New and Emerging Threats to the Health of the Gwent Population

Director of Public Health
Annual Report
2014
Publication Details

Title: New and Emerging Threats to the Health of the Gwent Population
Publisher: Aneurin Bevan University Health Board
Date: December 2014

ISBN 978-0-9929329-1-6
Acknowledgements

I would like to thank all my colleagues in the Aneurin Bevan Gwent Public Health Team for their help in compiling this report: the Editor-in-Chief Virginia Morgan and Editorial Team, Dr Jane Layzell and Kathryn Cross.

Special thanks to Dr Sarah Aitken, Dr Marysia Hamilton-Kirkwood, Tracey Deacon, Julia Osmond and Gemma Burrows for chapter contributions.

Special thanks to Scott Carey and Pamela Harris-Murton and the administration team also, for their support on design, graphics and production of the report.

Furthermore, I am grateful for the assistance of Public Health Wales Observatory (Nicola Sanders), Environmental Health (Huw Brunt and Daniel Rixon) and the Health Protection Team covering Aneurin Bevan UHB (Dr Lika Nehaul, Ceri Harris and team). Thanks are also extended to Katie Fry, Mark Bellis, Andrea Gartner and Linda O’Gorman for use of their material.

The Public Health Team has worked extremely hard this year on a range of issues, but notably with many divisions of Aneurin Bevan UHB on the Hepatitis C look back exercise. The Family and Therapies Division and Primary Care Division were essential to this. I am indebted to Mererid Bowley, Leah MacDonald and Wendy Warren for assistance in leading the response to this urgent issue. The Communications Team led by Richard Bevan and Karen Newman together with Dr Marysia Hamilton-Kirkwood supported the look back exercise and also should be thanked.
Foreword

“The greatest obstacle to those who hope to reform ... is complacency”

Diane Ravitch, Historian, American Educationalist

Great strides in looking after the population’s health in Wales have been made over the last fifty years. Mercifully the introduction of vaccines against major diseases of childhood has seen the need for ‘iron lungs’ for polio victims become a distant memory. The introduction of antibiotic and antiviral drugs have transformed the care of infectious disease. Smallpox has been eradicated.

However, in Public Health we are always scanning the horizon for new and emerging threats. Bacterial resistance means new drugs continually need developing. The influenza vaccine must be altered every year to protect against the changed wild virus strains that sweep the globe and arrive on our shores each autumn.

New and emerging threats mean there is no time to wait for the next challenge. Vigilance and ‘fleet of foot’, adaptable plans need to be maintained.

TB strains resistant to multiple drugs, and emerging diseases such as the Ebola virus remind us that protecting the health of our residents in Gwent occurs in a global context and that we are connected to international systems. The Health Board’s leadership of a response to a UK wide Hepatitis C incident is also discussed.

This year I will highlight several emerging threats to the population of Gwent and outline the multi-sectoral united action, which needs to be taken if earlier gains are not to be lost. Modern day epidemics of gambling, alcohol, misuse of new substances and additional social problems are considered.

Efforts to deal with new challenges must be met whilst maintaining planned actions on improving the health of the population.
Programmes such as ‘Making Every Contact Count’ and ‘Community Health Champions’ continue as part of our longer-term ambitions.

Assisting Aneurin Bevan University Health Board in ensuring inequalities in health are addressed through our programme for primary and secondary prevention of cardiovascular disease, a major cause of early death in our population, continues.

Intensified efforts on cancer-causing smoking (prevention and cessation), cancer screening and early detection, weight management and mental health promotion must also be maintained. The health outcomes of children in Gwent as monitored by the Plentyn Gwent Child database, along with ensuring every child in poverty has equal health chances must also remain our prime drivers.

Recently, I was shocked to learn that the ‘look-out’ boy sailors high on the icy masts of the Titanic did not have binoculars. This was because one of the senior crew had been replaced at the last minute and mistakenly left ship carrying a locker key for the cupboard containing the binocular allocation for junior staff. The remaining binoculars on board ship were assigned to higher officers, working inside ship on the ‘bridge’. It is highly probable that these young men would have seen the iceberg sooner had they been properly equipped.

In that tale is a lesson for us all, to equip those of us who ‘horizon scan’ for threats with the resources to keep our population safe. I am fortunate that Aneurin Bevan University Health Board has pioneered investment in local Public Health actions.

Never has the need been greater.

Dr Gillian Richardson  
Consultant in Public Health  
Executive Director of Public Health

October 2014
# Contents

Acknowledgements 3  
Foreword 4  
Contents 6  
List of Tables and Figures 7  
Glossary 9  
Chapter 1 – Alcohol 11  
‘What’s your poison’?  
People in Gwent are drinking too much alcohol  
Chapter 2 – New Psychoactive Substances 35  
'Lethal weapons' or 'Legal highs'?  
People in Gwent are experimenting with new drugs  
Chapter 3 – Gambling 49  
‘Harmless fun or threat to society’?  
Chapter 4 - E-Cigarettes and Shisha 61  
‘Old wolf in new clothing’?  
Chapter 5 – Improving Health & Healthcare in 2013 77  
Chapter 6 – Protecting Health in 2013 97  
Appendix A Hepatitis C look back exercise in Gwent: Recommendations 111
List of Tables & Figures

Chapter 1 – Alcohol

Figure 1: Percentage of adults reporting drinking above guidelines (males over 4 units, females over 3 units) on the heaviest drinking day in the past week, Aneurin Bevan UHB, 2008-2012

Figure 2: Percentage of adults reporting heavy (binge) drinking (males over 8 units, females over 6 units) on the heaviest drinking day in the past week, Aneurin Bevan UHB, 2008-2012

Figure 3: Percentage of adults reporting very heavy drinking (males over 12 units, females over 9 units) on the heaviest drinking day in the past week, Aneurin Bevan UHB 2008-2012

Figure 4: Adults reporting on the heaviest drinking day in the past week, Aneurin Bevan UHB, Count, 2013

Figure 5: Alcohol-specific hospital admissions (person based), European age-standardised rate per 100,000, persons, all ages, financial year 2012/13

Figure 6: Alcohol-specific hospital admissions (person based), European age-standardised rate per 100,000, males, all ages, Aneurin Bevan UHB and Wales, financial years 2003/04-2012/13

Figure 7: Alcohol-specific hospital admissions (person based), European age-standardised rate per 100,000, females, all ages, Aneurin Bevan UHB and Wales, financial years 2003/04-2012/13

Figure 8: Alcohol-specific mortality, 3-year rolling European age-standardised rate per 100,000, males, all ages, Aneurin Bevan UHB and Wales, 2003-2012

Figure 9: Alcohol specific mortality, 3-year rolling European age-standardised rate per 100,000 females, all ages, Aneurin Bevan and Wales, 2003-2012

Figure 10: Percentage change in standard death rate for various diseases, United Kingdom

Figure 11: Deprivation and Alcohol Related Mortality

Figure 12: Map of Health Board fifths of deprivation, Aneurin Bevan UHB
Figure 13: Map of Alcohol-specific hospital admissions (person based), persons, all ages, Aneurin Bevan UHB, financial years 2010/11-2012/13

Figure 14: Map of Alcohol-specific mortality, persons, all ages, Aneurin Bevan UHB, 2003-12

Figure 15a & 15b: Percentage of adults reporting drinking above guidelines on the heaviest drinking day in the past week

Figure 16: Map of the percentage of adults who report being obese

Figure 17: Percentage of adults who report being obese by deprivation fifths

Figure 18: Relative risks of contributions of obesity and alcohol to liver disease mortality (adjusted for all risk factors)

Chapter 2 – New Psychoactive Substances

Figure 1: Number and main groups of new psychoactive substances notified to the EU Early Warning System, 2005-13

Figure 2: Welsh National Database for Substance Misuse (WNDSM) Assessment Analysis All Ages

Figure 3: WNDSM Assessment Analysis, 12-17 years of age, Gwent

Figure 4: WNDSM Assessment Analysis by Substance and Age Group From 2012 to 2014

Chapter 3 - Gambling

Figure 1: People affected by the consequences of an untreated gambling disorder

Chapter 6 - Protecting Health in 2013

Table 1: Vaccine uptake in children reaching their second and fourth birthdays respectively between 01 April 2013 and 01 May 2014, who are resident in Aneurin Bevan UHB area

Table 2: Numbers of specified notifiable and confirmed infectious diseases reported in Gwent residents in 2013 (source Information Bureau for Infectious Diseases (IBID) and health protection team data)

Table 3: Reported environmental protection enquirers from Gwent during 2013 by Local Authority area and type

Table 4: Reported environment protection issues in Gwent during 2013 by Local Authority area and type

Table 5: Environmental protection incidents across Wales during 2013
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABUHB</td>
<td>Aneurin Bevan University Health Board</td>
</tr>
<tr>
<td>APB</td>
<td>Area Planning Board</td>
</tr>
<tr>
<td>ASH</td>
<td>Action on Smoking and Health</td>
</tr>
<tr>
<td>BHF</td>
<td>British Heart Foundation</td>
</tr>
<tr>
<td>COVER</td>
<td>Coverage of Vaccination Evaluated Rapidly</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardiovascular Disease</td>
</tr>
<tr>
<td>ENDS</td>
<td>Electronic Nicotine Delivery System</td>
</tr>
<tr>
<td>EPP</td>
<td>Exposure Prone Procedure</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>GAVO</td>
<td>Gwent Association of Voluntary Organisations</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HPT</td>
<td>Health Protection Team</td>
</tr>
<tr>
<td>HPV</td>
<td>Human Papilloma Virus</td>
</tr>
<tr>
<td>IBID</td>
<td>Information Bureau for Infectious Diseases</td>
</tr>
<tr>
<td>IGAS</td>
<td>Invasive Group A Streptococcus</td>
</tr>
<tr>
<td>INNU</td>
<td>Interventions Not Normally Undertaken</td>
</tr>
<tr>
<td>MECC</td>
<td>Make Every Contact Count</td>
</tr>
<tr>
<td>MEND</td>
<td>Mind, Exercise, Nutrition, Do it!!</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>MHRA</td>
<td>Medicines and Healthcare products Regulatory Agency</td>
</tr>
<tr>
<td>MMR</td>
<td>Measles, Mumps and Rubella</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
</tr>
<tr>
<td>NPIS</td>
<td>National Poisons Information Services</td>
</tr>
<tr>
<td>NPS</td>
<td>New Psychoactive Substances</td>
</tr>
<tr>
<td>NRT</td>
<td>Nicotine Replacement Therapy</td>
</tr>
<tr>
<td>PHW</td>
<td>Public Health Wales</td>
</tr>
<tr>
<td>PSHE</td>
<td>Personal, Social, Health Education</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>US</td>
<td>United States</td>
</tr>
<tr>
<td>WBAG</td>
<td>Wellbeing Activity Grant</td>
</tr>
<tr>
<td>WEDINOS</td>
<td>Welsh Emerging Drugs and Identification of Novel Substances Project</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WNDSM</td>
<td>Welsh National Database for Substance Misuse</td>
</tr>
</tbody>
</table>
Chapter 1
Alcohol

What’s Your Poison?
People in Gwent are drinking too much
The impact of alcohol on the health of people living in Gwent

Over 50% of men aged 25–64 years and over 40% of women aged 16-64 years living in Gwent report drinking more alcohol than is considered safe for their health on at least one day in the last week (figure 1). These survey results applied to the population estimate that around 206,100 people (117,900 men and 88,200 women) living in Gwent, are drinking more alcohol than is considered safe for their health on at least one day a week (figure 4).

Over 35% of men aged 16-64 years and over 30% of women aged 16-44 years report drinking heavily (binge drinking) on at least one day in the last week (figure 2). Heavy drinking equates to three pints of beer (more than eight units) for men and more than two glasses of wine (more than six units) for women. An estimated 128,400 people, (77,400 men and 51,000 women), living in Gwent are drinking heavily (binge drinking) at least once a week (figure 4).

Over 25% of men and around 20% of women aged 16-44 report drinking alcohol very heavily on at least one day in the last week (figure 3). The definition of very heavy drinking is more than 12 units for men, which equates to more than four pints of beer, and more than nine units for women which equates to more than three glasses of wine. An estimated 74,500 people, (45,100 men and 29,400 women), living in Gwent are drinking very heavily at least once a week (figure 4).

