

## System-Wide Enablers

**Objective:** Empower staff and optimise system-level enablers and collaborative approaches.

## Secondary and Specialist Care

**Objective:** Deliver advanced management and interventions for complex cases.

## Integrated Primary Care and Early Intervention

**Objective:** Provide early support to those 'at risk' and care to those diagnosed

## Population- Based Prevention

**Objective:** Prevent diabetes and identify risks early within the North Wales population



# Methodology

## DIABETES TRANSFORMATION PROGRAMME: DEVELOPING THE CASE FOR CHANGE

INTELLIGENCE GATHERING AND CO-PRODUCING THE WAY FORWARD

April 2024 onwards

Intelligence gathering process began with information from:

- Public Health Wales (engaged for modelling)
- Data profiling - service, best practice and technologies
- Clinically-focused discussions
- Staff and service user feedback
- Online survey
- Face to face events
- Stakeholder group
- MP and MS correspondence
- PALS
- Compliments and complaints
- Integrated Equalities Impact Assessment

Did you know...

Over 45,000 people are currently living with Type 2 Diabetes in North Wales.

Did you know...

25% more people are expected to be diagnosed with Type 2 Diabetes in the next ten years.

Public survey

22.11.2024

### CONSENSUS EVENT ONE

#### Understanding the current state

All known intelligence was presented to describe the current state and need for change. Design principles were developed based on conversations and circulated for feedback.

Stakeholder feedback on principles

13.12.2024

### CONSENSUS EVENT TWO

#### Co-developing principles for re-design

Feedback on the principles was discussed to agree the underpinning approach to change as well as discussions on what changes could be made to improve the service.

Equalities focus group

21.02.2025

### CONSENSUS EVENT THREE

#### Agreeing the vision

Based on all conversations and intelligence collected, agreement to change was made with a potential future model presented for initial feedback.

Full feedback collation and phase 2 EQIA

MAY 2025

### CASE FOR CHANGE

Approval to move to an Options Appraisal phase is being sought.

#### We're working with you to:

- Stop people developing diabetes wherever possible.
- Make sure services are as close to where people live as possible, and,
- Improve the way we plan for and manage diabetes services.



# Findings- Data & Evidence- Prevalence of Diabetes



Projected Diabetes Prevalence, 2024

49.28K



Projected Diabetes Prevalence, 2035

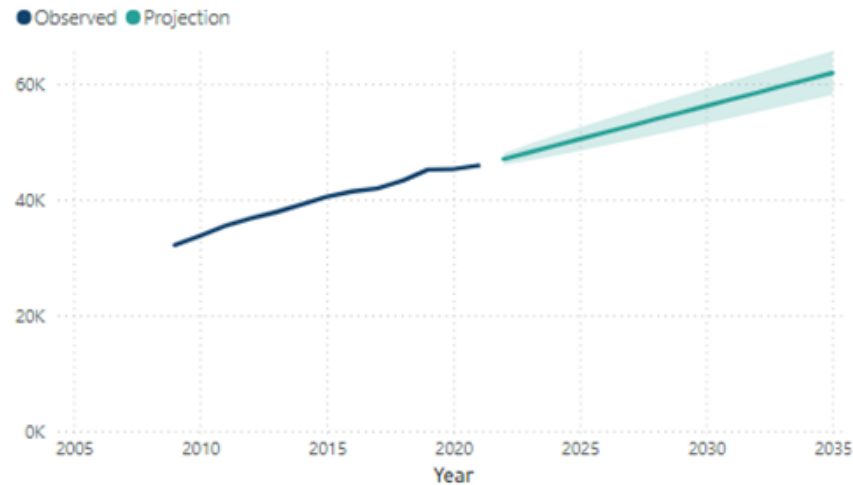
61.86K



Diabetes Prevalence Increase: 2024 to 2035

25.5%

People aged 17+ living with diabetes in BCU



The number of people aged 17+ living with diabetes in BCUHB is projected to increase to over 60,000 by 2035/36 ([based on PHW projections](#)). This dashboard explores potential consequences for people and for the health system. Diabetes is associated with a range of complications and with substantial health system activity.

