AN EXAMPLE

Meeting Date	7ᵗʰ June 2018		Agenda Item	4b
Report Title	**Staying Healthy**			
Report Author	Dr Nina Williams, Liz Newbury-Davies, Bethan Jenkins, Claire Thompson, Claire Fauvel			
Report Sponsor	Dr Sandra Husbands			
Presented by	Dr Sandra Husbands			
Freedom of Information	Open			
Purpose of the Report	1. To update and inform the committee on key quality and/or safety issues related to public health services under Staying Healthy; 2. To inform the committee of actions to mitigate; 3. To alert the committee to risks to quality and safety associated with these services			
Key Issues	**Safe and effective care** ABM Smoking Cessation Services: Minimum service standards are being developed Hospital Smoking Cessation Service**:** A review of service issues and needs is being undertaken Smoking Cessation in pregnant women: Work to Improve compliance with NICE maternal smoking guidance is in place. Substance Misuse Drug Related Deaths 2016: Highest rates for drug related deaths in ABM U HB in Wales is being investigated by the Area Planning Board. Immunisation: An MMR catch up cluster pilot found that almost 50% of those invited had already been vaccinated. The need for routine data cleansing in primary care has been highlighted and is being actioned through Strategic Immunisation Group (SIG).			
Specific Action Required *(please ✓ one only)*	**Information**	**Discussion**	**Assurance**	**Approval** ✔
Recommendations	Members are asked to: • **Receive**			

Assessment

Staying Healthy

3.1 Tobacco Control

3.1.1 ABM Cessation Services

Safe and Effective Care:
ABM cessation services are supporting a national work programme on developing minimum service standards. The standards will help to ensure quality control, quality assurance and quality improvement for cessation services in ABM, and across Wales.

The ABM Cessation Services Steering group are in the process of developing a risk register. The group are collaborating and addressing collective service issues within the Quality and Safety agenda.

3.1.2 Hospital Cessation Service

Workforce, Impact, Effective Care, Equality:
A meeting has been held between the Executive Director of Public Health and Neath Delivery Unit Director to explore service issues including the lack of service clinical lead.

A service review will now be undertaken to understand all service issues and needs, in order to inform next steps. The service review will consider issues across the standards within the Quality and Safety agenda for example workforce provision; effective care; equality of service, such as for mental health patients and pregnant smokers; and support for broader work such as training, and the smoke free hospitals agenda.

3.1.3 Smoking Cessation Pregnant Women

Effective Care:
National monthly meetings are being held to look at system wide improvements across Health Boards for maternal smoking. ABMU has no specialist MAMMS service for pregnant smokers in line with evidence and the requirements of the WG National Improvement programme.

Safe Care:
The ABM maternal smoking working group is progressing work to improve compliance with NICE maternal smoking guidance; referral to cessation services and improve attrition in cessation services for pregnant smokers

3.1.4 ABM UHB Smoke-Free Hospitals

Effective Care:
Smoking on hospital grounds continues to be a widespread issue. No further update to report at present as we are awaiting guidance on the Public Health Act regulations consultation.

Recommendations – Tobacco Control:
- Note the progress made and actions in place

3.2 Healthy Eating, Physical Activity and Obesity

As highlighted previously, the Obesity Pathway review identified a number of overarching considerations and recommendations for action, many of which related to quality and safety issues. The work will now be progressed through a business case approach for consideration by Board

Recommendations - Healthy Eating, Physical Activity and Obesity
- Note the action in place

3.3 Substance misuse- Drug Related Deaths 2016
See attached report or website link below
http://www.wales.nhs.uk/sitesplus/documents/888/Drug%20related%20deaths%202016%20-%20analysis%20of%20data%20from%20Office%20for%20National%20Sta....pdf

Data from ONS state that drug related deaths have risen and reached the highest ever recorded level. ABM UHB area has the highest recorded rate of drug misuse deaths at 11.4 per 100,000 population in 2016; a rise in a rate of 1.6 per population. However substantial increases in rates were also recorded in Cardiff and the Vale, Hywel Dda and Cwm Taf.

The highest rate of drug misuse deaths were recorded in Neath Port Talbot at 18.3 per 100,000 population. Swansea had a rate of 11.47 and Bridgend 5.12.

The highest number of deaths occurred within the 35-39 age group. The increase in drug misuse deaths in 2016 were driven by increases in three main drug categories: other opiates (not heroin / morphine), benzodiazepines and cocaine. Evidence indicates that poly-drug use is present in the majority of deaths.

Males account for the majority of deaths in all years for which the data is available and in 2016, accounted for 76% of drug misuse deaths. Deaths among men rose sharply in 2015 however deaths among women remained relatively stable until a substantial increase in 2016. The proportion of women dying from drugs other than heroin / morphine increased at a greater rate in 2016.