It should be noted that comparison with UK sales estimates suggest that national surveys including the Welsh Health Survey may underestimate alcohol consumption as they rely on self reporting methods. They may only represent 55-60% of the actual consumption rates (1) as they rely on self reporting methods (1).
**Figure 1**

Percentage of adults reporting drinking above guidelines (males over 4 units, females over 3 units) on the heaviest drinking day in the past week, Aneurin Bevan UHB, 2008-2012

Produced by Public Health Wales Observatory, using Welsh Health Survey (WG)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>46</td>
<td>42</td>
</tr>
<tr>
<td>25-44</td>
<td>58</td>
<td>47</td>
</tr>
<tr>
<td>45-64</td>
<td>58</td>
<td>41</td>
</tr>
<tr>
<td>65+</td>
<td>38</td>
<td>15</td>
</tr>
</tbody>
</table>

95% confidence interval

**Figure 2**

Percentage of adults reporting heavy (binge) drinking (males over 8 units, females over 6 units) on the heaviest drinking day in the past week, Aneurin Bevan UHB, 2008-2012

Produced by Public Health Wales Observatory, using Welsh Health Survey (WG)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>35</td>
<td>31</td>
</tr>
<tr>
<td>25-44</td>
<td>43</td>
<td>30</td>
</tr>
<tr>
<td>45-64</td>
<td>37</td>
<td>21</td>
</tr>
<tr>
<td>65+</td>
<td>16</td>
<td>4</td>
</tr>
</tbody>
</table>

95% confidence interval
Drinking too much alcohol is affecting people’s health

The Aneurin Bevan University Health Board (Aneurin Bevan UHB) hospital admission rate for diseases that are wholly associated with alcohol (alcohol specific) is significantly higher than the average for Wales (figure 5). It has more than the average for Wales over the last decade for both men (figure 6) and women (figure 7). This is specific evidence that an increasing proportion of people living in Gwent are causing serious damage to their health through drinking too much alcohol.
The Aneurin Bevan UHB alcohol specific hospital admission rate for men is double the rate for women. This is consistent with the survey results that more men than women are drinking heavily (figure 2) and very heavily (figure 3).

**Figure 5**

Alcohol-specific hospital admissions (person-based), European age-standardised rate per 100,000*, persons, all ages, financial year 2012/13

Produced by Public Health Wales Observatory, using PEDW (NWIS) & MYE (ONS)

* Using the 2013 European Standard Population
**Figure 6**

Alcohol-specific hospital admissions (person-based), European age-standardised rate per 100,000*, males, all ages, Aneurin Bevan UHB and Wales, financial years 2003/04-2012/13

Produced by Public Health Wales Observatory, using PEDW (NWIS) & MYE (ONS)

* Using the 2013 European Standard Population

**Figure 7**

Alcohol-specific hospital admissions (person-based), European age-standardised rate per 100,000*, females, all ages, Aneurin Bevan UHB and Wales, financial years 2003/04-2012/13

Produced by Public Health Wales Observatory, using PEDW (NWIS) & MYE (ONS)

* Using the 2013 European Standard Population
Drinking too much alcohol leads to early death

Deaths from alcohol-specific diseases have increased over the last decade for both men and women living in the Aneurin Bevan UHB area, although the death rate for men remains double the rate for women (figure 8, 9).

Liver disease is one cause of death that is increasing in the UK in contrast to a reduction in the death rate from malignant cancer and circulatory disease (figure 10). Alcoholic liver disease is included in these figures and may have contributed to the increase in alcohol-specific mortality.

Figure 8

Alcohol-specific mortality, 3-year rolling European age-standardised rate per 100,000*, males, all ages, Aneurin Bevan UHB and Wales, 2003-2012
Produced by Public Health Wales Observatory, using ADDE & MYE (ONS)

95% confidence interval

* Adjusted for ICD-10 coding changes and using the 2013 European Standard Population
Figure 9

Alcohol-specific mortality, 3-year rolling European age-standardised rate per 100,000*, females, all ages, Aneurin Bevan UHB and Wales, 2003-2012
Produced by Public Health Wales Observatory, using ADDE & MYE (ONS)

* Adjusted for ICD-10 coding changes and using the 2013 European Standard Population

Figure 10

Percentage change in European age-standardised mortality rates for various diseases from 2001 baseline, under 65s, Wales, 2001-2012

* Mortality for circulatory and respiratory disease has not been adjusted for coding changes from 2011
Drinking too much alcohol affects the health of the poorest the most

Alcohol (specific and attributable) deaths are highest in the most deprived communities and lowest in the least deprived communities in Wales (figure 11). This same distribution is seen in the Aneurin Bevan UHB area for both alcohol specific hospital admissions (figure 12, 13) and alcohol specific deaths (figure 12, 14).

**Figure 11**

Deprivation and Alcohol Related Mortality

Mortality by deprivation fifth, European age-standardised rate (EASR) per 100,000*, all ages, Wales, 2003-05 to 2010-12
Produced by Public Health Wales Observatory, using ADDE, MYE (ONS), fractions (PHE) & WIMD 2011 (WG)

*Using the 2013 European Standard Population

95% confidence interval

Rate ratio
The alcohol harm paradox

There is a paradox that a similar or slightly greater proportion of those people living in the least deprived parts of Wales drink above guidelines (figure 15a, b) but alcohol related deaths are highest in the most deprived communities (figure 11, 14).

Figure 15a, 15b

Self-reported alcohol consumption, age-standardised percentage by deprivation fifth, males and females 16+

Risk factors for liver disease

Alcohol affects the health of the poorest most because of the combined effect of too much alcohol and obesity. Poorer people are more likely to be obese than those who are more wealthy (figure 16, 17).
If a person is obese they are more likely to suffer from liver disease. Therefore, there are two risk factors rather than one, obesity and alcohol, which contribute to the likelihood of an individual developing liver disease (figure 18). This has a greater impact in our most deprived communities. Binge drinking also has more of an effect on the liver acutely. It is safer not to store the allocated weekly units for a one night a week binge since the liver is susceptible to acute poisoning in binge drinkers.

Figure 16

Map of the percentage adults who report being obese
**Figure 17**

Percentage of adults who report being obese by deprivation fifths

Percentage of adults reporting to be obese, by deprivation fifth, all persons, Aneurin Bevan UHB

Produced by Public Health Wales Observatory, using Welsh Health Survey (WG)

95% confidence interval

<table>
<thead>
<tr>
<th>deprivation fifth</th>
<th>2004/05 - 2008</th>
<th>2009 - 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most deprived</td>
<td>27</td>
<td>30</td>
</tr>
<tr>
<td>Next most deprived</td>
<td>26</td>
<td>25</td>
</tr>
<tr>
<td>Middle</td>
<td>22</td>
<td>28</td>
</tr>
<tr>
<td>Next least deprived</td>
<td>21</td>
<td>23</td>
</tr>
<tr>
<td>Least deprived</td>
<td>17</td>
<td>16</td>
</tr>
</tbody>
</table>

**Figure 18**

Relative risks of contributions of obesity and alcohol to liver disease mortality (adjusted for all risk factors)

Alcohol misuse = drink ≥15 units/wk; Obese = BMI ≥30

Hart et al. 2010
It can be seen that in comparison to a person who is not obese and does not misuse alcohol, a person who is obese has a small increased risk of dying from liver disease, a person who is drinking more than 15 units of alcohol a week has four times the risk of dying from liver disease, but a person who is both obese and drinks more than 15 units of alcohol per week has nearly ten times the risk of dying from liver disease.

**How children are affected by alcohol misuse?**

It is estimated that 2.6 million children in the UK are living with parents who are drinking hazardously and 705,000 are living with dependent drinkers. More than 100 children, including children as young as five contact ChildLine every week with worries about their parents drinking or drug use.

Alcohol use is a feature in the majority of domestic abuse offences with women, including mothers experiencing domestic abuse being up to 15 times more likely to misuse alcohol than women in the general population. Alcohol is known to play a part in 25-33% of known cases of child abuse. In a study of young offending cases where the young person was also misusing alcohol, 75% had a history of parental alcohol abuse or domestic abuse within the family (2, 3).
What should we be doing to reduce the harm alcohol causes to people in Gwent?


The Charter has five main elements for public health action. The building of healthy public policy, putting health on the agenda of policy makers in all sectors and at all levels. The creation of supportive environments, being aware of the impact of rapidly changing environments and working towards transforming physical, social resource and political environments so that health can be more easily protected and improved. Empowering communities to recognise their own problems, enable communities to seek to improve their own health through strengthening community action.

The development of personal skills, supporting personal and social development through the provision of information and education for life enhancing skills.

Finally, reorienting health services recognises the role of the health sector in moving beyond its responsibility for only providing clinical and curative services (4). Using this framework we are taking the following action to reduce harm from alcohol.
Building healthy public policy

The harm from alcohol to the health of people living in Gwent is escalating fast despite the efforts of the five local authorities in Gwent (Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen), the Aneurin Bevan University Health Board, Gwent Police and other partners in the Gwent Substance Misuse Area Planning Board to reduce harm from alcohol.

The scale of harm to health from alcohol for the population of Gwent is significant. To impact on a public health problem of this scale will require integrated, multi-faceted, multi-agency action (5). To achieve integrated, multi-faceted, multi-agency action will require the Gwent Substance Misuse Area Planning Board (the APB) and the five Local Service Boards in Gwent to agree a single strategic framework for action.

If a minimum price for alcohol is included in the Public Health Bill (Wales) it will be a huge opportunity to reduce the alcohol consumption of the heaviest drinkers and should be supported whole-heartedly by all the partners in the Area Planning Board and Local Service Boards.

A minimum price for alcohol is a targeted measure, particularly affecting heavy drinkers and very young drinkers, two of the groups suffering the greatest harms. Moderate drinkers would see very little difference in what they have to spend on alcohol. It would not really affect the cost of alcohol as virtually all alcohol sold in on-license premises is above any suggested level of Minimum Unit Price.
Pubs and clubs have a duty to ensure no irresponsible promotions take place within their premises and licensing authorities and Public Health work closely together to ensure that this is carried out through partnership working. If premises are found to be conducting irresponsible promotions Local Authorities may prosecute or may take proceedings to review the license of the premises, if it is found the actions that they take undermine crime and disorder, public nuisance, public safety and protection of children from harm.

There are a number of initiatives that are working that need to be done on a much greater scale to achieve a measurable reduction in the large number of people living in Gwent drinking more alcohol than is considered safe for their health.

To know if the action being taken to reduce harm to health from alcohol is being effective will require partner agencies to work together to share and analyse data to achieve a comprehensive understanding of the distribution and trends and what is working to reduce that harm. The monitoring system should include qualitative as well as quantitative data and intelligence to detect the emergence of new trends, such as the increase in binge drinking by young girls, any evidence of toxicity from counterfeit alcohol and any emergence of novel forms of alcohol consumption. The combined use of alcohol with other substances is particularly harmful and the pattern of combined consumption should be monitored to enable an appropriate response to be made.

**Creating supportive environments**

The density of outlets supplying alcohol in an area should be controlled particularly in areas of socio-economic deprivation. The harm to health from alcohol is highest in areas of socio-economic deprivation (figure 10, 11, 12) yet the distribution of licensed premises is often highest in these areas.

Cumulative impact areas restrict the granting of further licenses if objections are received against existing licensed premises in an area. If objections are received a license might be refused or be made subject to limitations if it is evident that it is likely to add to cumulative impact problems.
The passing of local By-Laws can be used to create alcohol free zones enabling people who want to choose not to drink alcohol to be able to enjoy going out in an area where the cultural norm is alcohol free.

Reduce the availability and accessibility of low cost alcohol and promotional ‘loss leaders’ by supermarket and other retailers and in licensed premises (e.g. ‘happy hours’).

**Strengthening community action**

Efforts should be made to make it easy to choose small rather than large measures of an alcoholic drink. It is now a duty for on-license premises to inform people purchasing alcohol mainly beer, cider, gin, rum, vodka, whisky and still wine in a glass, that smaller measures are available and this should be displayed on a price list.

Free drinking water in licensed premises needs to be made easily accessible. One way people are advised to reduce the amount of alcohol they drink is to drink a glass of water between each alcoholic drink (6). Licensing authorities and Public Health will work closely with the trade to ensure compliance on providing this information to customers and for the license holders to actively seek to promote smaller measures and water being made available.
Development of personal skills

Consistent messages to the public about the harms to health that alcohol can cause should be communicated. People do not know the harms to health from drinking too much alcohol in the same way that they know the harms to health from smoking tobacco. There is a need for much greater awareness of important messages about the increased risk of certain cancers, the risk of untreatable liver disease, the increased risk of a stroke and the number of calories in alcoholic drinks, the risk of injury and being assaulted while under the influence of alcohol.

