AGENDA ITEM
6.3

CTM BOARD	
POPULATION HEALTH BOARD REPORT	
Date of meeting	26 May 2022

FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report

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Approving Executive Sponsor	Executive Director of Public Health
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
CTM	Cwm Taf Morgannwg
TTP	Test Trace Protect

PHM	Population Health Management
PH	Public Health

1. SITUATION/BACKGROUND

The Board has given its commitment to progress CTMUHB as a population health organisation and endorsed a paper in May 2021, which focused on agreed projects to progress as a Population Health Organisation to successfully tackle the population health challenges in Cwm Taf Morgannwg.

This report updates the Board on the current status of population health in CTM, progress on the delivery of the population health agenda and highlights specific matters for Board attention.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

COVID- 19 Update

The evidence from the Office of National Statistics (ONS) survey, testing of health and social care staff and patients on admission, together with the waste water sampling, all indicate a decline in covid incidence and positivity rates. The number of care homes *"in incident"* has reduced steadily over recent weeks to three (at 16:30 hrs on 10/05/2022). The Omicron variant is the predominant variant in Wales, accounting for the majority of newly confirmed and sequenced cases, locally and imported (at 5pm 3rd May). The BA.2 Omicron variant now accounts for over 99% of recent cases and is dominant.

Vaccination Progress

Over the past 3 months the focus of the COVID-19 vaccination programme has been on:

1) Provision of COVID-19 vaccination to children aged 5-11 years
2) Provision of Spring boosters to those in high risk groups
3) Continuing the 'leave no one behind' campaign

A summary of progress is as follows:

1. CTM Uptake 12+ (as of 11/05/22) – 83.04% 1st dose (% of whole cohort), 95.36% 2nd dose (% of currently eligible*), 95.51% 3rd dose (of currently eligible*), 85.03% boosters (of currently eligible*).

2. Uptake in Homeless, Gypsy traveller population (as of 11/05/22) – 61.34% 1st dose (% of whole cohort), 73.67% 2nd dose (% of currently eligible*)

3. Uptake in pregnant women (as of 11/05/22) – 83.99% 1st dose (% of whole cohort), 94.95% 2nd dose (% of currently eligible*)

4. Uptake by deprivation quintile (as of 11/05/22) – 8.86% point gap in uptake 1st dose (% of whole cohort), 2.13% point gap in uptake 2nd dose (% of currently eligible*), 3.07% point gap in uptake 3rd dose (% of currently eligible*), and 9.66% point gap in the uptake of boosters (% of currently eligible*) between most and least deprived quintiles.

5. Uptake in children and young people with no underlying health conditions (as of 11/5/22):

   16-17 year olds – 79.71% 1st dose, 84.55% 2nd dose (of currently eligible*)

   12-15 year olds – 68.37% 1st dose, 80.88% 2nd dose (of currently eligible*)

   5-11 year olds – 17.01% 1st dose

6. Uptake of Spring boosters (as of 12/5/22) – 55.84% (of currently eligible*)

7. HMP Parc (as of 21/03/2022, all ages): 76.8% 1st dose, 74.17% 2nd dose, 52.28% boosters. 22.5% prisoners have opted out

8. (95.8% of opt outs are <50 years). Meeting with HMP Parc on 18/5/22 to discuss immunisation uptake and commence planning for 2022/23 flu season.

**Currently eligible defined as in JCVI eligible group plus individual has had the preceding COVID-19 vaccines, e.g. had 1st and 2nd doses and eligible for a booster*

COVID-19 Vaccine Equity Group – Currently working with the Specialist Immunisation team and wider CTM planning team to support Ukrainian people fleeing conflict, and access to vaccination based information.

It is hoped that the remit of the group will soon widen to include routine vaccination programmes and the seasonal influenza vaccination. A stakeholder survey is imminently being launched with group members to shape planning of the group.

Black, Asian and Minority Ethnic Groups vaccination uptake – A Black, Asian and Minority Ethnic Vaccine Equity Sub-Group was set up in January 2022 and a work plan developed in order to improve COVID-19

vaccine uptake amongst our minority ethnic groups in CTM. A number of actions came out of this subgroup including:

- Organisation of pop-up vaccination clinics within the University of South Wales Health Centre for new students and their families.
- Production of communication material, including provision of information for dissemination to CVCs to ensure that in line with messaging, people are aware that they don't have to be registered with a GP to attend for vaccination, and that CVC staff are able to signpost people to their local GP surgery for registration
- Attendance of numerous venues running ESOL (English for Speakers of Other Languages) courses (Including those in Merthyr Tydfil College) via the outreach team to promote vaccination and share information more widely including that of the EYST (Ethnic Minorities and Youth Support team) helpline.
- Attendance via the outreach team at Kepak Meat Factory, OP Chocolate Factory, Merthyr Tydfil College, High Street and wider shops and venues within Merthyr Tydfil, Rhondda Cynon Taf and Bridgend to identify and connect with community leaders and wider to promote vaccination.
- Establishing and forming connections with a number of faith networks and community leaders.

