Meeting Date	**4th October 2018**	**Agenda Item**	**3b**
Report Title	**Staying Healthy**		
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Presented by	Dr Sandra Husbands, Director of Public Health		
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 note the progress and actions in place.			

STAYING HEALTHY

1. INTRODUCTION

The report is to update and inform the committee on key quality and/or safety issues related to public health services under Staying Healthy and the actions to mitigate or alert of risks of quality and safety associated with these services.

2. BACKGROUND

ABM Cessation Services
Safe and Effective Care:
ABMU 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 ABMU Cessation Services Steering group are in the process of developing a risk register.

Hospital Cessation Service
Workforce, Impact, Effective Care, Equality
A meeting has been held between the Executive Director of Public Health and Chief Pharmacist 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.

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 ABMU 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

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.

Substance misuse - Drug Related Deaths 2016
Safe care:
Data from the Office for National Statistics (ONS) state that drug related deaths in the UK had risen to highest ever recorded level in 2016. This is the most recent year for which data are available. There has been a general trend, since 2005, for Wales to have higher rates of drug misuse deaths than England. In Wales the rate of drug misuse deaths rose from 58.3 per million in 2015 to 66.9 per million in 2016. ABMU Health Board area continues to have the highest recorded rate of drug misuse deaths in Wales, above the Wales average: in 2016 there were 11.4 drug related deaths per 100,000 population; 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 (Drug deaths in Wales 2016, Public Health Wales Substance Misuse Programme)

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

The highest number of deaths occurred within the 35-39 age group. The increase in drug misuse deaths in 2016 was driven by increases in three main drug categories: other opiates (not heroin/morphine), benzodiazepines and cocaine. Evidence indicates that using several drugs together 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.

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% of people who died of drug misuse came from the most deprived geographical areas; with 58% of them being in the most deprived quintile[1].

[1] Bottom 5th of population by deprivation scores.

Public Health Wales will publish its analysis of the next *Drug Deaths in Wales* report on 28th September. This Report will give a detailed insight analysis of death rates, causes of death and age profiles, from which mitigating actions can be taken by the Area Planning Board.

Recently there has also been an apparent cluster of serious infections and an increase in leg amputations in our hospitals occurring in people who inject drugs into their groins. This is being investigated by an Incident Control Team, led by Health Protection, to determine whether there is a pattern of increased infections and raised amputation rates in groin injectors across Wales. Analysis is being undertaken by the Field Epidemiology Service, which has not yet reported on its findings.

Western Bay Area Planning Board (APB) is holding a summit in early September to discuss these issues, including drug related deaths; drug associated violence and vulnerability (including County Lines) and their policing; and serious infections associated with drug use. The APB will use the summit to explore the issues and develop strategies to reduce drug misuse deaths and serious infections. The outcome of the summit will be reported back to this committee

Immunisation

Safe and effective care:

An 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 were identified as requiring MMR and invited to receive it. 101 attended, of which 49 did not require MMR, 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. The Strategic Immunisation Group (SIG) is working with the Primary and Community Services Directorate on solutions to rectify this and to look into reasons for non-attendance.

SIG reports into the Quality and Safety Forum and has undergone an Internal Audit. The Internal Audit Report on Vaccination and Immunisation, reported previously, identified potential risks for the SIG: key groups not operating as intended; performance issues not monitored; poor engagement and communication between health board groups and Primary and Community Services Directorate; and, with relevance to lack of data cleansing, no mechanism in place to ensure the quality of the data reported. A Management Action Plan has been developed to address the recommendations and will be reported to the Audit Committee.

3. GOVERNANCE AND RISK ISSUES

The Internal Audit Office has given us a rating of limited assurance for vaccination and immunisation and a management action plan is in place.

4. FINANCIAL IMPLICATIONS

None.

5. RECOMMENDATION

To note the progress 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	1.Staying Healthy Reporting Template 2. Drug deaths in Wales 2016, Public Health Wales Substance Misuse Programme						

Appendix 1

Staying Healthy Reporting Template

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?