Providing consistent, evidence based, effective substance misuse education to young people in formal and informal settings should be a priority. The evidence on what forms of Personal, Social and Health Education (PSHE) are effective and what are ineffective is well established, yet not all schools in Gwent are providing alcohol PSHE education that is consistent with the evidence on effective PSHE practice. The resources are available to support schools to provide effective alcohol PSHE and given the scale of the problem amongst young people (figure 1, 2, 3) alcohol PSHE consistent with the evidence on effective practice should be a priority in all schools for both educational performance as well as health reasons.

We need to increase general awareness of how much alcohol is in a drink. People think in terms of the volume of an alcoholic drink: a glass, a pint, a shot, a bottle and not in terms of the units of alcohol, which that volume contains. There is a need to provide easily understandable information about how much alcohol it is safe to drink and what is a harmful amount. There are national campaigns such as Change4Life, which already do this that could be widely disseminated locally. Information needs to be provided in a variety of ways to reach different sections of the population, particularly men in the most deprived communities. The opportunity should be taken to use social marketing techniques to design targeted campaigns about the dangers of both binge and regular drinking.
The population who are drinking unsafe amounts of alcohol vary from affluent, professional people drinking regularly at home to young people binge drinking at weekends. The same campaign message cannot be relevant to all. The design of future campaigns should be clear about who the target audience is, how best to reach them with the message, relevant messages about the harm alcohol might cause them and relevant incentives to change their behaviour.

Often individuals are unaware how much alcohol they are drinking. The first step towards an individual reducing their alcohol consumption is to recognise they are drinking a harmful amount. The partners in the Area Planning Board and the Local Service Board collectively provide services that have contact with thousands of individuals every month. Adopting a ‘Make Every Contact Count’ approach to ‘Have a Word’ about how much alcohol people are drinking would achieve the necessary scale of population education to start to reduce the numbers of people in Gwent drinking harmful amounts of alcohol.

Before a person decides to reduce the amount of alcohol they are consuming they must first recognise that the amount they are drinking is a risk to their health.
The AUDIT C short questionnaire is being promoted across Gwent as the preferred tool for professionals to use to identify people drinking unsafe amounts of alcohol. The more a person is drinking, the higher the AUDIT C score.

People with a low to moderate AUDIT C score are given brief advice about how to reduce their alcohol consumption and those with a higher score are referred to specialist, alcohol services. This is known as an Alcohol Brief Intervention. The ‘Making Every Contact Count’ (MECC) training programme incorporates Alcohol Brief Intervention training using the AUDIT C questionnaire. Over the last year, MECC training has been provided for General Practitioners (GPs), practice nurses and midwives across Gwent.

The Public Health Wales ‘Have a Word’ campaign has been designed to give front line staff the confidence to undertake Alcohol Brief Intervention.
Re-orientation of services

Individuals should be supported to reduce their alcohol consumption. How much support an individual needs to reduce their alcohol consumption ranges from none for those who have no dependence on alcohol to intensive, specialist help for those severely addicted, with a range of levels of intervention in between.

The scale of the problem of harmful alcohol consumption in Gwent means that the available resources need to be used effectively and efficiently to achieve the maximum possible impact. To achieve this will require a single, agreed alcohol treatment pathway for Gwent with all partners knowing which part of the pathway they are responsible for commissioning or providing.

In recognition that there are conflicting and confusing messages about how much alcohol it is safe to drink in pregnancy, a simpler ‘No Alcohol, No Risk’ message has been developed by the Public Health Team to support by the midwifery service in Gwent. National discussions continue as to whether or not this should become the standard message for pregnant women.
References

1. Gartner A et al. *A profile of alcohol and health*. Cardiff: WCfH; 2009. Available at:

2. Alcohol Concern, Children’s Society. Swept under the carpet: children affected by parental alcohol misuse. London: Alcohol Concern; 2010. Available at:

   http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2762991/

   http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index1.html


   http://www.nhs.uk/change4life/Pages/change-for-life.aspx
Chapter 2
New Psychoactive Substances

'Lethal weapons' or 'Legal Highs'? People in Gwent are Experimenting with New Drugs
The nature of the drug market has changed with increasing supply and demand for new recreational drugs. These are often too new to be judged as legal or illegal and include New Psychoactive Substances (NPS), also referred to as ‘legal highs’. These drugs are often affordable and easily accessible. In many cases, these substances have been designed to mimic Class A drugs, often producing the same or similar effects as drugs such as cocaine or ecstasy. Some of them (the synthetic cannabinoids) are pretending to be cannabis but are structurally different enough to be currently classified as legal substances under the Misuse of Drugs Act 1971.

The European Monitoring Centre for Drugs and Drug Addiction define a New Psychoactive Substance as:
'a new narcotic or psychotropic drug, in pure form or in preparation, that is not controlled by the United Nations drug conventions, but which may pose a public health threat comparable to that posed by substances listed in these conventions' (1).

With the major exception of mephedrone, which was classified as a Class B drug in April 2010, many new psychoactive substances are legal to use and buy from the Internet, in ‘head shops’ (a store that sells drug-related paraphernalia) from street dealers and friends.

**Legality and Safety**

The issue of whether it is legal or illegal to use a drug can result in confusion regarding its safety. The fact that NPS is legal does not mean that it is safe.

There are numerous types of NPS being produced. It is not possible to chemically analyse each substance in a timely fashion to provide enough information for them to be classified as illegal.

Within each NPS drug category the number of substances is continually rising (2), as can be seen in figure 1.
A person buying NPS is unlikely to be sure of what he or she is buying. It is also the case that the seller is unlikely to know what he or she is selling. NPS vary considerably and are often designed to mimic more ‘traditional drugs’.

The chemical composition and potential effects are often unknown. This can be true of even the manufacturer as substances can be mutated into another drug along the supply chain by the adding of unknown cutting agents or other drugs. Producers of the substances do not necessarily undertake standard testing processes for new medicines, one of the reasons why packaging states that they are not fit for human consumption.
A significant concern about NPS use is that if an unknown drug is taken resulting in adverse effects and there is a need for medical attention, health professionals are often unable to provide an appropriate intervention to counteract the effects of the drug.

In an attempt to address this issue WEDINOS (Welsh Emerging Drugs and Identification of Novel Substances) has been designed to collect and test substances. Appropriate evidenced based harm reduction information for individuals who misuse substances and interested professionals is disseminated via their website (http://www.wedinos.org/).
Samples are donated to WEDINOS anonymously. A code, known only to the donor is allocated, providing information about the substance being analysed free of charge, on the WEDINOS website. The media have raised concern that this service supports sellers and manufacturers of NPS by providing them with analytical information about their ‘product’.

Though it can be argued that the service has the potential to be abused, it has to be recognised that it has a valuable role in contributing to our knowledge base, including the usage and available types of NPS. This information is necessary to inform primary prevention and secondary prevention (harm reduction) interventions wherever possible.

The WEDINOS facility is accessed more frequently in the Aneurin Bevan UHB area than elsewhere in Wales. Between October 2013 and June 2014, some 237 samples were submitted. This compares with Betsi Cadwaladr: 61 samples, Powys Teaching: 5, Cwm Taf: 39, Cardiff and the Vale: 69, Abertawe Bro Morgannwg: 69, and Hywel Dda: 18, during the same time period.

It is unclear why there is increased availability of samples in the Gwent area but could be due to high levels of professional involvement or greater prevalence of NPS use in the Aneurin Bevan UHB area.

Between April and June 2014, 88 samples were submitted to WEDINOS from the Aneurin Bevan UHB area: during the analysis of these samples at least 40 different substances were identified either in combination or in isolation.

The full scale and impact of the use of NPS is not fully understood. There is no universal standardised surveillance system in Emergency Departments in Wales which captures this information. There is also no ICD 10 code which can be used due to the number of different sorts of NPS.
In addition to this as well as taking NPS orally, there is increasing experimentation with alternative modes of administration such as intravenous use. This potentiates the effect of the drug and also increases the risk of the spread of blood borne viruses between users if needles are shared.

It is reasonable to suggest that numbers recorded of those affected is likely to represent just the tip of the iceberg. As regards mephedrone alone, during 2013, 63 residents of Torfaen attended Emergency Departments at Nevill Hall, Royal Gwent and Ysbyty Ystrad Fawr hospitals, their presentation being associated with the use of this substance. This equates to an average of 5.25 presentations each month. Of these 63 people, 47 were under the age of 30, with 14 of them being between the ages of 15 and 20 years (personal communication, Deputy Chief Operating Officer Aneurin Bevan UHB from departmental audit).

**Who is most affected by NPS in Gwent?**

The pattern of drug use continues to evolve throughout the UK with use of NPS growing. Local data indicates that Gwent has a similar pattern.

The number of people in Gwent presenting for assessment and or treatment, where the primary drug is classified as ‘other substances’ has risen gradually since 2009/2010 as illustrated in Figure 2. These might include substances not known at the assessment or which are not in the drug list so could include NPS.

It should be noted that this data shows only the primary substance at assessment. In many instances more than one substance will be used.

The Welsh National Database for Substance Misuse (WNDSM) was established in 2005. It contains guidance on the common data sets and data definitions regarding substance misuse (3).

**Figure 2: Welsh National Database for Substance Misuse (WNDSM) Assessment Analysis All Ages**
Primary assessment data for substance misuse services illustrates that the age groups where “other drugs” are the principal reason for assessment for drug service use are 12-24 years of age. In the 12-17 age group there were 148 assessments and in the 18-24 age group, 118 assessments in 2012/2013 (figure 3, 4).
The age profile for NPS use in the Gwent area is similar to that of the rest of south Wales, the main users of NPS being teenagers and young people.

**Figure 4**

**WIDSM Assessment Analysis by Substance and Age Group From 2012 to 2014.**

---

**The impact on health inequities**

It is recognised that the effects of drug use are more pronounced amongst socially excluded groups and in the most deprived communities. The greatest numbers of children and young people presenting to services for assessment for treatment, where the primary drug of use is classified as ‘other substances’ reside in Blaenau Gwent and Caerphilly. These local authority areas have a higher proportion of deprived communities than the rest of Gwent. This is consistent with Intelligence Data from the police regarding drug seizures in these areas (4).
What should we be doing to reduce the harm New Psychoactive Substances cause to people living in Gwent?

Building healthy public policy

Reducing the harm associated with use of NPS should be regarded as a priority whether this is achieved through education or enforcement. A clear legislative framework needs to be developed by national government within which local agencies can operate. Collaborations between these agencies are of utmost importance. Action to identify and ban dangerous substances is the current national policy, so should be prompt and tools developed to enable this. Consistent messages regarding the risks and consequences of NPS use must be tailored to meet local need.

If we are to ensure early identification of trends of NPS use and effective interventions, greater information sharing should be promoted locally. The development of better data collection methods to reduce gaps in knowledge is vital and the need to engage with individuals who use NPS has been acknowledged.

The Gwent Substance Misuse Area Planning Board (APB) has undertaken a needs assessment to inform the commissioning of substance misuse services. Information gathered clearly demonstrates the increasing use of NPS and its associated harm. The APB has developed a commissioning strategy informed by the needs assessment which recognises that a multi-agency, partnership approach is needed to address the emerging threat from NPS at a local level.

The US has developed a system for temporarily banning new substances that are being classified. However classification is always one step behind production and so a new approach is being piloted in New Zealand which has 'decriminalised' NPS through the Psychoactive Substances Bill 2013. This enables regulation and licensing of a tightly controlled market for recreational drugs including safeguards, testing and regulation of new substances. Drug manufacturers must prove the product has ‘low risk of harm’ and pay research costs and fees to register.
In effect all NPS are therefore illegal until proven to be low risk. This is at variance with EU and US approaches which are not proving effective, so international interest in effectiveness of New Zealand’s approach is high (5).

**Creating supportive environments**

Due to the legal status of NPS implementation of drug enforcement legislation to reduce supply and use is not an option. However, an alternative approach is the use of consumer protection legislation. An example of this is local authority departments such as trading standards taking action against suppliers such as ‘head shops’ and related businesses that sell NPS. This can result in NPS being seized and criminal investigations being pursued. There are also issues with this approach such as the need to be able to test a product on sale to establish if consumer protection law is being breached. This requires significant financial resources which are not always available.

