ABM University Health Board	
Date of Meeting: 01/02/2018 **Name of Meeting: Quality and Safety Committee** **Agenda item: 3.1**	
Subject	**Staying Healthy Update (Health Care Standard 1.1)**
Prepared by	Dr Nina S Williams, Liz Newbury-Davies, Bethan Jenkins, Sally Pearson
Approved by	Dr Sandra Husbands
Presented by	Dr Sandra Husbands, Executive Director of Public Health

1.0 Situation

This report informs the Quality and Safety Committee on Public Health priorities being progressed within the Staying Healthy Health Care Standard 1.1, across Tobacco Control, Healthy Eating, Physical Activity & Obesity, Immunisation and Healthy Cities including Early Years.

2.0 Background

This report describes quality and safety issues related to key Public Health priorities within the Healthier Communities objectives of the Health Board's Annual Plan and within the Staying Healthy Health Care Standard. These include;

- Tobacco Control
- Healthy Eating
- Physical Activity & Obesity
- Immunization
- Healthy Cities, including Early Years

Consideration has been given to key components and core values of the Quality and Safety agenda across these areas and delivered through healthcare services, programmes or initiatives. These being: safe care; effective and individual care; workforce; equality; impact and timely care. A Staying Healthy reporting framework has been developed for this purpose as outlined in appendix 1. These seven themes collectively describe how a service provides high quality, safe and reliable person and population centred care.

This report identifies relevant issues and risks across these themes and key public health areas, and improvements or mitigation are highlighted.

3.0 Assessment

3.1 Tobacco Control

3.1.1 ABM Cessation Services

ABM cessation services are supporting the national cessation services integration work and the introduction of the unified cessation brand for Wales 'Help me quit'.

There has been progress in the development of resources, protocols, and standardised evidence based quit book, together with a training and development network for cessation advisors having been established. The national work supported by ABM locally, will underpin many quality and safety improvements needed for ABM cessation services, which were identified from the quality and safety assessment undertaken recently and reported to the last meeting of the Committee. Key issues predominantly featured on meeting the required standards for safe care; effective care such as non-compliance with NICE guidance; workforce problems; equality of service provision; and issues such as lack of equipment that affected and impacted on outcomes.

In light of this, combined with the national direction of travel and integration agenda, a local ABM Cessation Services Steering group has now been established. The aim is to aid greater collaborative working and effective communication between ABM cessation services; collective planning; analysis of service performance and smoking cessation target; and identification of risks and issues, with improvements or mitigation identified and progressed. The first meeting was held on 12.1.18, and work has started on developing a tobacco risk register.

3.1.2 'Time to Quit'

This ABMU funded service provides cessation support for in-patients, out-patients and ABM UHB staff

Workforce:

- The service continues to run without a clinical lead. One of the cessation practitioners has taken on a managerial support role for the service, which has directly impacted on the practitioner's capacity to see patients. There has also recently been difficulty validating 4 week quits in-patient smokers with carbon monoxide (CO) measurements, due to staff capacity.

Impact

- The lack of service clinical lead is directly impacting upon the staff and performance of the service, including less time spent ward rounds, or engaging in service improvement, etc. This is affecting service delivery, performance and outcomes.

Equality:

- The service is unable to offer support to mental health in-patients, due to staff capacity and lack of relevant staff training.

Effective Care:

- Inpatient referrals remain low despite NICE PH48 guidelines recommending the provision of support for smokers in a secondary care setting within 24 hours of admission, through offering a referral to the service for behavioural support to quit and prescribing nicotine replacement therapy (NRT). The Health Board is currently not meeting this or other NICE PH48 recommendations.
- The hospital service practitioners continue to undertake intensive awareness raising of the smoking pathway through a continued programme of brief advice training delivered to front line clinical staff; and conducting ward rounds to attract referrals.

- Work has now commenced with NWIS and Health Board IT to scope improvement of recording of smoking status on patient clinical systems and electronic referral mechanism to the cessation service.