The group continues to facilitate new working relationships/advocate for a co-production approach with the aim of ensuring equivalent access in different groups. For example, the Specialist Immunisation team will be attending the Bridgend Cohesion and Equalities Forum in June, and are liaising with the Well-being Centre team members in Gellideg, Merthyr Tydfil to answer any questions from community members around vaccination and promote uptake.

CTM community and staff vaccination survey (COVID-19/influenza) – Two surveys were undertaken in March 2022 to explore views and experiences of the CTM influenza and/or COVID-19 vaccination programmes in the community and amongst healthcare staff.

The Community Survey had a total of 542 responses. The majority of respondents identified as female (84.5%) and of white ethnicity (98%), with representation from the 3 Local Authority areas within the CTMUHB region. Respondents covered a breadth of age groups from 16-75+ years.

Community Survey Headlines

- The majority of respondents were up to date with their COVID-19 vaccinations; a small proportion had declined, or not yet received the booster.
- Not believing that another dose was necessary was the most common reason for not receiving the booster dose.

- Concerns about side effects, speed of vaccine development, vaccination during pregnancy, mistrust in the government and misperceptions about risk of COVID-19 were given as reason for delaying or declining vaccination.
- 80% of respondents said they would consent to further booster vaccinations to protect themselves and their families and so that life could return to normal. Those who were undecided, or against further boosters believed we need to learn to live without ongoing vaccinations and that vaccinations should be focused on the most vulnerable.
- General preference for any future vaccinations to be administered in primary care (GP surgery or community pharmacy) or mass vaccination centres.
- Text messages and letters were favoured as sources of information about future vaccinations.

The Staff Survey had a total of 355 responses. The majority of respondents were female (83%) and identified as White ethnicity (96%). Respondents worked across CTMUHB. Working arrangements varied, although they most commonly worked in patient facing roles all of the time (36%). All staff groups, except for healthcare scientists, were represented, with most respondents working within Nursing and Midwifery (35.14%) and Administrative and Clerical (29.43%).

Staff survey headlines

- The majority of staff respondents were up to date with their COVID-19 vaccinations (79.38%); a small proportion had declined, or had not yet received the booster (most were not yet eligible).
- Reasons for declining the vaccine included bad side effects from previous doses, concerns about vaccine content and necessity, and believing it was developed too quickly.
- The majority (77%) indicated that they would accept a future booster dose. Those who were undecided felt that boosters should be focused on the most vulnerable in society, and that we need to live without ongoing boosters.
- There was a general preference for any future vaccinations to be administered at work (n=263), via mass vaccination centres (n=202), GP surgeries (n=153) or via peer vaccinators (n=142).
- 68% of people said they would accept co-administration of influenza & COVID-19 vaccinations.
- Text messages, staff intranet and letters were favoured as sources of information about future vaccinations.

A full report of findings has been published and will be disseminated widely. These findings will be triangulated with findings from two evidence reviews about influenza vaccination uptake amongst priority groups, and findings from a qualitative study exploring staff uptake. This will generate recommendations which will be shared with the CTM

COVID-19 Strategic Board for implementation in future COVID-19 vaccination planning.

Prevention and Protection Directorate Update

The Prevention and Protection Business Case was withdrawn from the Executive Agenda while awaiting further policy direction from Welsh Government. However it was agreed to extend all current fixed term posts within the vaccination and testing teams to the end of March 2023, noting that there is likely to be attrition of staff within this time. If required the use of bank will cover the shortfall.

Asymptomatic testing will cease at the end of June and PCR testing will be restricted to healthcare staff only that are symptomatic. Laboratory testing capacity will remain as the sole provider, although it is possible that this will change.

We await an announcement on which population groups will be targeted for the autumn booster campaign.

Population Health Organisation Update

There were 37 actions outlined in "Cwm Taf Morgannwg University Health Board as a Population Health Organisation: a discussion and options paper for Board" and agreed at Board in May 2021. These have been listed as individual projects with the lead Executive identified, along with named Consultant in Public Health support. Work is ongoing and all relevant Board Members leading these areas have met with respective lead Consultants in the Public Health Team and allocated resources to scope and progress the projects. The progress on this programme of work is reported to Executive Team and Strategic Leadership Group regularly to assess and escalate any issues arising.