For NPS which have been classified as illegal, intervention is more straight-forward and action can be taken to disrupt sales via known routes such as internet sales, closing websites offering sales of banned substances. Substances sold as NPS often contain controlled drugs as well, should this be found to be the case drug enforcement legislation can be implemented as being in possession of, or supplying controlled drugs is a criminal offence.

Interventions for young people should focus on social media where young people spend leisure time. A number of third sector organisations have worked with the organisers of university fresher events and social gatherings such as clubs, parties and music festivals to raise awareness of the potential effects of NPS and provide support if and when necessary. A national social marketing campaign targeted at young people and young adults would be welcomed.
Professional education of Educational Welfare Officers, Head Teachers and Teachers – through INSET day training – School Counsellors, School Nurses and Youth Workers would also be beneficial.

Looked after children are particularly vulnerable and foster carers, care home workers and children and young people’s social workers would also benefit from training.

**Strengthening community action**

Statutory services such as the police and health service should work collaboratively with local communities to identify their needs and how restricting the supply of NPS can be addressed. Raising awareness of NPS amongst the public is paramount, with education being delivered at a local/community level, allowing campaigns to be tailored to meet the needs of specific groups. The idea that drug taking is an acceptable activity and an inevitable part of growing up needs to be challenged.
Development of personal skills

Prevention and education based interventions should focus on enabling individuals to take personal responsibility and to promote the choice not to take unknown, potentially harmful substances. It is important that we focus not only on substance misuse itself, but also on the root causes of the behaviour, helping people to develop necessary skills and values and building resilience in relation to risk taking behaviours.

Though use of NPS is not only the preserve of young people, use among this age group is most concerning. Resource should be targeted on educational skill development for this group through schools, youth services and non statutory services for young people. Ideally this would begin at primary school with age appropriate messages being communicated. Information should be made available to parents to enable them to support their children. Programmes such as the charity Care for the Family’s ‘How to Drug Proof your Kids’ training days for parents should be promoted and expanded.

The key message should be that because a substance is labelled ‘legal’ it does not mean that it is guaranteed safe. The content of the package are not necessarily ‘what it says on the tin’.

Although emphasis should be on prevention, another priority should be reducing harm for those who do use NPS. The WEDINOS system provides up to date information on the health effects of NPS, this should be used to enable harm reduction information to be publicised, increasing public awareness of the health risks and dangers of taking NPS. Identified information about specific harm to health and harm reduction messages needs to be shared with professionals and individuals who misuse NPS.
Re-orientation of services

Substance Misuse Services in Gwent provide specialist treatment for people with problems relating to NPS and other substances. Data from the WEDINOS system should be used in conjunction with service utilisation data to inform future service planning. However, many recreational NPS users would not consider themselves ‘substance misusers’ and would certainly not approach traditional services that they may see as associated with users of ‘hard drugs’. ‘Drop in’ clinic facilities for teenagers/young people wishing to discuss health issues including NPS are needed.

There are a number of professionals and organisations with whom those who use NPS will come into contact (for example primary care, accident and emergency department, and housing staff). It is important that these professionals are equipped with knowledge about NPS and where support and treatment is available. The DAN 24/7 website is useful. Messages need ‘post marketing surveillance’ to ensure they remain relevant and hit the mark.
References


5. New Zealand’s regulation of new psychoactive substances; A response to the futility of trying to ban such substances as they appear BMJ 2014;348;g1534
Chapter 3
Gambling

Harmless fun or threat to society?
To gamble = to ‘play games of chance to win money’. In the United Kingdom (UK) gambling commonly involves legal activities such as bingo, lotteries, roulette, gaming machines, sports betting (including football pools and spread betting), and increasingly commonly, internet gambling. Illegal gambling activities also take place within certain groups in the UK including betting on dog fighting, cock fighting and bare knuckle boxing. Each have their own risks to both the person betting on the game, and to the subjects of the game. These criminal activities, which involve a small minority of the population, are subject to Crown Prosecution with the police involved in their prevention and detection.

Gambling has to operate within prescribed legal and licensing guidelines within the UK but, the availability and accessibility of gambling activities is increasing, whilst education on the dangers of gambling lags behind.

The Faculty of Addictions Psychiatry (1) highlights increasingly easy access:

- On the high street, betting shops are visibly clustering together.
- There is an increase in fixed-odds betting terminals in betting shops.
- Participation in ‘remote gambling’ such as internet gambling continues to grow rapidly.
- Exposure to gambling advertising has increased.

The Gambling Act 2005, introduced a relaxation of the rules governing gambling allowing casinos, bookmakers and online betting sites to advertise their services on TV and radio in the UK for the first time (2).

The British Gambling Prevalence Survey showed that in 2010, 73 per cent of the adult population aged 16 or over (about 35.5 million adults) had participated in some form of gambling activity within the past year. This is compared with 68 per cent at the time of the previous survey in 2007(3). These figures suggest that gambling is increasingly being regarded as normal practice in our society, and that more people are engaging in gambling activities.
For the majority of people this is likely to be an infrequent, fun, social activity, a form of entertainment played within boundaries and limitations. For others however, risky and hazardous gambling behaviour can develop, potentially leading to problem gambling and gambling addiction.

Problem gambling can be defined as a situation in which gambling “disrupts or damages personal, family or recreational pursuits” (4). The Diagnostic and Statistical Manual of Mental Disorders V (DSM-V), redefines pathological gambling grouping it with addiction and related disorders and renaming it Disordered Gambling. Current research suggests that a greater overlap exists between alcohol and substance abuse and pathological gambling than was previously recognised (5). It has been estimated that in the UK the prevalence of known and diagnosed problem gambling has increased from 0.6% in 2007 to 0.9% in 2010 (3). This equates to nearly half a million adults.

“Problem gambling is typically a low prevalence activity, though it represents an important public health concern” (3). This is largely due to resulting issues - personal, domestic and social.
Who is likely to be affected by gambling in Gwent?
The negative effects of problem or addictive gambling have the potential to impact on the individual, their family and the wider community, as illustrated in Figure 1.

Figure 1

Consequences of untreated gambling disorders (1)

<table>
<thead>
<tr>
<th>The gambler – higher rates of physical illness, development of mental health conditions, severe financial difficulties, and criminal activity to fund gambling (Petry et al, 2005; Morasco et al, 2006).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Their family – for every problem gambler, 8 to 10 other people are directly affected (Lobsinger &amp; Beckett, 1996), including spouses (who may experience domestic violence; Mulleman et al, 2002), family members, children (with higher rates of behavioural, emotional and substance misuse problems) (Jacobs et al, 1989), friends and colleagues.</td>
</tr>
<tr>
<td>Wider society – likely increases in criminal activity attributable to gambling disorder, absenteeism from work and lost economic productivity (Orford, 2011).</td>
</tr>
</tbody>
</table>

Traditionally in the UK gambling and gambling problems have been thought to be the domain of adult males. There is evidence to show that this picture is changing. For example, more than half of women report having gambled once (excluding the National Lottery) in the past year (2). There has also been ‘a noticeable rise in female-targeted gambling marketing’ (2). Other markets currently being targeted for expansion by the gambling industry are the future markets i.e. young people, those living in areas of socio-economic deprivation disproportionately.
In the UK the legal age for gambling is 18 (except for the National Lottery which is 16). One of the three licensing objectives of the gambling Act 2005 is to protect children and other vulnerable persons from being harmed or exploited by gambling.

This objective is theoretically and ethically sound and is endorsed by many gaming establishments throughout the UK. However, there is evidence to show that children and young people are in fact gambling; The Gambling Prevalence Survey showed that in 2010 gambling prevalence amongst 16-24 year olds was 68% having risen from 58% in 2007. The survey also shows an association between problem gambling prevalence and age. The highest rates can be seen amongst the 16-24 year old age group (2.1%) compared with 0.9% of the adult population as a whole (3).

Gambling opportunities for children and young people are more accessible than ever, with easy access to the Internet, mobile phone apps and interactive televisions. Young people are especially susceptible to advertising and promotional messages encouraging gambling activity. This is often difficult to combat using the current legislation.
Why does gambling affect the poorest in our society most?

The Gambling Act 2005 relaxed prior restrictions regarding outlets such as bookmakers in towns and cities. It has been observed nationally and locally (2) that there has been an increase in the density of gambling outlets in socio-economically deprived areas with clusters of outlets becoming apparent. There has also been an increase in the installation of fixed odds betting terminals which are highlighted by the South Wales Gambling Services as a cause for concern in the Newport area.

These devices are located in betting shops. Each shop is allowed a maximum of four terminals. Players bet on games, usually roulette with fixed odds. These high stake machines are designed to allow for £100 to be staked every 20 seconds. The addictive nature of these terminals has been criticised and they have been referred to as ‘the crack cocaine of gambling’ (6).

What should we doing to reduce the harm gambling causes to the people living in Gwent?

Gambling is now widely accepted as having the potential to become a disorder comparable to that of drug or alcohol addiction (1). It is therefore an area where the sustainability of the support system needs to be highlighted. Interventions have to be put in place, which protect against the harm caused by gambling whilst acknowledging individual freedom of choice in relation to how money and time is spent.

Building healthy public policy

Nationally, there is a need for more research regarding how best to identify problematic gambling and how to tackle the issue (2).

‘Government policy for gambling in England and Wales currently rests with the Department for Culture, Media and Sport. Given the serious implications to public health consideration should be given to a greater role for the Department of Health in gambling policy’ (2).
The Health Survey for England and the Scottish Health Survey collect information regarding the number of individuals participating in some form of gambling over the last year (excluding the national lottery). The Welsh Health Survey does not collect this information, which would be of benefit in increasing our understanding of the issue in a Welsh context.

Creating supportive environments

Ensuring appropriate regulation and legislation relating to licensing and gambling activities is essential. This is of particular importance in areas of deprivation. There are various guidelines, policies and laws in place designed to protect the public whilst still enabling business to thrive, but these are not always observed.

Action should be taken to reduce the supply and accessibility of the means to gamble although further research is needed as to how this can be achieved. This could include for example, reducing the number of machines per person/location using the local licensing laws to restrict the number of local gambling outlets and the clustering of them. Particular attention should be paid to emerging methods of gambling such as Internet gambling, interactive television and mobile phones (2), which pose a problem regarding regulation.

Planning legislation to control the clustering of gambling outlets on the high street is currently being considered in England. If this is successful, it is likely that the legislation will be adopted in Wales.

Another course of action to be considered is the need to provide alternatives to gambling for recreation and entertainment.
Effective marketing restrictions relating to gambling should be ensured, especially as regards children and young people. It is of benefit to work with the Association of Bookmakers to provide appropriate advertising messages at appropriate times so that children will not be exposed to these communications.

‘Free’ betting advertising and incentives to sign up to receive ‘free’ bets should be discouraged. Advertising should also include responsible gambling messages. Access to gambling premises by children and young people should also be addressed, through for example, regular test purchasing (2). Promotion at Sports events such as football matches promotes gambling indiscriminately.

**Strengthening community action**

Gambling negatively affects the poorest in our society the most. In order to tackle the issue it is important that we acknowledge the need to build the capacity of communities through addressing the often underlying issue of socio-economic disadvantage. Interventions should focus on strengthening community resilience and working in partnership to de-normalise gambling in the community through awareness, information and education.

Sports gambling is a growing sector of the gambling market with the promotion of gambling being much in evidence at sporting events. We need to work towards the restriction of the promotion of gambling at these events as well as highlighting the dangers of gambling and signposting to support services.
Development of personal skills

Information about gambling in the wider context of addiction and its dangers should be made readily available to the public. Messages and format should be tailored to meet the needs of those most at risk of developing a gambling problem. Organisations that can help tackle problem gambling include Gamblers Anonymous.

Information provided should:

- encourage the individual to reflect on their own gambling behaviour
- outline the potential harm associated with problem gambling including financial, family and health
- offer advice about what to do if an individual loses control over his/her gambling
- offer advice regarding self help and steps to reduce gambling
- give details of how to access professional help
- offer advice for those living with a person with a gambling problem
- members of the public should be informed about responsible gambling and of the negative aspects of gambling and the losses this could bring to their lives and that of their families - financially, domestically and socially, as well to their own health and well-being. For this to be achieved, professionals and organisations from all sectors need to work in partnership across Gwent.