#### Notes on interpretation:

- This dashboard takes a simple approach to projecting consequences of the rise in diabetes. For the most recent year where data is available on the factor of interest, the rate per person with diabetes is calculated. This is then multiplied by the projected increase in diabetes prevalence.
- This simple approach may miss complexities, such as trends in the factor of interest that are independent of changing diabetes prevalence, the impact of health system actions, or the impact of age of the population with diabetes. However, given data limitations and the goal of looking at a broad range of consequences, it is a practical way to get a quick overview of potential impact.
- The historical trend in the factor of interest is also shown, and can give a sense of how realistic the projected trend is.
- Many of the consequences of diabetes are not coded directly under diabetes. This dashboard describes some of these consequences, but is not comprehensive. For example, under prescribing we look only at diabetes-specific prescribing, and spend data is limited to the programme budget category for diabetes.
- Consequences of diabetes occurring in people with diabetes may not be attributable to diabetes. For example, diabetes raises the risk of cardiovascular disease, but eliminating diabetes would not eliminate cardiovascular disease. In this dashboard, we do not attempt to separate attributable and non-attributable risk (although this may be done in an extension).
- Throughout, year generally refers to financial year (except where otherwise stated).



# Findings- Data & Evidence- Prevalence of Diabetes- Risk Factors

- **Overweight/Obesity: accounts for 80-85% of the risk of developing Type 2 diabetes.**
  - Currently around 59% of adults in North Wales are overweight or obese
  - 26% of children in their first year at primary school are overweight or obese in North Wales
- Family history
- Deprivation: more disadvantaged at higher risk
- Ethnicity: people of African-Caribbean; Black African; South Asian descent at higher risk
- History of gestational diabetes: 7-fold increased risk of Type 2 diabetes later in life.
- Low birth weight infants in later life have an increased risk
- Other lifestyle behavioural factors including physical inactivity, smoking and alcohol



Data & Evidence- Complications of Diabetes- Multisystemic- reduction in risk through condition management

## **Macrovascular – Atherosclerotic CVD leading cause of death in Type 2 DM**

**CVA-** 2 x risk in first 5 years

**MI and heart failure** - 2.5 x risk

**Peripheral arterial disease** – contributing to foot ulcers

## **Microvascular**

**Diabetic Kidney Disease** - leading cause of Chronic Kidney Disease and End-Stage Renal Disease

**Retinopathy** - leading cause of preventable sight loss - 25% of people with Type 2 DM develop some degree of retinopathy

**Diabetic neuropathy** – peripheral, autonomic, sensory and motor – around 50% of people with DM affected



## Findings- Data & Evidence- Complications Diabetes- 2

**Foot problems** – aetiology - PAD and peripheral neuropathy - risk factor for foot ulcers, sepsis and amputation (~70% of amputations in BCUHB)

**Metabolic – Dyslipidaemia, Diabetic Ketoacidosis & Hyperosmolar Hyperglycaemic State** (Dyslipidaemia as CVD risk - DKA and HSS presenting as life-threatening emergencies)

**Psychosocial** - Diabetes may negatively impact on quality of life and is associated with an increased risk of anxiety and depression. The prevalence of depression is about twice as high in people with diabetes as in the general population

**Reduced Life expectancy** - in people with type 2 diabetes, the risk of death is 32% greater than expected, and is mostly in younger people and females. Life expectancy reduced by ~10 years in T2DM



# Findings –Specialist and Secondary Diabetes Care

- Diabetes care and management is across broad range of secondary care services including; endocrinology, dietetics; outpatients; structured education; specialist psychology, ophthalmology,
- Over 2,300 Emergency Department attendances with principal diagnosis of diabetes between April 2021 and November 2023.
- 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 (2021/22).
- Type 2 diabetes accounts for 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.
- The percentage of total inpatients with any mention of diabetes is higher for residents from the most disadvantaged areas compared to the least deprived.
- Inpatient mortality for people with diabetes (20.6%) is considerably higher than for people who do not have diabetes (8.1%).