Drug harms are typically associated with social and economic deprivation and this relationship is strikingly illustrated in the data on drug misuse deaths. Almost 34% dying of drug misuse came from the most deprived areas; rising to 58% for those in the most deprive quintile.

It is intended that the Western Bay Area Planning Board will hold a summit, in the near future, to explore the increase and aim to develop a strategy to reduce drug misuse deaths locally.

3.4 Immunisation

MMR catch up pilot was undertaken by school nursing for 5-18 year olds during the Easter holidays 2018 in a primary care cluster: 557 children identified and invited, 101 attended of which 49 did not require vaccination as they had already been vaccinated. This was confirmed by the parent hand held record. The pilot highlighted the importance of data cleansing prior to routine and specific activities such as a planned catch up immunisation session. Strategic Immunisation Group

(SIG) is working with primary care services directorate on solutions to rectify this and to look into reasons for non- attendance. SIG reports into quality and safety forum.

Recommendations Substance Misuse and Immunisation:

- Note the progress made and actions in place

Governance and Assurance

Link to corporate objectives *(please ✓)*	Promoting and enabling healthier communities		Delivering excellent patient outcomes, experience and access		Demonstrating value and sustainability		Securing a fully engaged skilled workforce		Embedding effective governance and partnerships	
	✓									
Link to Health and Care Standards *(please ✓)*	Staying Healthy	Safe Care		Effective Care	Dignified Care		Timely Care		Individual Care	Staff and Resources
	✓	✓		✓						

Quality, Safety and Patient Experience

The issues highlighted cover quality, safety and effective care and actions are intended to improve patient experience and outcomes through prevention and early intervention.

Financial Implications

Work being undertaken within current resources.

Legal Implications (including equality and diversity assessment)

The actions are within the Governance framework and equality and diversity are taken into account in all actions.

Staffing Implications

Maintenance of consistent data quality and immunisation uptake rates are dependent on sufficient staffing resource.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

A more equal and healthier Wales. Prevention and early intervention issues raised should promote long term health needs but genuine collaboration, integration and public involvement still requires more work.

Report History	Some issues raised at Quality and Safety Forum 3/5/18
Appendices	Staying Healthy Reporting Template

Appendix 1

Quality & Safety Committee

Staying Healthy Reporting

Focus: The committee's focus is on all aspects aimed at ensuring the quality and safety of healthcare, including activities traditionally referred to as 'clinical governance'

Overarching NHS driver is to ensure core values are enacted with particular reference to:
Putting quality and safety above all else: providing high value evidence based care for our patients at all times i.e. *"doing the right thing, in the right way, in the right place, at the right time and with the right staff".*

Focus for reporting	Things to consider
Safe Care	Are we providing safe care? How do we know? What are the issues or concerns e.g. accidents, incidents, near misses, not meeting safety standards for service delivery etc.
Effective Care	Are we meeting required standards of effective care? How do we know? E.g. NICE or other effectiveness or quality standards for service delivery, evidence based approaches adopted?
Individual Care	• Are we improving user experience? How do we know? • Do we engage, consult and listen to our population? How is this then used to improve and • deliver services? What about feedback from patients/end users, complaints / compliments?
Workforce	Are staff encouraged and enabled to improve the services they deliver? Do staff have the right skills/competency to deliver; do they have access to appropriate CPD and skills development? Are there concerns regarding the workforce's (directly managed or in the wider system/providers) ability to deliver?
Equality	Are we providing accessible and equitable services? How do we know? We need to consider both the issue of health inequalities and how different population groups might be differentially impacted / benefitting from the service but also access/equity from the perspective of the 9 protected characteristics (Equality Act 2010). Do we undertake some form of HIIAs and HEAs? Do we understand geographical and social disparities in our populations and their effects on access to and/or effectiveness of services?
Impact *(not about performance)*	Are we improving population health and/or wellbeing, as it relates to quality & safety? *N.B. This is not about performance against targets or benchmarked comparators.* This is about what impact, if any, are elements related to quality and safety affecting/impacting on outcomes e.g. lack of staffing means a lower uptake rate of imms/vacs or failure to adhere to best practice/evidence base has led to...? Is it likely to change in the near future?
Timely Care	Are people receiving the care they need in a timely manner? How do we know? E.g. waiting times, delays in service delivery etc.
Other	Are any of the issues noted above likely to change in the near future? What are your predictions? What action could/should/is being taken by whom, to address areas of concern and by when?

Appendix 2

See attached report or website link below

http://www.wales.nhs.uk/sitesplus/documents/888/Drug%20related%20deaths%202016%20-%20analysis%20of%20data%20from%20Office%20for%20National%20Sta....pdf