Re-orientation of health services

Identification of a gambling problem is paramount if an individual is to receive help. For some people (and/or their family) recognition of a problem is straightforward. For many individuals however, problem gambling remains undiagnosed, often co-existing with debt, mental health or substance misuse problems.
Health professionals working in primary care services and a range of other services including mental health and criminal justice services and debt advice agencies are in a position to help problem gamblers (1). A number of screening tools have been developed for use with high risk clients to identify problem gambling. An appropriate intervention can then be provided, for example a brief intervention or referral for specialist care. A brief intervention is designed to prevent a person from moving from being at risk of developing a gambling problem to developing a full disorder.

Very often to enable behaviour change for any addiction professional help and support is needed. Specialist support for gambling in the statutory sector is limited but might include psychosocial or psychopharmacological treatment. The National Problem Gambling Clinic located in London is currently the first and only NHS centre to treat pathological gamblers and support their families in the UK. It has been suggested that substance misuse services should be able to fulfil this function as they already provide other specialist interventions, which help people with addictions (1).

A number of UK charities address the issue of gambling, providing support for the individual and their partner, carrying out research and raising public awareness.

These include:

Gamblers Anonymous UK (www.gamblersanonymous.org.uk).

GamCare (www.gamcare.org.uk).

The Gordon Moody Association also provides treatment and housing for problem gamblers.

The South Wales Gambling Service is one of three Gambling Risk and Harm Minimisation Projects across the UK, working in partnership with Newport Citizens Advice Bureau and The Association Recovery Service.
References


Chapter 4
E-Cigarettes and Shisha

Old wolf in new clothing?
Why do e-cigarettes have the potential to harm the health of people in Gwent?

In response to growing concerns about the quality and safety of these nicotine containing products, the UK Medicines and Healthcare products Regulatory Agency (MHRA) conducted consultation and research and concluded in June 2013 that all e-cigarettes in the UK should be regulated as medicines.

Electronic cigarettes, also known as e-cigs, vaporisers or ENDS (electronic nicotine delivery systems) are battery powered devices that deliver nicotine to the user by heating and vaporising a solution that typically contains nicotine, propylene glycol and/or glycerol, plus flavours. As there is no combustion involved with the operation of e-cigarettes, there is no smoke and no other harmful products of combustion, such as tar and carbon monoxide (1). Consequently they are being marketed as a less harmful alternative to tobacco cigarettes.

E-cigarettes typically consist of a battery and a vaporising chamber into which a liquid solution is dispensed and heated. The liquid can come in sealed cartridges or can be poured into the chamber, and most (but not all) contain nicotine. The liquid is available in a range of flavours including tobacco, fruit and sweets.

Initially e-cigarettes were designed to look and feel like a real cigarette. The technology is becoming more sophisticated and more recent versions are produced in different shapes, sizes and colours. Some come with ‘puff counters’ or downloadable software that allows consumers to control and monitor their usage (1) or to link with other users through social networking (2). These products and their use is increasingly distancing itself from the language associated with tobacco smoking and is often described as ‘vaping’. E-cigarettes were introduced to the UK market seven years ago and have grown to represent a market estimated to be worth £91.3 million a year (3).
The promotion and availability of e-cigarettes has increased rapidly, and they are now a common sight in television commercials, social media, point of sale displays and sports/culture sponsorship (2). Increasingly the tobacco industry has taken ownership, and all major tobacco companies are currently active in this sector (3).

However, in October 2013, mandatory medicinal regulation of e-cigarettes was rejected by the European Parliament, and alternative legislation was accepted. Under the ‘European Tobacco Products Directive’, only products making therapeutic claims such as smoking cessation or reduction would have to undergo regulation as medicines. All other e-cigarettes must be regulated as consumer products and meet certain quality and safety standards including restrictions on nicotine content, health warnings on packaging and restrictions on advertising.

In the consultation of the Public Health White Paper ‘Listening to you – your health matters’ the Welsh Government has proposed introducing restrictions on the use of e-cigarettes in enclosed public places, consistent with current restrictions on tobacco products.

As yet there is no evidence from clinical controlled trials that e-cigarettes are any more effective for smoking cessation than existing nicotine replacement therapy products.
In addition, some e-cigarettes contain much more nicotine than traditional cigarettes making consumers more dependent. However smoking cessation with specialist support and NRT is known to be the most effective method of quitting.

It is clear that smokers are increasingly using e-cigarettes to help them cut down or quit, and smoking cessation services will need to work with these aids in addition to pharmacological options (3). Information from an ASH survey of e-cigarette use (6) reinforces this, as it suggests that the most cited reasons for use relate to a desire to quit smoking and not harm reduction. It is possible that the replacement of a tobacco cigarette with an e-cigarette that mimics smoking in every other respect may make it harder for some smokers to break the behavioural association of smoking. Therefore these smokers may be better supported by other methods.

Increasingly, however, there has been recognition that for some smokers, quitting altogether is not an option and that harm reduction would be an appropriate strategy (7, 8). For these smokers switching to an e-cigarette may bring benefits to their health. However, it would be counterproductive if harm minimisation becomes the preferred approach rather than a last resort (3). In the US in particular, the marketing of e-cigarettes has reinforced this approach and could be seen as discouraging smokers from quitting.

One of the key elements of UK and International Tobacco Control Policy has been efforts to ‘de-normalise’ smoking as a behaviour. The underpinning rationale of this approach has been two-fold:

- To create an environment in which young children are not routinely exposed to smoking as a normal behaviour of adults
- To support those smokers who are attempting to quit by providing environments which reduce cues to smoking behaviour or reduce the opportunity to smoke
A number of strategies have been adopted or are being considered to achieve this de-normalisation, including prohibition of tobacco advertising, bans on smoking in enclosed public places and other areas such as hospital grounds and playgrounds, point of sale display regulations and standardised packaging.

The widespread use of e-cigarettes in public places and their uncontrolled marketing and promotion could undermine these attempts by re-introducing smoking behaviour as a normal activity. E-cigarettes are marketed as a socially acceptable alternative to smoking and companies are adopting many of the advertising, promotion and sponsorship approaches of the tobacco industry to promote a product, which in some cases closely resemble cigarettes (9).

E-cigarettes are marketed to consumers as a healthier alternative to smoking, as a stylish and glamorous lifestyle choice and as allowing freedom to smoke whenever, wherever (2).

Marketing is widespread and includes celebrity endorsement and association with fashionable venues. Sponsorship of sporting events such as Birmingham City Football Club and British Superbikes Championship is reminiscent of tobacco sponsorship in the 1980’s that was subsequently banned (2).
It has been noted that e-cigarette marketing closely mirrors imagery used in old tobacco advertising (10), and uses methods that are known to be appealing to children and young people (for example attractive colours and flavours, celebrity endorsement, sponsorship of youth oriented events).

Currently, under law, tobacco products are hidden from view in retail outlets, but alongside products that look exactly like cigarettes on display, undermining the public health impacts of this policy. It seems unreasonable to expect that young children would be able to distinguish between the two. In addition, if young people commence their nicotine addiction through e-cigarettes, but find the habit too expensive to support, they are left only with traditional tobacco products to satisfy their addiction.

The potential benefits of e-cigarette use relate to harm reduction for existing smokers who are unable to quit smoking completely but wish to reduce their risk. Given that around a fifth of the adult population smoke, smoking remains the biggest avoidable cause of mortality and a major contributor to health inequities, the potential benefits of a safer form of smoking are considerable. There are however, risks to this approach in confusing the current very clear messages on tobacco (9) and care must be taken to minimise this risk.

It is obvious that tobacco companies are attempting to gain influence and a ‘seat at the table’ at strategic level by engaging policy makers and other anti-tobacco organisations through the potential of e-cigarettes for harm reduction (2). Policy makers must therefore be vigilant to this and ensure that public health policy cannot be influenced by the industry.

In practical terms, there is a need for clear guidance to support health professionals and NHS stop smoking services in implementing a harm reduction approach with their patients and clients.
How safe are e-cigarettes?

Nicotine is a poison. Scientific testing indicates that e-cigarettes vary widely in the amount of nicotine and other chemicals they deliver and there is no way for consumers to find out what is actually contained in the product they have purchased (11, 12). It is anticipated that the new European Tobacco Products Directive will address this issue to ensure that products are appropriately labelled and provide a known dose of nicotine.

There is a growing recognition of the risks of poisoning through contact with nicotine contained in these products. This risk is increased by the way that many are packaged and flavoured in ways that are attractive to children (10). The National Poisons Information Service (NPIS) 2013/14 annual report highlights that enquiries to their service regarding e-cigarette refill solutions have been increasing year on year. During 2013/14 204 enquiries were received, which is more than the total number of enquiries received about these products in the past six years. Children aged less than five years were involved in 22% of the enquiries. Ingestion was the most common route of exposure, but inhalation, eye and skin contact were also reported. This data is concerning and highlights the need for action on safe packaging and storage of e-cigarettes (13).

To whom could e-cigarettes pose a health threat?

The presentation of e-cigarettes as a safe, desirable and socially acceptable way to smoke may provide a route to nicotine addiction for children and young people. Although e-cigarettes are preferable to smoking tobacco, we must question whether it is desirable for e-cigarette use to be encouraged in non-smokers, regardless of whether or not it leads to use of tobacco at a later date. The high levels of addictive nicotine in e-cigarettes ensure pharmacological addiction.
In the US, the Centres for Disease Control and Prevention (14) found that e-cigarette use, while relatively low, increased significantly among middle and high school students between 2011 and 2012.

A number of smaller scale surveys have been conducted with young people in the UK, which do not indicate widespread use of e-cigarettes. However, awareness of e-cigarettes and perception of safety relative to tobacco is high (6, 15) and this together with the rapid growth in promotion of e-cigarettes is a cause for concern. It is crucial that longitudinal studies in the UK examining e-cigarette use as a potential gateway to future tobacco use are undertaken.

**What do we need to do to reduce the harm from e-cigarettes to people in Gwent?**

The growth of the e-cigarette market represents a considerable and ongoing challenge to both public health organisations and regulators. There is a possible benefit to e-cigarettes in terms of harm reduction for those smokers unable to quit. However, there are potential risks to public health as well and ongoing research is urgently needed to establish the nature and scale of these risks.

We must ensure a balance is struck between access to appropriately regulated e-cigarettes for those unable to quit, while taking care to avoid a future generation addicted to nicotine.

Public Health Wales (3) advises that:

- Smokers who wish to quit or reduce their smoking, should be advised to access one of the free NHS services which provide scientifically proven support including a range of tested nicotine replacement products.
• The promotion of e-cigarettes should be strictly limited to smokers only. It should not promote the concept of safe smoking and should only be as a harm reduction strategy. Whether any marketing should be allowed at all requires urgent review.

• Their use should be prohibited in workplaces, educational and public places to ensure smoking prevention and cessation efforts are not undermined.

• E-cigarettes should not be available to those under 18. Anything that might increase their appeal to children should be avoided e.g. flavouring, packaging.

• Promotion must not appeal to non-smokers, in particular children and young people. This could include product appearance and packaging being plain in order not to attract people into using it. There should be no flavoured products.

• Improved population and patient level data definitions and recording is required to enable the true impact of harm reduction strategies to be measured.

• We should extend tobacco product regulation to e-cigarettes. This should include requirements for retailers to be included on the proposed tobacco retail register.

• Research is needed to increase our understanding of e-cigarettes in particular the safety; effectiveness; role in normalising smoking behaviour and role as a gateway to nicotine addiction and smoking, particularly in children.
**What is shisha?**

Shisha, also known as hookah, narghile and hubble bubble, is a way of smoking tobacco and other substances using a waterpipe. Waterpipes are mainly used to smoke tobacco, which may be flavoured with fruit or syrup, but herbal mixtures are also smoked.

The device works by placing a tobacco or herbal mixture in a bowl, covered with perforated aluminium foil. Burning charcoal is placed on top of the foil. The user breathes in through a hose attached to the water jar, and smoke from the tobacco and charcoal is drawn down through the body of the waterpipe, passes through the water, into the hose and finally into the mouth of the user. Disposable mouthpieces may be attached to the end of the hose to reduce risk of infection. The size of the waterpipe, number of hoses and other features may vary (16).
Who uses shisha?