3.1.3 'Start Here' - Level 3 community pharmacy cessation services

This ABMU funded service provides cessation support for smokers in the population in a community setting on a one-to-one basis. 84 community pharmacies have been approved to deliver a Level 3 local enhanced service for smoking cessation. The risks below have been discussed at the L3 Steering Group and a paper to the primary care forum will be presented on 26/01/18 on the proposed mitigating actions to increase performance and reduce risks identified.

Workforce:

- Lack of staff within both the Primary and Community Services Delivery Unit and local Public Health resource has meant a delay in proceeding with further service development and quality improvements. A Level 3 working group has been convened and support is being provided from Community Pharmacy Wales Development officer. Issues and sharing best practice to inform ABM activity is discussed also at the national Tobacco and Pharmacy Leads group.
- Heads of Primary Care are developing a plan to address the growing community pharmacy agenda and enhanced services roll out (including level 3 smoking cessation), combined with the reduced capacity of the Primary and Community Services Delivery Unit to support it.
- Level 3 smoking cessation training for pharmacists is moving from face to face to online, including the motivational interviewing element. This is a risk to the service, as evidence suggests that the most effective motivational interviewing training is carried out face-to-face.
- Face-to-face training for technicians cannot be sustained either, due to lack of capacity in Primary and Community Services Delivery Unit to deliver it.

Safe and Effective Care:

- CO monitors need to be calibrated every 6 months to ensure their safe use and accuracy of CO readings. Primary and Community Services Delivery Unit staff usually carry out the calibration, but have been unable to undertake the intended level of contract monitoring visits in 2017/18, due to staff capacity, and so have not been able to carry out the calibrations. As an interim short term measure, Stop Smoking Wales advisors will work with the Primary and Community Services Delivery Unit team to visit community pharmacies, to distribute new Help Me Quit resources and undertake the calibration at the same time.

Impact:

- Primary Care and Community Services Unit purchased 20 CO monitors for pharmacies providing level 2 cessation services. However, a faulty batch of monitors was received. These have been returned to the suppliers new monitors are awaited. As a result, four pharmacies are unable to delivery services at present.

Timely Care:

- There are delays in smokers being seen by a pharmacist in some areas. This is being managed locally, to ensure that patients can be signposted to another pharmacy quickly and effectively

3.1.4 Stop Smoking Wales (SSW) – 'Help Me Quit'

This Public Health Wales funded all-Wales service, provides cessation support for smokers in the ABM population in a community setting, on a one to one or group basis

Workforce:

- Competency development improvements are in progress, including motivational interviewing training, which is required for the role

Effective Care:

- Currently there is no feedback mechanism within SSW to report back to the referring midwife informing of whether a pregnant smoker has attended for cessation support. Improvement work to be progressed between ABM midwifery team and SSW.

Impact:

- All staff advisor vacancies are now at full capacity and bank staff are being used to cover any sickness and annual leave to ensure the clinic schedule operates effectively. Limited engagement work is currently being undertaken as there are two vacant Healthy Lifestyle advisor roles. Advisors are now marketing and promoting the Help Me Quit service as part of their role, and more effective collaboration is being undertaken across ABM cessation services.
- With the introduction of Help Me Quit and choice conversation for the smoker, the use of telephone support for cessation has increased. As clients are not seeing advisors face to face this has resulted in problems with recording CO validation of their quit attempt at 4 weeks. Improvement measures are being planned with community pharmacy under the level 2 service specification; despite the problems pointed out above with CO validation.
- The Service is now able to see clients who have quit smoking within 2 weeks. This will help with supporting clients discharged from hospital and who have quit recently before joining the service.

Equality:

- Clients are now offered both face to face and telephone services in the Welsh language. The new quit book has been produced bilingually. Resources in other languages or in large print/Braille are not available presently. Support is now provided for clients from protected characteristic groups

3.1.5 Smoking cessation with population groups: Pregnant women

Workforce:

- A Programme of training is to be delivered to community midwives on smoking cessation and CO monitoring to improve on non-compliant practice with NICE guidance. CO monitoring is to be included in midwives yearly CPD updates.