Public Health Leadership

As part of this commitment, the Chair and independent members agreed to four leadership actions for population health improvement:

1. Use influence to advocate for more resources to tackle health inequalities.
2. Instigate *Constructive Disruption* both in the Health Board and Welsh Government, for example:
    a. Re-balance between RTT vs. population health outcomes, and
    b. Change language from 'Demand/Capacity' to 'Need/Demand/Capacity'
3. Champion action and challenge proposals and Board papers to think of the impact on inequalities in health across the population. Useful tool

could be the routine use of Health Equity Audits and Health Inequality Impact Assessments.

4. Connect with our communities and hold monthly surgeries in different localities to better understand the health issues and experiences of our population so that decisions are rooted in our communities' lived experiences.

In discussion with the Chair, Deputy Director of Public Health and Head of Engagement and Involvement, the following actions have been agreed:

- The Chair has agreed an Objective with the Minister of Health and Social Services for assurance and development of Independent Members related to inequalities of health outcomes.
- A series of development sessions for Independent Members on the contribution of the wider determinants of health to inequalities of outcomes for our population and using the COM-B model of behavior change. This includes behavioral risk factors, clinical risk factors, housing, education, employment, first 1000 days of life, along with evidence based action to reduce inequalities. This will allow Independent Members to fully contribute to a system wide approach to addressing inequalities in their role.
- Development of an *aide memoir* and campaign images to support Independent Members and partners in CTM to systematically address the factors that drive inequalities in health outcomes in our population.
- Mapping the formal and informal networks of independent members including a gap analysis. This will facilitate a targeted approach to challenge the system to reduce inequalities in a systematic way through these networks.
- A development session on Health Equity Audit, using the recent stroke health equity audit to better understand the role of this approach in identifying action to reduce variation and systematically improve outcomes for all residents of CTM.
- Continued Independent Member support for a programme of engagement with community groups to better understand the health issues and experiences of our population to support decision making.

Outcome Measurements

One of the actions was to review and report on a set of population health outcome measures. These measures are important to ensure that there is clarity on what the organisation and partners are seeking to achieve and provides ambitious timescales for delivery.

The table below provides the most recent data against each of the measures and a baseline for action. Where further work is needed on a measure, progress against this is given.

	Goal	Why (rationale)	Current	Progress/Further information
1	By 2026, in men and women in CTM, Life Expectancy (LE) at birth and Healthy Life Expectancy (HLE) match the Wales average	Life expectancy and healthy life expectancy are good summary measures of the overall health of the population. The inequality gap should be measured in comparison to Wales as well as between deprivation groups within CTM	LE gap – 1.1 years lower than Wales for men and 1.3 years for women	Produced by PHW Observatory
			HLE gap – 3.7 years lower than Wales for men and 1.7 years for women	Produced by PHW Observatory
2	By 2026, the Slope Index of Inequality (SII) in Life Expectancy at birth and Healthy Life Expectancy between the most and least deprived population quintiles in CTM has been reduced by 20%	This indicates the inequalities within the health board foot print between the most and least deprived.	To be calculated	PHW Observatory due to send data for this measure using an updated method by the end of May 2022, as SII is no longer calculated.
3	By 2026, Avoidable Mortality in CTM matches the Wales average	Avoidable mortality is a good summary measure of the performance of wider public health (preventable) and health & care (amenable) systems	Based on 2020 data (latest), CTM is at 339/100,000 population and Wales is at 287/100,000 population	Updated March 2022 from ONS annual report
4	By 2026, Life Expectancy in people with mental health problems in CTM matches that of those without	Physical health outcomes for people with mental health problems are unjustifiably poorer than those without. This is preventable and is responsive to coordinated action across public services	To be calculated	Not currently calculated and not possible with the current life expectancy methods used. Work ongoing to explore the feasibility of application of WHO research data to CTM.
5	By 2026, the prevalence of key LTCs (stroke, diabetes, cancer and heart disease) in people with mental health problems in CTM matches that in those without		To be calculated	Not routinely collected. Current exploration ongoing into feasibility of calculating this measure from the Population Segmentation and Risk Stratification (PSRS) data.
6	By 2026, Infant Mortality Rate (IMR) in CTM is lower than 2 per 1000 live births and percentage of	Early life experience is predictive of future health and wider social outcomes. IMR is an important indicator of	Latest data for IMR in CTM is 3.6 per 1000 live births (2019). Percentage of live	From ONS data and Observatory, PHOF tool, using WCCHD data.