Shisha smoking is often a social activity, with two or more people sharing a waterpipe. The origins of waterpipe use are in Middle Eastern countries, with prevalence estimates of regular use of 11-36% in these countries (17). A systematic review examining global use of waterpipes found increasing prevalence in Western countries, particularly among high school and university students (18), although only one study in this systematic review was based in the UK (17).

There is not a lot of information about prevalence of waterpipe use in the UK, although there are two noteworthy studies. One study surveyed 937 students at Birmingham University and found that 38% had tried waterpipe smoking (17). Of these, 8% were regular (at least monthly) smokers and this was similar to the prevalence of cigarette smoking (at 9.4%). It is interesting to note however that 65% of waterpipe smokers in this survey did not smoke cigarettes, and nearly all waterpipe users thought it to be less harmful than smoking cigarettes.

A national cross-sectional survey of UK adults (19) found that the prevalence of ever use of waterpipes was 11.6%. The prevalence of frequent use (at least once or twice a month) was relatively small, at 1%. Younger people were more likely than older people to have ever used a water pipe, and ever use was more likely among males than females. Ethnicity was also important, with an increased likelihood of ever use among those of Asian or mixed ethnicity compared to White ethnicity.

The harmful effects of shisha

*Waterpipe smoking is no safer than cigarette smoking*

Waterpipe users commonly report the belief that the water filters out any harmful chemicals as the smoke passes through it (17,18).
The health effects of waterpipe smoking have not been as extensively studied as cigarette smoking, however, research to date indicates that it is associated with many of the same risks (16). Studies have shown both that waterpipe smoke contains levels of harmful chemicals similar to that found in cigarettes (20) and that following use of tobacco or herbal waterpipes, levels of carbon monoxide and heart rate (as well as nicotine in tobacco preparations) are equal to or higher than that seen after smoking cigarettes (21, 22).

There have also been reports of carbon monoxide poisoning resulting from waterpipe use (23, 24). Longer term health effects are less clear, although there is some evidence indicating that waterpipe smoking doubles the risk of lung cancer, respiratory illness, low birth weight and periodontal disease (25). Lastly, secondhand smoke from waterpipes is likely to be more harmful than that from cigarettes (16, 26).

*Herbal shisha is no safer than tobacco shisha*

While herbal shisha may not contain nicotine, the process of burning charcoal and inhaling smoke produces carbon monoxide and benzene, both of which are extremely harmful (16).

*Waterpipe smoking is as addictive as cigarette smoking*

Waterpipe smoking is often a social activity, undertaken fairly infrequently, and it is therefore possible that infrequent users may not be tobacco dependent (16). Although some nicotine is absorbed into the water, users can still be exposed to a sufficient dose to cause addiction, and compared with cigarettes may need to smoke more or for longer in order to alleviate nicotine cravings (26).
What action should we take?

There is currently no good quality data demonstrating the extent of the problem in Wales. Although prevalence of regular waterpipe use appears relatively low in the adult population, there is a case to be made for intervening where prevalence is likely to be higher, for example in Asian and mixed-ethnicity populations, and particularly younger men. In addition, there are actions that can be taken at a national level. The following recommendations are proposed:

- Ensure herbal waterpipe products are subject to the same regulations as other tobacco products, including restrictions on advertising, labelling, age of sale and taxation.

- Undertake targeted awareness campaigns to raise knowledge and awareness of the health harms of waterpipe smoking, that is culturally sensitive and based on a detailed understanding of common beliefs and misconceptions.
References


13. US Centres for Disease Control. Tobacco product use among middle and high school students - United States 2011 - 2012. MMWR 2013; 62(45); 893-7. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6245a2.htm


Improving health and healthcare 2013 - the year in focus
There were two large and unexpected incidents requiring reactive work to protect population health during 2013 – the discovery that a large number of former patients may have been exposed to Hepatitis C virus by a former healthcare worker, and an extensive measles outbreak in a nearby Health Board area which threatened to affect our area. This required Health Board and Public Health Wales staff to scale down some of the proactive work to improve health and healthcare, which had been planned for 2013.

**Exercise Golau – the Hepatitis C ‘look-back’ exercise**

During 2013, the Health Board was made aware that a retired former healthcare worker had been diagnosed with Hepatitis C, and had unknowingly transmitted the virus to two former patients. An extensive look-back exercise was then coordinated by the Director of Public Health, to identify all the patients at risk, and to offer them initial screening, follow up testing and treatment of these infected with the virus. It was the largest exercise of its kind undertaken in Wales to date. The look back was extended to include Cwm Taf Health Board and Betsi Cadwalader University Health Board, and ultimately involved a number of different NHS organisations across the four UK nations, tracing patients treated over a career of more than 30 years.
Hepatitis C is a virus, which can only be transmitted through blood and other body fluids. Some individuals seem to be able to destroy the virus naturally after being infected, while others can harbour the virus for a very long time before it leads to illness, and a few people will become ill within a fairly short time of being infected. The main health problems caused by the virus affect the liver, and if untreated can lead to liver failure and in a few cases liver cancer. The virus was identified relatively recently in 1989, with reliable testing only available since the early 1990’s.

A thorough review of clinical records took place, to identify patients who had definitely or possibly had an ‘exposure prone procedure’ (EPP) undertaken by the affected healthcare worker. (This is a procedure, which risks a healthcare worker sustaining an injury, which would cause them to bleed into a patient’s body cavity or open wound.)

Relevant patients were identified, traced and invited to call a helpline to discuss any urgent issues or questions they might have, and make an appointment to see a health professional for further discussion and testing for Hepatitis C exposure. Specifically trained call handling staff were used to man the bilingual free phone helpline, which initially operated 8am to 8pm seven days a week. Over 4,500 calls were received.

For a few patients where clinic attendance was felt to be inappropriate, either home visits were arranged, or care was managed by the GP.

Over 50 dedicated clinics were held in Aneurin Bevan UHB between September and November 2013. These were held at a range of locations and at different times of the day and during evenings and weekends to make them as accessible as possible for patients. Clinics were also held in Cwm Taf Health Board and Betsi Cadwalader University Health Board. Clinic appointments were made for women to find out if they had markers for Hepatitis C virus in their blood.
Where this was the case patients were tested to see if it was the same genotype as the healthcare worker, to determine if the healthcare worker was responsible for their infection. Three additional patients with ongoing Hepatitis C infection were eventually identified; one was very likely to have been infected by the original healthcare worker, while the other two had infection unrelated to the healthcare worker. Procedures such as tattooing and piercing carry risks of acquiring Hepatitis C for example. All three women were offered appropriate treatment and ongoing support through their local Hepatitis clinical services.

Three further patients who had probably been infected by the healthcare worker were identified through the records of local Hepatitis clinics. Lessons learnt during this exercise will help to inform appropriate responses to any similar incidents that may occur in the future. Our detailed recommendations to Welsh Government and the UK Advisory Panel on healthcare workers infected by blood borne viruses are in Appendix A, but the key recommendation is that occupational health guidance should be strengthened by requiring all healthcare workers performing exposure prone procedures to receive enhanced checks for blood borne viruses, especially those who have been employed by the same organisation since before 2007 when enhanced screening guidance was first introduced for new or transferred posts.

**MMR vaccination ‘catch up’ Campaign**

In 2013, the Swansea Bay area of Wales saw the biggest outbreak of measles since the introduction of MMR vaccination. Measles is a highly infectious disease, which can have complications resulting in serious or even life threatening health consequences.

The most effective way to protect against measles is two doses of Measles, Mumps and Rubella vaccine (MMR), given at 12 and 40 months of age - which also ensures protection from mumps and rubella, two other diseases which can have severe health consequences.
After an unfounded health scare in the late 1990s, some parents declined MMR vaccination for their children. Although there has been a slow increase in uptake since, in early 2013 it was estimated that 17,492 individuals aged between two and 18 years in Gwent were not fully immunised and remained at risk from measles, mumps and rubella.

Aneurin Bevan Local Public Health Team responded swiftly to the Swansea outbreak by declaring a public health emergency, and working across the Health Board divisions and with the Planning team. The Health Board made available necessary resources and prioritised the response to try and prevent the outbreak spreading into the Gwent area.

This required an MMR ‘catch up’ campaign targeting the under immunised school aged population, particularly those aged 10 to 18 years who had never had an MMR vaccination.
A three-pronged approach was implemented to actively encourage people to get their unprotected children/young people immunised with MMR through offering:

a) Vaccination sessions at two colleges of further education (six campus sites), five special schools, 42 secondary schools (including four Independent schools) and those Primary Schools identified with 50 or more children un or partly under immunised.

b) Primary Care vaccination clinics prioritising Primary School age children, with practices identifying and inviting children aged four to 11 years with immunisation needs.

c) Eight ‘drop in’ clinics run from local hospitals, for those who were unable to attend their GP practice or who missed their school session.

Vulnerable groups with access issues e.g. those in the prisons and living on traveller sites were actively offered vaccination at suitable locations.
Information materials were disseminated in 12 different languages to target various ethnic minority groups in the Newport area. Young people not in employment, education or training were asked to attend their GP for vaccination, if they were under immunised.

Between April and July 2013, 14,432 unscheduled doses of MMR were given in the Aneurin Bevan UHB area. Of these, 8,926 were administered in General Practice, 2,940 in Saturday Drop-in Clinics, 2,094 in secondary schools/college sessions and 472 to healthcare staff.

Although a number of cases of measles were diagnosed in school-aged children across the Health Board, further spread in each case was contained by a rapid response to specifically vaccinate other susceptible children in that school in addition to the wider efforts to encourage MMR uptake. The actions taken with confirmed and suspected cases of measles are described in Chapter 6.

Aneurin Bevan UHB population did not experience the high numbers of measles cases seen in neighbouring Health Boards. As a result of the catch up campaign, there has been an increase in the uptake of two doses of scheduled MMR vaccine in children aged under five, and also in the percentage of those aged 16 years protected by MMR. An uptake rate of 95% for full vaccination is required for ‘herd immunity’, the level at which infection is unable to take hold in a population and cause disease outbreaks.

We have not quite achieved this yet in Gwent – so there remains an ongoing risk of measles, mumps or rubella disease outbreaks, but uptake has increased substantially compared with previous years, and rates will hopefully continue to increase.
**Additional public health achievements in Gwent during 2013:**

During the year, a lot of proactive work aiming to improve both population health and health care was completed in Gwent, despite the distractions of measles and the look back exercise. Some of these achievements are summarised in the following pages.

**Making Every Contact Count (MECC) and improving community health education**

Preventing poor health and promoting healthier lives is absolutely essential to reduce the burden of chronic disease on people and services, reduce health inequalities and sustain the NHS for future generations. Prudent healthcare relies on co-production of health with patients at the level of the consultation and, as such, helping our patients and clients change ill-health behaviour is increasingly important to the organisation.

<table>
<thead>
<tr>
<th>Aneurin Bevan UHB children</th>
<th>Uptake 2012-12 (Pre measles emergency)</th>
<th>Uptake 2013-14 (Post measles emergency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>two doses MMR @ age 5</td>
<td>89.4%</td>
<td>92.6%</td>
</tr>
<tr>
<td>one dose MMR @ age 16</td>
<td>88.7%</td>
<td>94.5%</td>
</tr>
<tr>
<td>two doses MMR @ age 16</td>
<td>78.3%</td>
<td>88.2%</td>
</tr>
</tbody>
</table>

**Table 1**
MECC is a programme of work which aims to empower the NHS workforce to use the hundreds of thousands of patient contacts to help people change behaviour to improve their health and wellbeing.

We want the improvement of health behaviour to be a routine, non-judgemental and integral part of professional’s role. In 2013 we focussed on the development and delivery of motivational interviewing brief intervention training for a number of professional groups including General Practitioners (166 trained), Practice Nurses, (83 trained) and Health Visitors (79 trained).

This is part of an ongoing programme of training planned for a wide range of professional groups over the next few years, including Midwives, hospital Pharmacists, and learning disability and mental health workers. We have been making this training sustainable by using a ‘train the trainer’ model. Organisational development work continues, to link in with national prevention programmes and to increase regular referral to support.
The **Community Health Champions Network** offers members of the public the opportunity to develop skills, knowledge and confidence to improve their own health and informally support others in their community, by signposting to appropriate services.

The programme has been developed in partnership with Gwent Association of Voluntary Organisations (GAVO), Torfaen Voluntary Alliance, Communities First and Local Authorities across Gwent.