Effective Care:

- The latest audit of maternal notes where 150 notes were reviewed shows an improvement of 96% compliance, of women having a CO reading recorded at booking as per NICE PH guidance 26. Further improvement planned to ensure full compliance; and 'mop up' activity at dating scan for any women not having received a CO reading at booking
- There is no electronic recording of CO monitoring (a key performance indicator) in the maternity IT system, which is managed by NWIS. The IT Department has been working with NWIS to incorporate CO level in their next update of the WPAS system on Myrddin
- Following the introduction of the electronic referral through Myrrdin of pregnant smokers to Help Me Quit, there has been improvement in referral numbers and now 100% of smokers are referred by midwives at booking
- MAMMS (Models for Advice to Maternal Smoking Cessation Support) now being discussed across all Health Boards under the NHS Wales National Improvement Programme. Work is progressing locally to scope provision of cessation support by the antenatal team and department. Engagement activity with pregnant smokers is being undertaken to identify barriers and enablers to cessation support.

Impact:

- The maternal stop smoking pathway is being redesigned to encourage midwives to monitor CO throughout pregnancy in line with NICE guidance, and re-refer to Help Me Quit if the woman has declined cessation support at first invitation
- At present Help Me Quit cannot find a method of reporting back to the community midwife on cessation progress of the pregnant woman. An interim measure is being developed by the local public health team.

3.1.6 ABM UHB Smoke-Free Hospitals

Effective Care:

- Smoking on hospital grounds continues to be a widespread issue and visible problem despite the Health Board smoke-free site policy.
- The Smoke free working groups established in Princess of Wales and Neath Delivery Units have not met this period. Further work is to be explored with other Delivery units in preparation for legislation on smoke-free hospitals, as per Public Health (Wales) Act.
- Caswell Clinic has become completely smoke-free from 1st October 2017 with positive effect on staff and patients. Evaluation in progress

Recommendations – Tobacco Control:

The ABM Cessation Services group should report to and be held accountable by the Health Board's Quality and Safety Forum and Committee.

3.2 Healthy Eating, Physical Activity and Obesity

Not all relevant Health Board policies contribute to the creation of an environment that supports/promotes a healthy weight, e.g. healthy vending, procurement of services and design of estates that supports physical activity. There is a need to ensure that health impact is built into all policy decisions within the Health Board.

A task and finish group was set up to review the existing obesity pathway and it identified the lack of a coherent, joined up obesity care pathway for adults. It also a number of quality and safety issues, including compliance with evidence based practice; need for appropriate training of staff related to their role across the pathway; equity of access to support/interventions; lack of service provision at tier 3 for children; evaluation of impact of service provision and the need to understand the activity, quality and outcomes being achieved across many services/activities, including those related to a range of other LTC pathways. There are also issues highlighted that relate to the interface with tier 4 (bariatric surgery) services.

3.2.2 Level 1 - Community based prevention and early intervention (self-care)

Effective Care:
Level 1 action is currently variable. There is a need to work through and with strategic partnerships to support and champion a range of community level activities that support healthier lifestyle behaviours including physical activity, healthy eating and mental wellbeing as part of a place based, holistic approach to the prevention of obesity. Initiatives/programmes need to be based on a behavioural assessment and behaviour change techniques.

- Programmes are not always based on behaviour change principles.
- Lifestyle advice, information and should be consistent across chronic disease pathways.