	Low Birth Weight (LBW)	population health as it reflects the structural factors affecting population health	births with LBW was 7.1% (2020)	
7	By 2026, the current inequality in smoking prevalence between groups at extremes of deprivation in CTM has been eliminated	Smoking rates are the largest single cause of inequalities in health	The current gap in smoking prevalence between the most and least deprived fifths is 9.3% points (2018/19-2019/20)	National Survey for Wales contract will be coming to an end which means we might have difficulty comparing the data in 5 years' time.
8	By 2026, the prevalence of overweight & obesity has been reduced by 5 percentage points from its current levels	Obesity influences life expectancy and is an important proximal risk factor for many long term conditions	Current prevalence of obesity & overweight in CTM is 63.6% (2018/19-2019/20)	From National survey
Other relevant goals	Bowel screening to reach 70% target		62.1% in 2019/20	From PHW Screening data
	Breast screening to reach 85% target		73.3% in 2019/20	From PHW Screening data
	Cervical screening to reach 85% target		72.6% in 2019/20	From PHW Screening data

Population Health Management Work Stream

Population Health Management (PHM) seeks to understand patient populations, groups or clusters by characteristics related to their need and use of health care resources. In CTM one PHM tool has been developed, the population segmentation and risk stratification(PSRS) tool, which can help Secondary Care, Primary Care Clusters, GPs, Local Authorities (LAs) and other partners to decide how best to use limited time and resources to deliver anticipatory and pre-emptive care for patients. Segmenting the population based on a range of factors can identify groups by their holistic need and ability to benefit from prevention, early interventions and anticipatory care.

Implementation of PSRS in CTMUHB

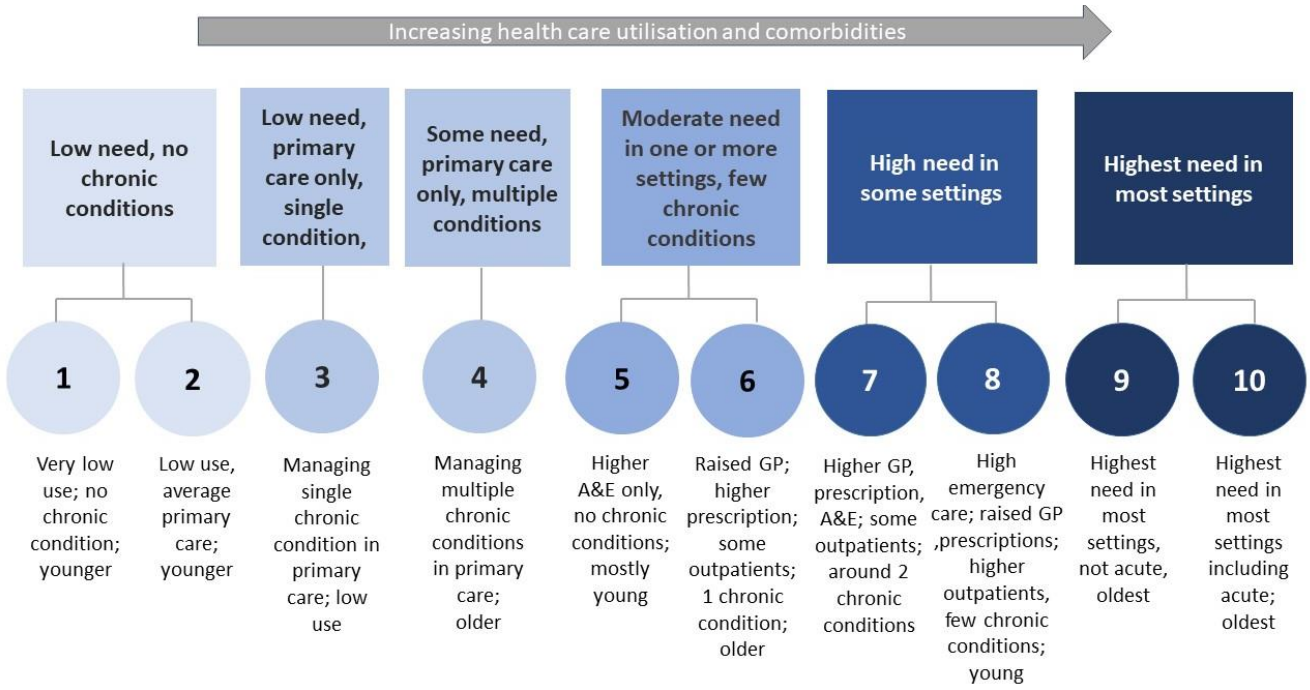
Over October/November 2021, 48 of the 49 GP practices across CTM agreed to the Data Processing Agreement (DPA) for their practice data to be included in the analysis. In February 2022, the first data set was received by the Local Public Health Team (LPHT) as well as initial GP practices, followed in April by data being received for 45/49 practices in CTM. Data

for all remaining signed practices is planned to be accessible following the next quarterly update in May 2022.

A summary of the initial data has been provided to Health Board executives and stakeholders. This highlights some data which will be available, patient distribution across CTM and allows the stakeholder group to feedback where more detailed analysis is required for targeted health planning.

Segment breakdowns and the proportion of patients within each segment/risk strata by cluster are shown below.