Champions receive free training; Agored Cymru Accredited Champions Training delivered by GAVO, and Awareness Sessions on various health topics delivered by local service providers. A ‘Train the Trainer’ model is being piloted in Caerphilly to enhance the sustainability of the programme.
Evidence based healthcare

In 2013, the Bevan Commission outlined its approach to “Prudent Health Care” and proposed the need for immediate and urgent action to ensure that evidence based medicine was being applied in the health care setting and ensuring the best outcomes for patients with the limited resources available. Prudent healthcare aims to deliver health care that fits the needs of the patient and actively avoids ineffective care that is not to the patients benefit.

There are four key principles to this work.

- Stop doing things where there is evidence that it doesn’t work
- Invest only in what gives tangible benefits
- Investigate areas where evidence is not clear
- Improve quality and clinical outcomes

The Health Board and the local Public Health Team worked together to develop a programme of work around Prudent Health Care based on NICE evidence of effective treatments and a review of actual Health Board clinical activity. Treatment for varicose veins was the first topic to be considered, in collaboration with local Vascular Surgeons.

Agreement was reached for four criteria for surgical intervention in individuals with varicose veins, based on evidence of effectiveness in preventing future medical complications:

- Superficial vein thrombosis and venous incompetence including haemorrhage
- Healed venous leg ulcer
- Venous leg ulcer that has not healed after 2 weeks
- Lower limb skin changes: pigmentation or eczema
**Investigating inequities in cancer mortality**

The local Public Health Team and Health Board staff have also been working together to review prevention, incidence trends, and services for various cancers. There appears to be good evidence that survival rates for many cancers in Wales are less good, compared with other parts of Europe. It is not presently clear why this is, and the reasons may be different for different types of cancer.

Possible reasons are patients failing to present with symptoms soon enough to allow early diagnosis and therefore more effective treatment, delays within the process of diagnosis and treatment once patients have sought help, or failure to optimise treatments. Data on the ‘stage’ of cancer with which patients are presenting would help to answer some of these questions, but are not routinely available; and work is ongoing to try to address this. A strategy to decrease inequities in cancer mortality is part of the Public Health Team work plan. As part of this work, incidence and trends for **head and neck cancer** diagnoses in Aneurin Bevan UHB were investigated during 2013.

Head and neck cancers are a group of many different types of cancers, most of which are uncommon and some are rare. Sites include the mouth, lips, larynx, pharynx, thyroid, nose, salivary glands etc.

Treatment of these cancers often has permanent effects on organs essential for breathing, speaking, eating and drinking and therefore patients need expert support before, during and after treatment.

Head and neck cancers appear to be becoming more common generally, and there was a 25% increase in case numbers in the Aneurin Bevan UHB area between 1991 and 2011. Most (around 75%) of this increase is in women.
Historically, the majority of these cancers occur in older people with a history of smoking and/or excessive alcohol consumption. Risk increases with the amount of either, and is multiplied in those who both smoke and drink excessively. Increasing rates of tobacco use and alcohol consumption in women is likely to explain some of the rise in these cancers in women.

However, there is now increasing evidence that some specific types of head and neck cancer in younger people of both sexes, particularly mouth cancers, are strongly associated with human papilloma virus infection (HPV). Some 22% of head and neck cancers are now thought to be related to HPV infection.

There are many different types of HPV virus, some of which seem to confer a much higher risk than others of developing cancer at the site of any infection. The viruses can be transmitted by sexual activity, including oral sex. Some studies have suggested that up to 40% of women are infected within two years of becoming sexually active, with infection rates in both sexes increasing with numbers of sexual partners. The correct use of condoms or dental dams reduces but does not eliminate the risk of sexual transmission.
Vaccination against key types of HPV virus is likely to have the greatest effect on reducing HPV associated cancer rates.

The strong causal link between HPV and cancer of the cervix in women is now well documented, but HPV is also a prominent risk factor for genital warts and cancers of the vagina, vulva, penis and anus. These cancers are very rare, but around 80-90% of anal cancers, 40-50% of penile cancers and up to 90% of mouth cancers are associated with HPV infection.

Teenage girls in the UK are currently routinely offered vaccination against some types of HPV to prevent cancer of the cervix and genital warts. However, there is increasing evidence internationally that unless preventative measures in terms of vaccinating teenage boys are taken, then the annual number of HPV related oral cancers will exceed that of cancers of the cervix by 2020. The UK Joint Committee on Vaccination and Immunisation have been considering whether HPV vaccination should be offered to teenage boys across the UK.
Stopping smoking and moderating alcohol intake are key preventive measures against head and neck cancer in general, but encouraging the eventual vaccination of both sexes against HPV prior to the onset of sexual activity and the use of condoms and/or dental dams during sexual activity is also crucial.

**Completion of the British Heart Foundation ‘Hearty Lives’ projects**

2013 also saw the ending of two major projects funded by the British Heart Foundation, under their ‘Hearty Lives’ initiative to improve primary prevention of heart disease. These projects started during 2009 when the NHS in Wales was in the throes of one of the largest re-organisations ever; but both have managed to make a lasting contribution to the heart health of their local populations, and provide useful learning for other areas.

**In Hearty Lives Torfaen,** several linked projects provided a co-ordinated approach to addressing obesity. The use of BHF materials within schools to improve physical activity and dietary knowledge has been continued by most of the local schools, with some support being provided by local education officers. The ‘Total Health 2’ groups and the GP led obesity clinic were unable to be sustained after the end of the project, but they helped several hundred people to lose significant amounts of weight and gain the necessary knowledge and skills to maintain this. A lot of valuable learning arose from these two services, which has helped to shape both the national ‘Foodwise’ programme, and also the remodelling of the various Gwent wide Aneurin Bevan UHB adult weight management services into a single more efficient and better co-ordinated service at levels two and three of the Wales Obesity Pathway. The project also supported an enhanced use of the MEND programme for children, and this work is also guiding the consideration of revised and extended obesity services for children across the Health Board.
In Blaenau Gwent ‘Smoke Free Blaenau Gwent’ piloted an innovative approach to discouraging young people from smoking using drama and young people’s strong sense of social justice along with their natural aversion to being manipulated. The programme has been developed into a package, which can be used by other areas, probably best used in schools or other organisations, which already have some activity around reducing smoking. This approach has been cascaded into Newport and Cardiff.

Work towards a ‘smoke free’ environment in all Aneurin Bevan UHB premises was also taken forwards in 2013 with the appointment of two smoke free officers (in post since January 2014). These officers have proved effective in discussing smoking with individuals continuing to smoke on Health Board premises and supporting them to access nicotine replacement products.

**Supporting quality and health improvement through Primary Care**

The Public Health Team has supported Primary Care colleagues in the development of a ‘Primary Care Dashboard’ for quality outcomes, which was piloted by Blaenau Gwent GPs, with a view to use across Gwent in future years.

A cardiovascular prevention programme was also piloted with a GP surgery in Blaenau Gwent as part of the proposed Living Well Living Longer initiative to reduce inequalities in health within the Health Board area. The Public Health Team and Primary Care & Networks Division have been working together on the new approach to CVD risk screening which will be delivered in areas with the highest rates of premature mortality from cardiovascular disease.

The new programme will be launched in October 2014. Patients at risk will be referred to lifestyle programmes such as smoking cessation, weight management, exercise referral and alcohol services. The programme will also work closely with Communities First to identify and make visible other community assets that may help patients to reduce their risk. The programme is joint funded by Aneurin Bevan UHB and the Welsh Government Inverse Care Law initiative.
Community health improvement initiatives
During 2013, the local Public Health Team worked with health professionals from the Health Board and youth workers from Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen local authorities to develop the ‘Health and Wellbeing Youth Worker Toolkit’. This provides practical ideas for running health related activities on food and fitness, emotional wellbeing, sexual health, smoking, alcohol and drugs. It was launched in 2014.

The Public Health Team has responsibility for managing the Health Challenge Wales Wellbeing Activity Grant. Locally, the grant is administered through the Gwent Wellbeing Forum, which includes representatives from all the five local authorities. A portion of the grant is allocated to local authority areas for targeted projects responsive to local need, the remainder allocated for Gwent-wide projects.
Along with funding the implementation of the Community Health Champions programme, in 2013 the grant supported:

<table>
<thead>
<tr>
<th><strong>Gwent wide</strong></th>
<th><strong>‘Beat the Silent Killer’</strong></th>
<th>Nearly 600 CO detectors were purchased, and the five ‘Care &amp; Repair’ supplied and fitted them in households that are occupied by older and/or vulnerable people throughout Gwent.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Substance misuse education</strong></td>
<td></td>
<td>A training package and toolkit for school-aged children to enable schools to provide accurate and consistent information was developed by the Gwent Area Planning Board for Substance Misuse – the grant was used to purchase additional resources to support the implementation of the toolkit.</td>
</tr>
<tr>
<td><strong>Torfaen and Caerphilly</strong></td>
<td><strong>Keep Well this Winter campaign</strong></td>
<td>Promotion of this campaign for older people.</td>
</tr>
<tr>
<td><strong>Monmouthshire</strong></td>
<td><strong>Smoke free playgrounds</strong></td>
<td>The grant funded signage for the campaign to be implemented in 2013.</td>
</tr>
<tr>
<td><strong>Blaenau Gwent and Monmouthshire</strong></td>
<td><strong>Cabsafe scheme</strong></td>
<td>Targeted campaign designed to get people home safely after a night out by sending a text message to a central number and receiving a reply with details of three licensed taxi firms.</td>
</tr>
<tr>
<td><strong>Newport</strong></td>
<td><strong>Health Challenge Newport</strong></td>
<td>Promotion of new brand and website to encourage population to adopt healthy lifestyles.</td>
</tr>
</tbody>
</table>
References

Protecting Health in 2013

http://www.healthchallengewales.org/play-flu-game
Our local Public Health Wales Health Protection Team

Public Health Wales NHS Trust supports health boards in Wales to meet their statutory responsibility to protect the health of their populations through the provision of Local Health Protection Teams.

Our local (‘Gwent’) Health Protection Team is currently based just outside Pontypool, and has responsibility for the management of communicable disease incidents, outbreaks, and other infection incidents in the community throughout the Aneurin Bevan UHB area.

They also work with other appropriate partners to deal with any environmental issues, which may threaten the health of the population, and with partners in the Gwent Local Resilience Forum to ensure robust plans and action to protect the public in the event of any major emergency.

The team works closely with a similar but slightly larger team, which is based in Cardiff; and which supports Cardiff & Vale and Cwm Taf Health Boards, and their four constituent Local Authorities.

Together, these two local teams are officially known as the ‘South East Wales Health Protection Team’, and together with the North and Mid & West Health Protection Teams provide a comprehensive, 24-hour service supporting all Welsh Health Boards, Local Authorities and Local Resilience Fora.

The teams also work together on national and international work programmes, and collaborate on training and development opportunities, and provide cross cover and ‘surge capacity’ for each other when necessary.

Health Boards are responsible for the delivery of healthcare services provided by GPs and other NHS staff across their area.
This includes diagnosis and treatment of infectious diseases, control of communicable disease incidents within health service premises, and delivery of the scheduled childhood and adult immunisation programmes.

Healthcare professionals also play an important role in controlling the spread of infectious diseases through specific healthcare interventions.

Local Authorities have statutory responsibilities for the investigation of food and waterborne infections. This is done through their Public Protection or Environmental Health departments.

The Consultant in Communicable Disease Control who heads up the local Public Health Protection Team is also the ‘Proper Officer’ for communicable disease control for each of the five local authorities in Gwent, and has legal powers and duties for infection control which complement those of Local Authority officers.

Such a close geographical and collaborative working relationship with Aneurin Bevan University Health Board and officers from the five Local Authorities helps our local Health Protection Team to deal swiftly and efficiently with incidents.
It can also prevent small incidents escalating into more serious problems by facilitating the gathering of early intelligence about communicable disease, infection in the community, and also (acute) environmental incidents, which might pose a potential public health threat.
Measles in ‘Gwent’ in 2013

Although we managed to avert an outbreak on the scale of that seen in neighbouring Health Boards, we still had 26 (microbiologically confirmed) cases of measles in the period March–June 2013. Prior to that the last confirmed case had been in 2011. Over 100 suspected cases were also reported locally during that period.