## Specialist diabetes: The Super Six (WITHIN ACUTE TRUST)

### 1. A) Patients in hospital

In-patient care

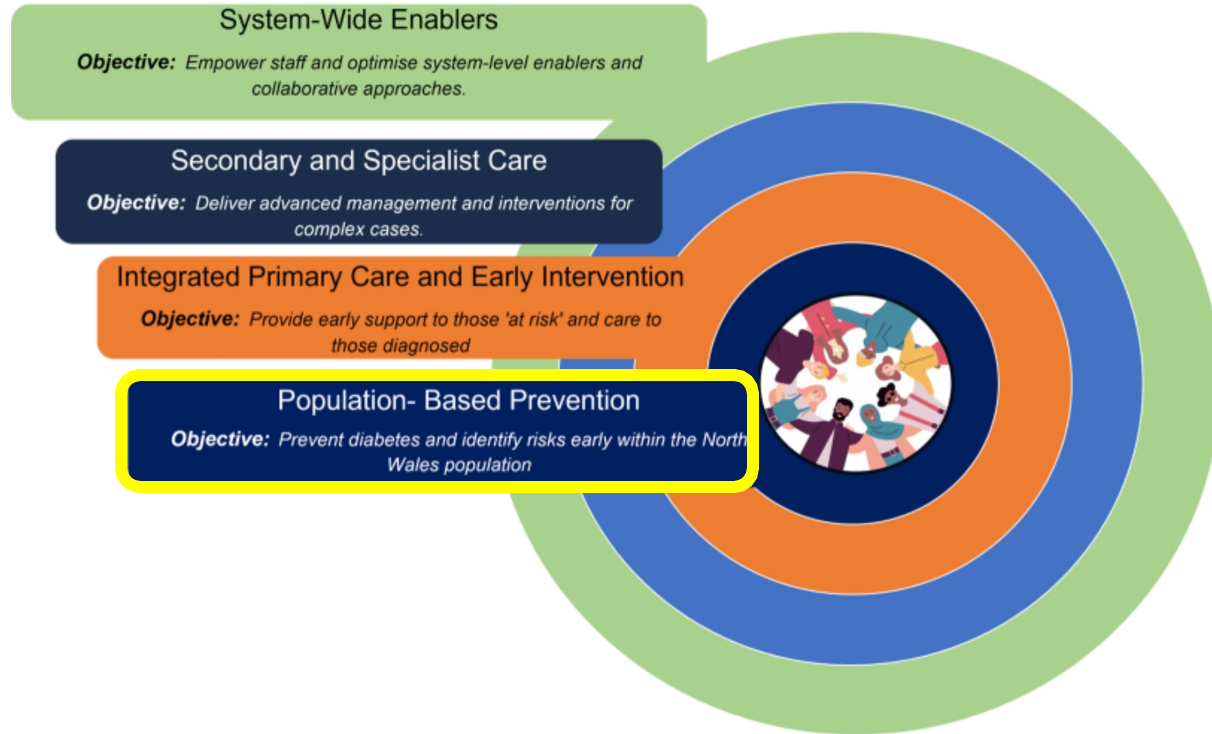
Peri-operative care

### B) MDT services:

- 2. Antenatal diabetes
- 3. Foot diabetes
- 4. Pumps
- 5. Adolescent/Type 1 Diabetes (poor control)
- 6. Renal (eGFR between 20-40 and less-in joint conjunction with Renal)