CTMUHB Data-driven segments



Percentage of patients in each segment and risk group by primary care cluster in Rhondda Cynon Taf

Percentage of patients in each segment and risk group by primary care cluster, RCT

% in each Segment	Cynon North	Cynon South	Rhonnda North	Rhonnda South	Taf Ely North	Taf Ely South	RCT	CTM UHB
Segment 1	24.4%	22.7%	23.9%	23.5%	28.0%	27.4%	25.3%	**25.4%**
Segment 2	17.7%	18.0%	17.3%	16.7%	16.2%	17.4%	17.1%	**16.5%**
Segment 3	4.5%	4.6%	4.6%	5.2%	5.0%	6.1%	5.1%	**5.6%**
Segment 4	13.1%	14.4%	13.9%	13.8%	14.0%	12.2%	13.5%	**13.4%**
Segment 5	8.5%	8.6%	7.9%	9.0%	6.3%	7.3%	7.9%	**7.7%**
Segment 6	14.2%	14.0%	14.6%	13.1%	14.8%	14.3%	14.1%	**14.2%**
Segment 7	6.5%	6.6%	6.5%	7.1%	5.5%	5.4%	6.2%	**6.5%**
Segment 8	3.7%	3.4%	3.4%	3.9%	3.0%	3.2%	3.4%	**3.2%**
Segment 9	4.5%	4.5%	4.6%	4.6%	4.5%	3.9%	4.4%	**4.7%**
Segment 10	3.0%	3.2%	3.2%	3.1%	2.8%	2.6%	2.9%	**2.8%**
Risk strata (%):								
High risk	5.4%	5.8%	5.2%	5.7%	4.7%	4.4%	5.2%	**5.0%**
Moderate risk	16.1%	17.1%	16.3%	16.3%	14.1%	13.4%	15.4%	**15.0%**
Low risk	78.5%	77.1%	78.4%	78.0%	81.2%	82.2%	79.5%	**80.0%**

Note: Segments based on health care utilisation and comorbidities; using primary care data from Jan - Nov 2021, secondary care data from Nov 2020-Nov 2021. Risk of emergency admission calculated using Johns Hopkins ACG System based on primary and secondary care.

Please note the full summary documents are available to be shared.

The PSRS population-level data received by the LPHT is being incorporated into the Population Health profiles at local authority and cluster levels. Information in the profiles will include wider population health measures as well as specific population segmentation data such as the distribution of patients across segments, proportion within each risk strata and case mix adjusted analysis by practice. As stated above, the practices are anonymized. It is hoped these profiles will be utilised in the planning of services to those most in need, reducing inequalities. This analysis allows for more targeted interventions for patients most in need of support.

GP practices have been provided with patient-level data using the DCHW portal which can be accessed via a named administrator in each practice. This allows individual practices to understand both the characteristics and proportion of their patients across the segments as well as the patients at high risk of admission in the following year.

The PHM team are working closely with Primary Care clusters to assess the use of segmentation in service provision. As originally agreed as part of the transformation programme, characteristics of specific segments may help identify patients in need of a more multi-disciplinary approach to support. It is intended that this work feeds into the wider conversation of how we are able to reconfigure and better integrate services to support more appropriate demands on primary care and with a view to lessening future avoidable admissions into hospital.

Pilots will be undertaken with practices to identify patients who would benefit from a referral to the SWIYC Community Health and Wellbeing Teams (Merthyr and RCT) and Integrated Teams (Bridgend). This will include clinicians reviewing the accuracy of the segments to identify specific patient characteristics. This is an initial assessment of the use of linked data to identify patients who might benefit from targeted interventions.

A separate research project is being conducted by the LPHT in parallel with the above and examines the predictive ability of segmentation including the development of the CTM UHB data-driven segmentation model to date. This methodological work was originally planned to be a separate project to investigate the predictive ability of segmentation. As the work progressed it was expanded to include the development of the actual segments to be rolled out. Objectives include the determination of whether a new combination of variables in the segmentation could improve prediction of future healthcare need and an assessment on the effect of the Covid time period on segmentation.

The governance arrangements for PHM in CTM since October 2021 have included a regular stakeholder meeting as well as an overarching Steering Board for PHM. Note that PSRS is one component of PHM in CTM and progress will be reported via these new governance structures.

Healthy Weights and Obesity

Children, young people and families:

The HENRY programme is a universal programme aimed at encouraging improved healthy lifestyle of families of children aged 0-5. Healthy Families: Right from the Start Programme has been commissioned for CTM, and is a franchised service where a small team of employed staff are trained to deliver the 8 week programme to families of children up to the age of 5. This 'HENRY approach' brings together support for parenting efficacy, family emotional wellbeing and behavior change with information about nutrition, active play and physical activity, setting and achieving goals as a family and oral health. The programme was launched digitally in September 2021 (due to Covid-19 restrictions) as a universal programme. Health and social care practitioners can refer families into the service, families can also self-refer. The programme is currently delivered across 8 weeks consisting of 1 hourly group or 1:1 sessions. As Covid-19 restrictions diminish, it is planned to implement face to face programmes in the community providing a crèche facility and healthy snack for families. Additional training for staff who work with families (flying start areas and family support services) such as health visitors has been delivered and work is progressing to target social media posts, advertising HENRY, to areas of high deprivation and incidences of childhood obesity (using the latest CMP data).