3.2.3 Level 2 - Community and primary care weight management services

Equality

- There is inequitable access to weight management services via antenatal services or primary care.
- There are currently no level 2 children or family based multi component programmes
- Early identification and intervention of overweight or obesity is inconsistent across primary and secondary care and of unknown quality. We need to reduce variation, including systematic weight screening and implementing Making Every Contact Count (MECC)

Safe Care/Effective Care:

- Although a childhood obesity pathway for 0-5 years has been drafted, there are no level 2 or 3 services for children and young people and as such the management of obese children is risk managed individually, by Health Visiting and Primary Care. Consideration needs to be given to how to provide effective care to children and young people who meet criteria for level 2 or 3 services.

Individual Care:

- ABMU HB is the second highest prescriber in Wales of medication used for weight management (e.g. Orlistat). Pharmacology support should be reviewed by auditing compliance with guidance about management of patients on Orlistat.

Workforce/Impact:

- Nutrition and Dietetics Service has limited capacity to support delivery of the Foodwise Community Based Weight Management Service and limited resources to provide an adult level 2 service. They are currently reviewing the existing adult weight management programme, looking at potential skill mix opportunities, to increase capacity, working with primary care to support delivery at a cluster level.

3.2.4 Level 3 - Specialist multi-disciplinary team weight management services

Equality/safe care/effective care/impact/timely care:

- No level 3 service is available for children locally and no recognised support offered to those meeting level 3 criteria. Consideration is needed for children who meet level 3 criteria, so they are supported as part of a whole pathway approach.
- The Level 3 Service for Adults is currently in developmental phase and funded for one session per week. Current capacity does not meet estimated population need. Issues regarding the tier 3 adults' service include limited funding, lack of capacity, the need for a review of the existing model in order to establish impact on health outcomes and ensure adherence to the All Wales Service Specification, NICE guidance and pre-surgical model for bariatric surgery.

3.2.5 Level 4 - Specialist medical and surgical services (including bariatric surgery).

Equality/safe care/effective care/impact/timely care:

- A level 4 adult service is available in ABMU, as part of the regional South Wales service. However, locally, adults have limited access to the level 4 service due to the lack of a coherent, joined-up obesity pathway, including access to level 3.

Workforce/Effective care:

- Dietetic resource allocation to support the Level 4 service WIMOS is well below required capacity (0.4wte).

3.3 Immunisation

3.3.1 Childhood immunisation

The NHS Wales Delivery Framework 2017/18 states that Health Boards should achieve and maintain uptake rates in the following performance indicators:

- 95% of 1 year old children to have received 3 doses of the 5 in 1 vaccine
- 95% of 5 year old children to receive 2 doses of the MMR vaccine.

Effective care:
Public Health Wales produce quarterly and annual COVER reports which report the above outcome measures.

The latest quarterly COVER report (COVER 124, July–Sept 2017) indicates that ABM continues to reach the 95% target for 1 year olds, but not the 95% target for 2 doses of the MMR by age 5 years. This is in line with other Health Boards.

There are differences amongst and within primary care clusters in terms of reaching the performance indicators. The success of the cluster network development programme (Quality and Outcomes Framework) has developed and strengthened the multi-professional team working. Clusters routinely include Public Health and community teams as core members which facilitates successful collaboration and discussion on immunisation, with this included often as a standing agenda item.

For 2017/18 clusters have been required to participate in three clinical priority pathway areas, with one being determined locally. 5 out of the 11 clusters have chosen MMR as their local pathway, this will require them to adopt a quality improvement approach using data and small tests of change (PDSA cycles), to support clinicians and practices to enhance their care in this clinical priority pathway area.

However, following the Cabinet Secretary for Health and Social Services decision to implement a range of measures to help NHS Wales manage the current demand on the health service as a whole, QOF will be relaxed until 31st March 2018 to enable GPs and their teams to focus efforts on caring for their most vulnerable and chronically sick patients during the winter period. Under the measures, GMS contractors can discontinue participation in the majority of QOF targets for the period to 31 March 2018. The action taken applies to all QOF; the only indicators not relaxed are those specifically for flu. Therefore, this may result in clusters and invidual practices not continuing with MMR improvement work. Should practices and clusters choose to continue and present their pathway work a summary of themes and good practice will be presented to the Childhood Immunisation Group.