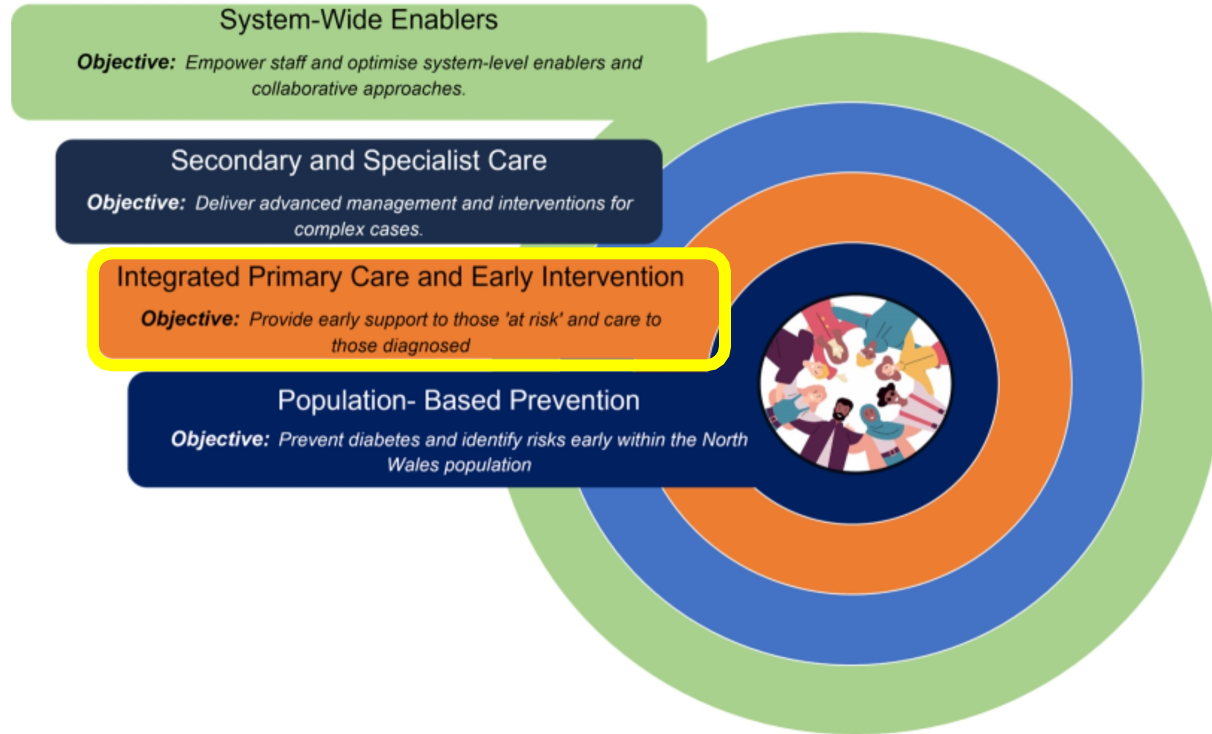


# Population-based Prevention



- The model is focused on individuals, their families and the communities they live in.
- At the heart of this is keeping people healthy so there is a strong focus on population based prevention.
- Supported strongly within the data, evidence and identified throughout engagement.
- Around half of all type 2 diabetes can be prevented or delayed.
- Population based programmes include those that increase physical activity, promote healthy weight and weight management, as well as approaches that address the determinants of health.

# Integrated Primary Care and Early Intervention



The model is underpinned by effective and integrated prevention and early intervention offer delivered through primary care.

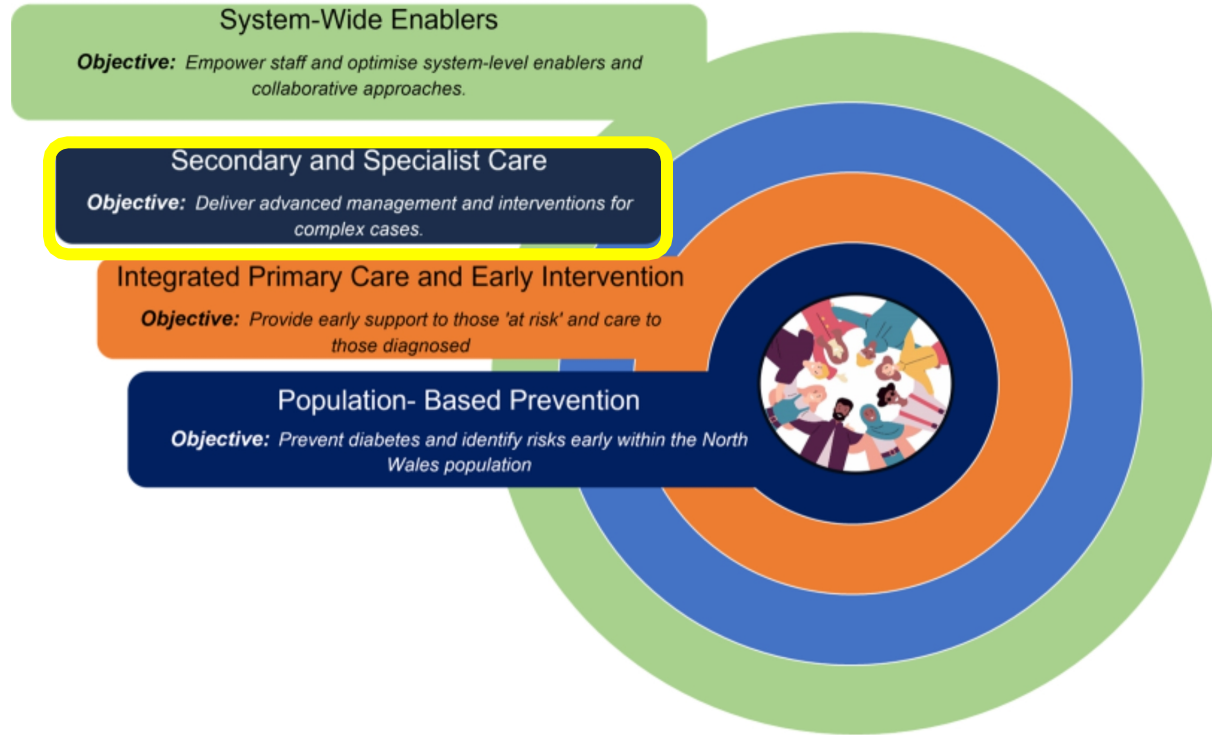
This should include boarder prevention offers, as well as managing those at risk of diabetes and supporting those with diabetes to remain healthy and avoid complications.