Quarter 4 (Jan-Mar 2022) has seen a slight drop in referrals to the programme and work is currently being undertaken to understand this drop. Early discussions suggest that the lack of face to face appointments across health and social care may have had an impact upon the ability of colleagues to undertake MECC conversations and to refer.

Merthyr Children and Families Pilot

Work has been progressing to develop a Children and Families Pilot for the Merthyr Tydfil area of CTM. This programme will both look to address the wider obesogenic system in Merthyr by working with settings such as primary schools and pre-schools as well as deliver a targeted 1-1 family support intervention to identified families in need with at least one child aged 3-7. Some updates below:

- We are in the process of appointing a dietetic lead to support the delivery and systems approach of this pilot
- We have appointed administration staff and all family support workers who have a broad skill mix and are from the local area
- Procurement of equipment and training to support delivery is on track, for end of year HB and finance deadlines
- MI, physical activity and nutrition training provisionally booked for May for project staff and partners as appropriate
- Utilising Healthy Start Healthy Future branding for the pilot to ensure dovetailing of information and communication

Weight Management Service for Children and Young People

Initial work has been focused on progressing the overdue development of an integrated adult weight management pathway in Cwm Taf Morgannwg. An Implementation Group for the adult service has been convened and includes representatives from community Paediatrics and a Paediatric dietitian. The need for services to support children and young people in CTM is clear and though no additional funding has been made available to develop children's services, the planning of such services will take place with a task and finish group brought together to progress the recommendations and guidance of the All Wales Weight Management Pathway (Children, Young People and Families).

Adults
Level 1: Foodwise

As part of the paper that was signed off by the Executive team of CTMUHB in the summer of 2021, proposals were developed to support and strengthen level 1 services with the recruitment of a Public Health Dietitian and Dietetic Assistant Practitioner for the delivery of the Food Wise™ in the community across CTM. Recruitment for these roles will take place in Q1 2022/23 with delivery expected to begin in Q2. The role of the Level 1 service will be to support and underpin the integrated Level 2/3 service. The Public Health Dietetics teams across Wales have also been working to develop digital and hybrid offers to patients and have recently published their Nutrition Skills for Life pages. We have also utilised a proportion of

the Health Weight Health Wales allocation for 2021/22 to buy resources to support the delivery of Level 1 Foodwise across our population.

WISE

The Wellness Improvement Service (WISE), developed by the Primary Care team of CTMUHB, will be offering patients from the pre-diabetes and cardiovascular risk programmes opportunities to utilise Second Nature as an additional weight management programme for patients.

Level 2/Level 3 Integrated Weight Management Programme

In late 2021, CTMUHB authorised a proposal to create an integrated weight management service for CTM. The proposed service will, once fully operational, see around 900 level 2 patients in a dietetic led service and 100 patients in a multi-disciplinary team, psychologically led level 3 service.

Whilst there have been some delays in certain areas in progressing this work there have been key milestones achieved and we therefore plan to establish delivery from September 2022.

- A Weight Management Service Implementation Group has been established, chaired by the Director of Public Health, to expedite all areas and outstanding actions
- Secured siting of the service in Dewi-Sant Hospital, Pontypridd. This site has been recently refurbished to support bariatric patients attending dental and lymphedema services and has good transport links for the population of CTM. Further work is ongoing to find other locations where clinics can take place to ease the travel burden upon patients
- Recruitment of administration and dietetic staff has taken place and these staff will be utilised to prepare the service and begin communicating referral pathways and systems to colleagues across the health board
- Job descriptions have been signed off for our key service leads of Psychology Weight Management Lead and Service Manager (Adult Weight Management)
- Secured funding to recruit a GPwSI and a Secondary Care Consultant Lead for the Weight Management Service

A final decision regarding the additional funding for the service from the health board was agreed in April 2022.

CTMUHB Staff Weight Management Service

CTMUHB Staff Wellbeing Service have set up a psychologically informed weight management service for staff. A number of cohorts are running since

it was launched late last year. The earliest feedback from the groups show staff making real change in terms of their relationships with food, health related behaviours, self-esteem and weight loss. The programme has been set up with baseline pre and post course measures though data is not yet available to share as the courses are still running.