The first confirmed measles case in Gwent in 2013 was linked to the outbreak in Swansea and other cases identified during the period had links to people outside of Gwent, or occurred in unimmunised / partially unimmunised close contacts of other cases. The highest numbers of (confirmed) cases were in Newport (11 cases) and Caerphilly (10 cases). Fourteen were aged ten to 18 years and nine of the cases required hospital admission.

The Health Protection Team followed up all suspected cases to identify vulnerable contacts, who were then offered MMR vaccination, or other measures as appropriate. Advice was also given on exclusion and other measures to reduce spread of the illness.
Details of the wider MMR catch-up campaign put in place in the Aneurin Bevan UHB area to manage the outbreak are set out in Chapter five. Unfortunately despite the huge increase in vaccination coverage achieved by this campaign, there are still significant numbers of school age children in Gwent who are not fully protected against measles, mumps and rubella.

During the course of the outbreak, there were comments that measles is a mild disease. However, the experience of the Health Protection Team, who spoke to patients, or to family members, was that the individuals with confirmed measles were very unwell and a third of our confirmed cases were in fact admitted to hospital.

Vaccines are highly effective in preventing illness, death and disability, from infectious diseases. The measles outbreak demonstrates the consequences to individuals, and to the population at large, of having significant numbers of individuals, across different age groups who are not fully protected.

There are many examples of other serious infectious diseases, once under control, returning when immunisation rates fall, either through loss of confidence in vaccines, or disruption to health systems. Examples include whooping cough in the UK, diphtheria in Russia, and polio in parts of West Africa and in Syria.

Uptake of the routine childhood vaccination programme in Gwent

‘COVER’ (Coverage of Vaccination Evaluated Rapidly) reports are produced by Public Health Wales each quarter, and annually. They report on uptake of the immunisations in the UK routine childhood schedule in children reaching key birthdays. 95% is the level of uptake required for each vaccine in order to protect the whole population from the relevant disease(s).

The March 2013–April 2014 COVER Report (1) shows that uptake rates in Gwent are very good for those vaccinations offered to children under the age of two, with more than 95% of children under the age of two receiving all age appropriate vaccinations.
This is the case in all areas of Aneurin Bevan UHB, except for two areas where Hib/Men C uptake is 93% and 94%.

However in most areas of Aneurin Bevan UHB, those vaccinations offered to children aged between two and five years have a much lower uptake rate, insufficient to provide full population protection against diphtheria, tetanus, whooping cough, polio, mumps, measles and rubella for the remainder of the childhood and teenage years. No area has yet managed to ensure that the crucial 95% of all children are fully protected against all these diseases by the age of five. This puts all children potentially at risk from these diseases by enabling the causative organisms to circulate freely in the population. Even in the most affluent areas of ABUHB, only 89% of children are fully protected, whereas in the least affluent areas, only 84% are fully protected.

### Table 1

<table>
<thead>
<tr>
<th>(i) % uptake in children reaching their 2nd birthday</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP/Po3</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>97.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(ii) % uptake in children reaching their 4th birthday</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR2</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>90.5%</td>
</tr>
</tbody>
</table>

**Notes:**

- **DTP** = diphtheria tetanus pertussis vaccine, **Po**=polio vaccine, **Hib**=Haemophilus influenzae type b vaccine (protects against meningitis caused by Hib bacteria), **Men C**=meningococcal C vaccine, **PCV**= pneumococcal conjugate vaccine, **MMR** = measles, mumps and rubella vaccine, **4 in 1** = combined booster doses of **DTP/Po** in a single vaccine

**NB** several vaccines require a number of doses to be given in order to achieve full immunisation against the specific disease(s).
Additions to the scheduled childhood vaccine programme during 2013

A few changes were made to the childhood vaccine schedule in 2013.

(i) Men C (Meninogococcal C) vaccine: since July, only one dose is given as part of the primary infant course, and a booster dose was introduced for teenagers – in Gwent this was offered to all children in Year 9 at secondary school.

The booster dose (given in combination with a Hib booster) for children between 12 and 13 months of age was retained (uptake of 94.1% in children reaching their 2nd birthday in 2013/14).

(ii) In 2013, rotavirus vaccine was added to the schedule for infant immunisation. Rotavirus is the most common cause of gastroenteritis worldwide in children under five years of age – it is responsible for causing 111 million episodes of gastroenteritis requiring care at home. In England and Wales, an estimated 130,000 episodes of rotavirus-induced gastroenteritis occur each year in children aged under five, with around 12,700 hospitalised (2,3).

(iii) Fluenz vaccine was introduced as part of an extended influenza vaccination programme 2013/2014 for children. In the first year, it was offered in Wales to children at 2 years and 3 years of age through their GPs, and to children in school Year 7 in school.

Hepatitis C look-back exercise

The Health Protection Team undertook initial investigations when a retired healthcare worker was reported to have Hepatitis C, and alerted Aneurin Bevan UHB. The team worked with the health board during the planning and conduct of the exercise. More details are given in Chapter five, and in Appendix 1.
Notifications of infectious diseases

The Health Protection (Notification) (Wales) Regulations 2010 require doctors to notify cases of infectious disease or contamination that present a significant risk to human health. Diagnostic laboratories also have to notify specified causative, i.e. microbial, agents they identify as part of investigations into the cause of infectious diseases in patients. Notification is made to the Proper Officer of the Local Authority in which the patient presents for medical care.

The purpose of notification is to enable the prompt investigation, risk assessment and response to cases of infectious disease and contamination that present a significant risk to human health. This includes identifying the likely cause of illness as due to microorganisms or toxic agents, so that control, or other appropriate, measures can be put in place.
The following table gives details of the numbers of diseases/conditions notified under the Health Protection Regulations (Wales) 2010.

### Table 2

<table>
<thead>
<tr>
<th>2013</th>
<th>Numbers of notified cases</th>
<th>Numbers of confirmed cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pertussis</td>
<td>52</td>
<td>54</td>
</tr>
<tr>
<td>Campylobacter</td>
<td>730</td>
<td>7</td>
</tr>
<tr>
<td>Salmonella</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>E-Coli 0157</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Cryptosporidium</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td>Giardia</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Meningitis</td>
<td>23</td>
<td>15</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Influenza A</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Influenza B</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>Legionella</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Measles</td>
<td>188*</td>
<td>26</td>
</tr>
<tr>
<td>Mumps</td>
<td>170</td>
<td>41</td>
</tr>
<tr>
<td>TB</td>
<td>36</td>
<td>26</td>
</tr>
<tr>
<td>Scarlet Fever</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Invasive Group A Streptococcus infection</td>
<td>29</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

*Measles – the figure shown is for the numbers of cases notified during the calendar year 2013. There were no further confirmed cases after the outbreak.*

Certain infectious diseases can only be notified when the microbiological result is known, because a number of microorganisms can cause the illness. Legionella infection is one of these – Legionnaires disease manifests as pneumonia, and a number of other bacteria can cause a so-called atypical pneumonia.
Likewise, invasive Group A streptococcus (IGAS) infections require a positive microbiological result before it can be notified. IGAS are serious infections that result from the penetration of group A streptococci bacteria into the tissues and organs of the body. They require prompt antibiotic treatment. The infections they cause include sepsis (an infection of the blood that causes a high temperature, rapid heartbeat and rapid breathing), necrotising fasciitis, and toxic shock syndrome.

**Environmental Public Health Protection**

Environmental public health is the discipline of identifying, assessing and managing risks linked to environmental hazards that can adversely affect individual and population health. Work in this field attempts to prevent or minimise hazardous exposures and impacts and contribute to healthy, fair and sustainable environments.

In Wales, the Environmental Public Health service (i.e. the service dealing with environmental hazards other than those responsible for communicable diseases) is led by Public Health Wales. It is delivered collaboratively through Public Health Wales’ Health Protection Team and Public Health England’s Centre for Radiation, Chemical and Environmental Hazards Wales.

This integrated Team provides partner agencies (such as Health Boards, Welsh Government and local authorities) and the public with independent, specialist and contextualised advice and support.

It undertakes pro- and re-active work around agreed environmental public health priorities and aim to minimise exposures to, and resulting ill-health from, environmental hazards.
Table 3: Reported environmental protection enquiries from Gwent during 2013 by Local Authority area and type
Table 4: Reported environmental protection issues in Gwent during 2013 by Local Authority area and type.

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Number of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blaenau Gwent</td>
<td></td>
</tr>
<tr>
<td>Caerphilly</td>
<td></td>
</tr>
<tr>
<td>Monmouthshire</td>
<td></td>
</tr>
<tr>
<td>Newport</td>
<td></td>
</tr>
<tr>
<td>Torfaen</td>
<td></td>
</tr>
</tbody>
</table>

Table 5: Environmental protection incidents across Wales during 2013

<table>
<thead>
<tr>
<th>Type</th>
<th>Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological - mostly blue-green algal toxins in recreational waters</td>
<td>7</td>
</tr>
<tr>
<td>Chemical - fires/explosions - 7 at waste management sites</td>
<td>12</td>
</tr>
<tr>
<td>Chemical - contamination</td>
<td>1</td>
</tr>
<tr>
<td>Chemical - deliberate</td>
<td>4</td>
</tr>
<tr>
<td>Chemical - release / spill</td>
<td>24</td>
</tr>
<tr>
<td>Radiation</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total incidents across Wales</strong></td>
<td><strong>50</strong></td>
</tr>
</tbody>
</table>

The 158 enquiries from across Wales made to the environmental health protection team cover a wide range of areas, including formal enquiries related to Planning Applications and Environmental Permits for industrial processes (nearly half of all enquiries), queries about water quality (virtually all concerning private water supplies), air quality and a wide range of other topics (4).
References


Appendix A

Recommendations from the 2013 Aneurin Bevan UHB Hepatitis C look back exercise:

1. UK Health Boards and other health bodies should ensure that all health care workers performing exposure prone procedures (EPP) receive enhanced checks for blood borne viruses. This is particularly important if initial employment occurred before enhanced screening guidance was introduced (2007). This recommendation would, if implemented, close a possible loop hole in existing guidance. Strengthening of existing occupational health guidance should be considered by the UK advisory group on Hepatitis as a matter of urgency.

2. Pensions Agencies of England and Wales, Scotland and Northern Ireland should be able to access the databases of others as a matter of course.

3. Sharing of information between UK nations for coordination and response should be facilitated by joint protocols which clearly outline information governance and confidentiality aspects for all patients affected by the look back exercise (including the healthcare worker).

4. Doctors general training should stress the importance of formal notification of infectious diseases to the Proper Officer of the relevant Local Authority. This is usually the local NHS Consultant in Communicable Disease Control who is formally designated by Local Authorities in this role, and has accompanying legal powers and duties.

5. We recommend a review of hepatitis clinic records should be standard in any look-back exercise. Of the four patients now known to have been
infected by the health care worker, two were initially identified from local hepatitis clinic records, one was subsequently identified from the records of the hepatitis clinic in another Health Board, and only one was identified from the look-back exercise. Another two previously undiagnosed but unrelated hepatitis C patients were also identified from the look back exercise.

6. Hepatitis C patients need detailed employment histories taken and if a new patient is a healthcare worker who has undertaken EPPs, links to other locally registered patients with Hepatitis C should be considered. Genotypes assist in tracing possible individuals of concern.

7. Legal, Ethical and Information Governance advice to an Incident Management Group is essential.

8. Incident Management Groups should include patient advocates in addition to all professional stakeholder groups involved in the response to an incident.

9. Communications should help the media and public to be realistic in expectations on the time the look-back exercise will take and to bear with those responding to the incident.

10. Phased posting of patients “invitation to test” letters should be according to the helpline capacity.

11. Early notification of GPs 96 hours before the ‘Go Live’ date enabled patients with additional factors (e.g. those who were terminally ill) to be excluded from mail.

12. Individual appointments with nurse advisors (in special clinics) where patient questions can be answered as well as blood tests offered is the ideal and recommended response to such an incident from our experience.
13. Positive tests (at any phase) should initially be communicated verbally to patients by a health care professional rather than by letter alone.

14. Coordination of large scale incidents will require a coordination hub to be staffed daily for first few weeks.

15. Database management should be limited to very few identified individuals under the direction of a data warehouse specialist.

16. Closure of an exercise needs careful planning in the same way as ‘Going Live’ with a Communications strategy mirroring that at commencement.

17. The designation of foetal scalp electrode application as an EPP3 means that their use now needs to be captured in birth registers with name of the healthcare worker who applied it.