Timely care:
Recent audits have highlighted a number of cancelled immunisation clinics between January and October 2017. In addition some immunisation clinics have queues of children waiting to be appointed for their immunisations. The Child Health System (CH2000) operates to appoint the younger children in the first instance, therefore the queues will mostly consist of children awaiting their pre-school boosters scheduled to

be given at 3 years 4 months, and could therefore contribute for our lower performance in achieving 2 doses of MMR by the age of 5 years.
The MMR Task and Finish group was established last year to address these issues and is taking the following actions: (1) write a letter to target practices with cancelled clinics and queues (2) develop a 'directive', which will include the requirement for practices to notify the health board primary care team of cancelled clinics and the need for ad-hoc / additional capacity at the next clinic, in order to compensate for the cancelled clinic. These draft documents will be considered with the 11 cluster leads during their meeting at the end January 2018.

A further significant issue is the number of children with missed immunisation appointments; some of which have missed in excess of 30 appointments. This negatively impacts on the number of children waiting for immunisation appointments. The Strategic Immunisation Group has agreed to limit the number of appointments offered to each child by the Child Health System to four. The named Health Visitor will continue to promote immunisations and work collaboratively with GPs, following agreed national and local policies.

The current Child Health System relies on staff to manually input immunisation data. It relies on paper information being sent to the department following immunisation clinics, this information having already been input to the GP data system and assumed to be of good quality. On a national level work is progressing towards the introduction of a new child health system. It is anticipated that the upgraded version will have a 'read-across' from the GP system, which will enable Health Boards to have greater confidence in the data. To date we have undertaken numerous 'data-cleansing' procedures, which are necessary, but time consuming and labour intensive. The new child health data system should be more efficient, accurate and contribute to reducing risks.

Vaccination uptake records show that, over the years, the number of vaccinations received through childhood had an increase from 14 to 35 by 16 years of age. This presents a significant increase in work required by the Child Health Department. However, there is no new funding for pressures and the service is very much at risk. A paper has been presented to Children's Services Group regarding this matter. In addition, it appears that not all funding intended to support the immunisation programmes has reached the service. Financial and workload pressures risk information not being entered as currently recommended, which could lead to discrepancies in our Health Board's uptake rates, and delays in children receiving appropriate vaccinations.

Impact:
ABMU Health Boards General Medical Services Governance Framework for 2017/18 has identified a set of measures using existing data, to identify and prioritise which practices will receive a governance review for 2017/18. Measures have been selected based on the Health & Care Standard domain areas and includes Childhood and Influenza Immunisation as a trigger.

For 2017/18 three practices will receive an in-depth governance review, this will include a peer review of immunisation uptake rates, a review of the practice system and processes in place to offer and promote vaccinations and any initiatives to

improve access to vaccination through opportunistic vaccination, drop in and catch up clinics, after school appointments etc. Those identified for a standard review (21 Practices) will include a follow up in this area if identified as necessary i.e. low uptake, high number of queues and cancelled clinics. A summary of learning and actions will be shared with relevant forums.

Health Visiting services have a Domiciliary Immunisation Policy but this has had limited success for a number of reasons namely:

1) Many families have declined the offer, reporting they would rather attend the Community Health Clinic
2) The model is labour intensive as Health Visitors do not hold a stock of readily accessible vaccines.
3) As most Health Visitors do not routinely vaccinate, confidence is not easily maintained. So, there is little support for this in some areas. In other areas a small team approach has been developed
4) As this was new work with no additional funding the approach is not currently the most prudent.

As a new activity, in response to Primary Care sustainability issues, Health Visiting services are developing a proposal and business case for delivery of the 8 week infant medical examination and primary immunisations programme.