One key indicator though is that demand massively outstripped supply. Once CTMUHB's Level 2/3 weight management service is up and running the coordinators of both services will work together to ensure patients and staff (90% of which live in the geographic area of CTM) are signposted to the right service to them depending on need.

The design of the programme has been led by the Consultant Clinical Psychologist for the Staff Wellbeing Service and the specific nutrition elements have been assessed by our Public Health Dietitians. The Public Health Team also ensured that the All Wales Weight Management Pathways specification documents were shared to ensure the service is based upon the most recent evidence.

Maternity:

Cwm Taf Morgannwg (CTM) has a well-defined weight management during pregnancy programme called BUMP Start. The data shows that around 34% of pregnant women in CTM who book in to appointments are obese (BMI >30). The Public Health Midwife, alongside all community midwives, utilise the "Foodwise in pregnancy" package to support women with a BMI of 35-39.9.

The Public Health Midwife sees women with a BMI over 35 at 16, 24 and 36 weeks. In 2020-21, average weight gain in this group was 5.2kg. An additional 0.6 full time equivalent Midwife post has been recruited to ensure equity of service to include the Bridgend locality area.

The most recent data shows that the BUMP Start service is now reaching over 90% of women with BMI over 35 and average weight gain in pregnancy is consistent at between 6-6.9kgs, which is within the recommended weight gain for this population group.

Smoking Cessation Activity
Help me Quit

The smoking cessation service *Help Me Quit* continues to perform well attracting and supporting clients to quit smoking, in the context of the pandemic. Data for December, January and February is presented below:

In the month of December 2021, there were 92 client episodes (-11% December 2021), with 69 treated smokers (-7% on December 2020) and 66 persons self-reporting being smoke free at 4 weeks (+2% from

December 2020). 99% of scheduled assessment sessions were completed within 14 days of initial contact date. Of community service clients, 58% were female (42% male), with 4% aged under 25 years; 28% aged 25-44years; 57% aged 45-64 years and 11% aged over 65 years.

In the month of January 2022, there were 187 client episodes (+17% January 2021), with 114 treated smokers (-7% on January 2021) and 35 persons self-reporting being smoke free at 4 weeks (-17% from January 2021). 99% of scheduled assessment sessions were completed within 14 days of initial contact date. Of community service clients, 55% were female (45% male), with 5% aged under 25 years; 45% aged 25-44years; 42% aged 45-64 years and 8% aged over 65 years.

In the month of February 2022, there were 154 client episodes (-19% February 2021), with 122 treated smokers (-9% on February 2021) and 78 persons self-reporting being smoke free at 4 weeks (-0% from February 2021). 100% of scheduled assessment sessions were completed within 14 days of initial contact date. Of community service clients, 57% were female (43% male), with 1% aged under 25 years; 36% aged 25-44years; 46% aged 45-64 years and 17% aged over 65 years.

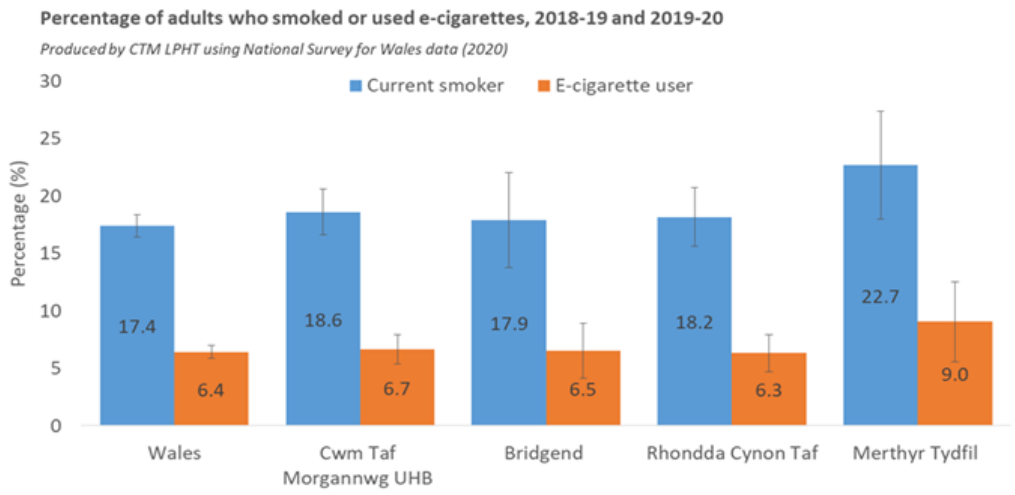
Minister's measures

Measure 3

Percentage of adults (aged 16+) reporting that they currently smoke either daily or occasionally.

NOTE: It has been recommended that we use the 2018/19 and 2019/20 data. National Survey for Wales's data from 2020/21 shows unexpectedly large differences in adult lifestyle behaviors compared with previous years. It is likely these are affected at least in part by the change in survey mode and some changes to questions. Asking some questions for a reduced period of the year may also have had an impact. It's not possible to separate out what may be real changes and what are artificial. Data for the next full year (2021-22) may provide more insight when available (likely summer 2022).