Data, evidence and stakeholder intelligence showed that a strong prevention focus and holistic, patient orientated delivery model, was needed to deliver this.

It was identified that transformative change was needed within primary care to develop an effective offer.

*Example: For people who are at a higher risk of developing diabetes, there is evidence that structured lifestyle support can prevent or delay the onset of type 2 diabetes – this could be linked to primary care and delivered as part of a wider (primary care plus) offer.*

# Secondary and Specialist Care



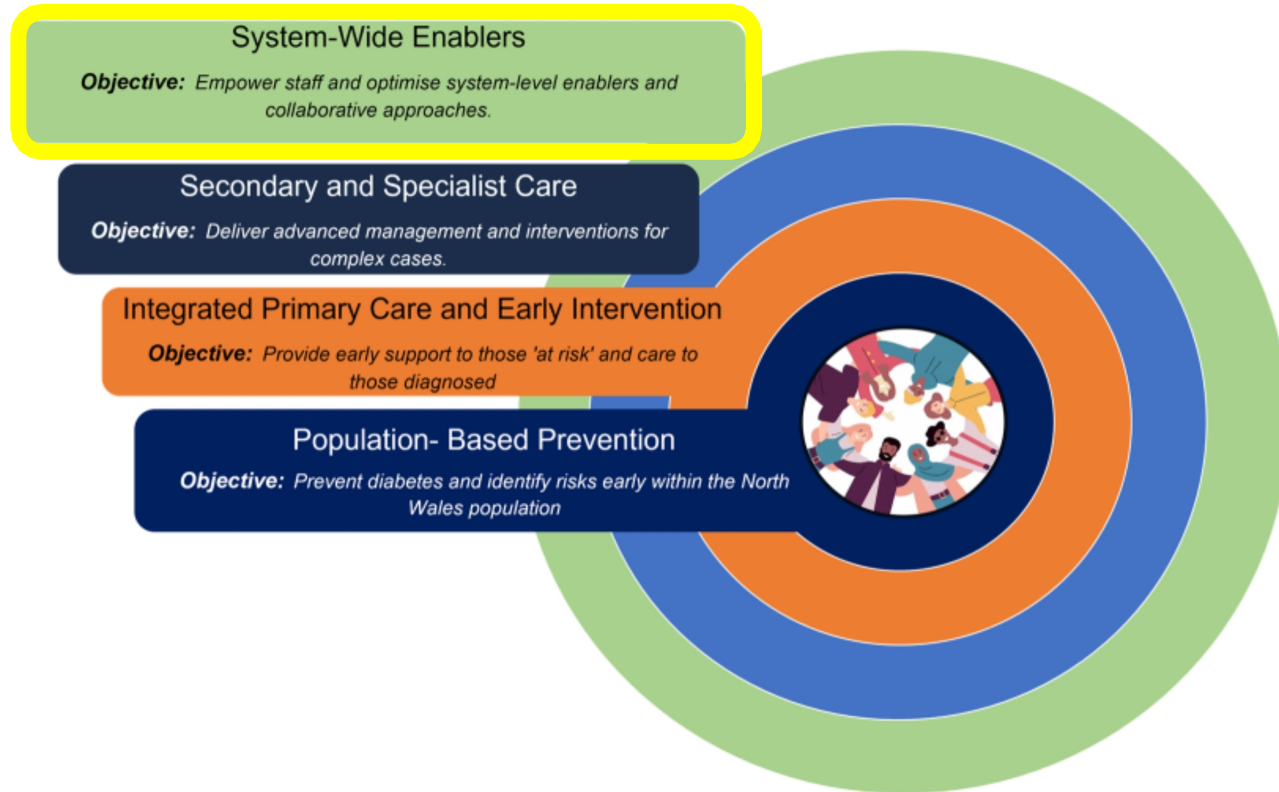
The need for effective secondary and specialist care which integrates with primary care, identified through data, evidence, stakeholder intelligence and strong theme within consensus workshops.

This includes treatments, clinical management, and complications associated with diabetes that would be most effectively delivered in specialist and secondary care settings.

Need to maximize use of these services to keep people living with diabetes well and to avoid complications.

*Example: Psychological support is important specialist service for people living with diabetes as evidence shows that people with diabetes who experience depression and anxiety are more likely to develop complications.*

# System-Wide Enablers



Key to the model are enablers that wrap around all elements of care and services, recognizing cross-cutting requirements for successful pathways, and advancements in technologies and evidence-based interventions this includes:

- Workforce
- Data and Intelligence
- Digital offers
- Technology
- Behavioral and peer based support systems

These are the factors that support self-care and effective self-management.