Other:
The schools influenza immunization campaign has been a great success this season, with uptake at its highest level since the programme began. ABMU HB currently has the highest uptake of the seven Health Boards in all year groups; children aged 4 (reception) 73.9%; aged 5 (year 1) 74.5%; aged 6 (year 2) 75.2%; aged 7 (year 3) 72.8% and aged 8 (year 4) 73.7% (PHW, Influenza Update 11, Jan 4 2018).

From 2018/19 all children in primary schools will be offered the nasal flu vaccination (reception to year 6). The roll out of the schools flu immunization programme for 2018/19 will include all primary school aged children. Plans are progressing with consideration given to staffing, the storage and transportation of vaccines and the additional workload faced within the child health department.

3.3.2 Influenza immunisation uptake rates

Effective care:
The current WG influenza targets are:

- 75% target for those aged over 65 years and pregnant women
- 55% target for those with a chronic condition who are deemed ‘at-risk’
- 60% for front line staff
- No target as yet has been set for the children’s influenza immunization programme.

Flu vaccination uptake is routinely included as a standing item on the cluster agenda. Clusters peer review uptake and consider opportunities to improve uptake either as a cluster or through sharing good practice. Some clusters have adopted fluenz parties and commissioned the District Nursing Service or a Practice Nurse to undertake flu immunisation within the homes of those patients unable to travel to the practice.

Equality:
To date ABM has not reached any of the Welsh Government targets for influenza vaccination. That said some GP practices have had a successful flu campaign. To date in ABM

- 8 practices have reached target for the 65 years and over
- 8 practices for under 65 years in the 'at risk groups'
- 59 practices are below 50% uptake for those under 65 years in at risk group

(PHW Influenza Summary Update 11 Jan 2018).

An action of the Primary Care Flu Planning group is that lower performing practices are followed up by the primary care teams, with actions agreed to improve uptake. A comprehensive programme of support to GP Practices to plan their campaigns has been offered by ABM Public Health Team. Flu vaccinations will continue to be offered until March 2018.

Workforce:
Staff issues have been raised where general practices have had to cancel clinics due to practice nurse sickness and other staffing issues. The Primary Care Team are implementing a process whereby practices are contacted to discuss reasons for cancelling clinics.

The Health Board's staff flu immunisation campaign has not yet met the uptake target (to date 55.4% uptake has been achieved) this year. It is recommended for 2018/19 that the number of 'Flu Champions' trained to support the staff campaign be proportionate to each Service Delivery Unit.

Timely care:
The Welsh Health Circular for the influenza programme stipulates that the children's influenza vaccination campaign be completed before the Christmas holidays, in order to protect eligible children and reduce the amount of flu circulating within communities. The nasal flu vaccine also has a shorter shelf life than the injectable vaccines used for adults so it is imperative that the majority are vaccinated before the end of the year. The schools campaign was completed on 15th December 2017. However, many GP Practices still have a large number of 2 and 3 year old children not yet vaccinated.

The Joint Committee on Vaccinations and Immunisations (JCVI) has recommended that an adjuvanted trivalent vaccine be offered to individuals aged over 65 years from next year, and the quadrivalent vaccine offered to those in at risk groups. ABMU Health Boards response to this advice has been circulated to all GP practices.

Recommendations - Immunisation:
The committee is asked to note the key issues and risks presented, and is asked to note the actions being taken to improve performance or to mitigate risk; and elements where progress needs to be strengthened; and to support the direction of travel identified.

3.4 Healthy Cities including Early Years

The Health Board and Swansea LA have signed up to jointly fund Phase VI of the WHO Healthy City Programme until end of 2018.

The Healthy City Board has focused on Early Years to improve young children's development outcomes and improve their life chances, with a clear aim of closing the gap in readiness for school between advantaged and disadvantaged groups. The main risk is the business case for a more sustainable model to continue the early year's worker pilot.