Smoker (Q4) 2019-2020	2019-2020 (Full Year)
18.8%	17.6%



Measure 4

Percentage of adult smokers who make a quit attempt via smoking cessation services.

There are a range of services that support people who smoke to quit, including Help me Quit, community pharmacy, MAMSS and hospital based services.

This shows that the percentage for CTMUHB for 2020/21 is 3.99%

Period (2020/21) | Service (All services)

Area Code | Period | Service

Indicator

Health Board	Number of Welsh resident smokers treated by smoking cessation services.	Estimated number of Welsh resident smokers.	Percentage of the estimated smoking population of Wales who made a quit attempt via smoking cessation services.
Wales	14,842	448,405	3.31
Betsi Cadwaladr University Local Health Board	3,562	100,305	3.55
Powys Teaching Local Health Board	423	15,162	2.79
Hywel Dda University Local Health Board	2,072	57,108	3.63
Swansea Bay University Local Health Board	1,797	56,496	3.18
Abertawe Bro Morgannwg University Local Health Board	.	.	.
Cwm Taf Morgannwg University Local Health Board	2,737	68,581	3.99
Cwm Taf University Local Health Board	.	.	.
Aneurin Bevan University Local Health Board	2,757	90,549	3.04
Cardiff and Vale University Local Health Board	1,494	60,204	2.48

Source: Stats Wales

Although CTM has the best performance in Wales, there is a way to go to hit the 5% target. In addition, to effectively address inequalities in health associated with smoking we should strive to exceed this target.

Measure 5

Rollout of an 'Ottawa' style in-hospital smoking cessation service.

This model systematically identifies, treats and follows smokers over the long term in hospitals, primary care clinics, and other outpatient settings. Discussions are taking place with tobacco leads within the health board on the potential shape of any enhanced hospital smoking cessation model and attendant funding implications. A number of delivery models are being explored and costed to afford a realistic accommodation of services. A smoking cessation sub-group of the Respiratory Planning and Delivery Group is being established to take forward the development and implementation of inpatient smoking cessation services and reduction of maternal smoking rates in CTM. The first meeting of this group is scheduled for 17 May.

Arrangements are underway to move existing programmes, currently under the auspice of Prevention and Early Years to alternative funding streams, which would allow for additional demands from the Ottawa model.

Supporting reduction of the number of people smoking during pregnancy

Within CTM, MAMSS is offered on an opt-out basis to all expectant mothers who are identified as smokers. This coming year, the work will focus on increasing the number of referred smokers who go on to attend treatment session 1. Actions include:

- Reintroduction of CO monitoring; risk assessment for this has been signed off by Infection Control and will start on approval from department leads, maternity risk forum and antenatal forum
- Re-start face to face delivery of the service
- Improve recording of smoking status at the end of pregnancy
- Pilot work with a GP surgery to identify/ refer pregnant smokers at the earliest opportunity i.e. before the antenatal booking appointment; this work is at an early stage.
- Explore the potential availability of NRT in clinical areas, to support re-referrals in antenatal clinic, Day assessment unit, early pregnancy unit, postnatal clinics. This would also align with the development of the HMQ in hospital model

We know that for women who engage with our MAMSS service the conversion to becoming a treated smoker is high – 56% in quarter 3 2021/22 statistics below

NOTE: Quit attempts have not been CO confirmed in the past 2 years.

Quarter 3, 2021/2022

quarter 3 reporting for smoking cessation MAMSS (Help me quit for baby)									
total booked	1139	100%							
total smokers	187	16.40%	non co verified - likely very inaccurate						
total referred	232	124%	24% being re-referrals / late bookers (this is a target for CTM)						
attended assessment	63	27%	of those referred						
attended Treatment session 1	61	26%	of those referred						
quit smoking	35	15.00%	of those referred			non co monitored therefore self reported			
		56%	of those who attended						

TUPE transfer of Local Public Health Team staff to CTMUHB

Following discussion between Public Health Wales and Health Board Chief Executives and Executive Directors of Public Health, a decision was made to transfer staff employed by Public Health Wales in Local Public Health Teams into Health Boards. The original date of 30th March 2022 was postponed to 30th September 2022, due to pressures of Omicron.

Work is ongoing with the establishment of a local project team, including Finance and People directorates, to plan for a smooth transfer process.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 There are no specific risks or matters for escalation to board

4. IMPACT ASSESSMENT

5. Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Staying Healthy
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.

Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Creating Health

6. RECOMMENDATION

6.1 The Board is asked to **note** the contents of this update report including the progress made on the commitment to be a population health organisation.