3.4.1 Safe/Effective Care

The Healthy City Board has focussed on Early Years and is the main reporting board for the Early Years Steering Group to oversee progress. Action on closing the gap in readiness for school between advantaged and disadvantaged groups is by

- Increasing awareness of nursery and school readiness through a universal approach (public facing and developed with parents - Best Start parenting campaign)
- Assessment and signposting
- Service reorientation and development (JIG-SO universal holistic service antenatal to age 2 years and a pilot of a unique Primary care funded Early Years Worker post - employed by the Council and hosted in a primary care network)
- Data and service quality
- CYP Commissioning Board and business case – Chair of narrowing the gap sub group is CPHM.

3.4.2 Individual/Timely Care

EYW pilot: Over 106 referrals in under a year with 336 beneficiaries. Key issues arising are parental and child mental health issues, behaviour, lack of routines. Offers a 12 week intervention programme and signposts to other local services when ready. The main risk is the business case for a more sustainable model to continue the early year's worker pilot as there is no cover for her if on leave.

Equality:

- The network is 50% Flying Start and access depends on geographical entitlement and not on need. The early year's worker post is meeting unmet need identified by the primary care workforce in areas outside of Flying Start. The intervention enables parents and families to manage their child's issues but also their own concerns with signposting to services if ongoing support needed.

Workforce:

- A single worker is not sustainable and a business case has been made to all 5 networks in Swansea for extension of the pilot. Three networks have agreed to part fund the pilot rollout, but with a triage system. The funding is not enough to replicate the pilot, so a clinic based system will be tried and individual intervention will be dependent on need, if no other alternative is possible. There has been

some press interest in the project, but there are concerns from participants about appearing in a BBC television programme.

3.4.3 Future of WHO Healthy City Programme

Healthy City Board meeting (extraordinary meeting) and joint Health Board/Council meeting has been arranged for March 2018 to discuss the way forward for the programme.

Healthy Cities Board works to two overarching and four core themes – these are:

Overarching themes:-

- Improving health for all and reducing health inequalities,
- Improving leadership and participatory governance for health

Core themes include:-

- Investing in health through the life course and empowering people
- Tackling the European Regions major health challenges of infectious and non-communicable diseases
- Strengthening people centred systems and public health capacity, emergency preparedness and surveillance
- Creating resilient communities and supportive environments

Re-application to continue to phase VII requires renewed commitment and interest to continue with adequate support to deliver the programme from all partners including Swansea PSB. Loss of momentum has been apparent in recent months with reduced attendance at meetings and lack of progress in some areas, like nutrition and physical activity and community approaches. The early years work has had some momentum and influenced the inclusion of “Give Every Child the Best Start” objective in the PSB well-being plan for Swansea. The biggest impact has been to move to a universal approach based on need rather than geography.

Also Swansea University joined the Healthy University scheme and is working well with the Healthy City Board on, for example, wellbeing, physical activity, alcohol misuse; healthy nightlife – establishing a help point, saving ambulance call outs; creation of a drop off point with safety and behaviour messaging and achievement of the purple flag status

Workforce:

- There is no dedicated Healthy Cities team – 2 joint healthy city coordinators have taken on the work, as additional roles, on voluntary basis and one has been able to incorporate this into her public health role with support from partners under the Healthy City Board. This is not a sustainable model, as competing priorities within have reduced the ability to have a more strategic approach to embedding HC principles of delivery, based on the Ottawa charter and current European Acts, which have underpinned the Future Generations Bill.

There are a number of key issues that need to be addressed in order for the benefits of the Healthy City programme to be fully realised. These include;

- Visibility and engagement within the wider Health Board and a programme of dissemination of the learning acquired.
- Full time co-ordination
- Partnership funding for programme priorities

4 Recommendations

- The committee is asked to note the key issues and risks presented across the Staying Healthy agenda within the body of the report.
- The committee is asked to note the actions being taken to improve performance or to mitigate risk; and elements where progress needs to be strengthened; and to support the direction of travel identified.
- The Committee is requested that this group therefore reports to and be held accountable by the Health Board's Quality and Safety Forum and Committee.

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*	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

performance)	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?