Norfolk Health & Wellbeing Board

Date: **Wednesday 26 April 2017**
Time: **9:30am**
Venue: **Edwards Room, County Hall, Norwich**

Membership	Substitute	Representing
William Armstrong	Alex Stewart	Healthwatch Norfolk
Cllr Yvonne Bendle	Cllr David Bills	South Norfolk District Council
Cllr Bill Borrett	Cllr Margaret Stone	Adult Social Care Committee, Norfolk County Council
James Bullion	Catherine Underwood	Adult Social Services, Norfolk County Council
Dr Hilary Byrne	Antek Lejk	South Norfolk Clinical Commissioning Group
Matt Dunkley	Don Evans	Children's Services, Norfolk County Council
Cllr Penny Carpenter	Cllr Marlene Fairhead	Great Yarmouth Borough Council
Cllr Paul Claussen	Cllr Trevor Carter	Breckland District Council
Pip Coker		Voluntary Sector Representative
Dr Anoop Dhesi	Antek Lejk	North Norfolk Clinical Commissioning Group
T/ACC Mike Fawcett		Norfolk Constabulary
Lorne Green	Dr Gavin Thompson	Police and Crime Commissioner
Joyce Hopwood		Voluntary Sector Representative
Dr Ian Mack	Chris Humphris	West Norfolk Clinical Commissioning Group
Dan Mobbs		Voluntary Sector Representative
Cllr Elizabeth Nockolds		Borough Council of King's Lynn and West Norfolk
Maggie Prior		North Norfolk District Council
Cllr Andrew Proctor	Cllr Roger Foulger	Broadland District Council
Dr Louise Smith		Public Health, Norfolk County Council
Cllr Roger Smith	Cllr Shelagh Gurney	Children's Services Committee, NCC
Dr John Stammers	Melanie Craig	Great Yarmouth & Waveney Clinical Commissioning Group
Cllr Vaughan Thomas	Adam Clark	Norwich City Council
Dr Wendy Thomson		Norfolk County Council
Cllr Brian Watkins		Norfolk County Council
Tracy Williams	Jo Smithson	Norwich Clinical Commissioning Group
Joanna Yellon		NHS England, East Sub Region Team

Standing invitation to attend Board meetings:

Christine Allen	David Wright	James Paget University Hospital
Dennis Bacon		Norfolk Independent Care
Mark Davies	John Fry	Norfolk & Norwich University Hospital
Roisin Fallon-Williams	Geraldine Broderick	Norfolk Community Health & Care
Dorothy Hosein	Edward Libbey	Queen Elizabeth Hospital
Michael Scott	Gary Page	Norfolk & Suffolk NHS Foundation Trust
Jonathan Williams	Paul Steward	East Coast Community Healthcare

Persons attending the meeting are requested to turn off mobile phones.
For further details and general enquiries about this Agenda please contact the Committee Administrator:
Karen Haywood on 01603 228913 or email committees@norfolk.gov.uk

1	**Apologies**	Clerk
2	**Chairman's opening remarks**	Chair
3	**Minutes**	Chair
4	**Members to declare any interests**	Chair
5	**Any urgent business**	Chair
Items for discussion/action		
6	Health and Wellbeing Index and Health Inequalities (presentation)	Tim Winters
	Transformation and Integration	
7	Norfolk & Waveney Sustainability & Transformation Plan (STP):	
	a) STP Chairs Governance Group (verbal update)	Chair
	b) STP update (**To follow)**	Wendy Thomson
8	Norfolk Integration and Better Care Fund 2017-19: Planning and approval	James Bullion/ Catherine Underwood
	Wider health and wellbeing	
9	Healthwatch Norfolk Strategy 2017-20 and focus for business 2017/18 (presentation)	Alex Stewart
10	Suicide Prevention in Norfolk	Jane Sayer/ Nadia Jones
11	Smoking in Norfolk	Louise Smith
	a) Tobacco Control Strategy and action plan	
	b) NHS Smokefree	
Information updates		

- **Next Steps on the NHS Five Year Forward View** – you can access this recent report on the NHS England website at the following link
- **Healthwatch Norfolk** – you can access the most recent HWN Board minutes at the following link
- **Norfolk Health Overview & Scrutiny Committee** – you can access the most recent NHOSC papers at the following link

Norfolk County Council

Health and Wellbeing Board
Minutes of the meeting held on Wednesday 8th February at 9.30am
in the Edwards Room, County Hall

Present:

Chris Bean	Norfolk and Norwich University Hospitals NHS Foundation Trust
Cllr. David Bills	South Norfolk District Council
Hilary Byrne	South Norfolk Clinical Commissioning Group
Cllr. Penny Carpenter	Great Yarmouth Borough Council
Cllr. Shelagh Gurney	Vice Chair, Children's Services Committee
Joyce Hopwood	Voluntary Sector Representative
Sarah Jones	Children's Services, Norfolk County Council
Dr Ian Mack	West Norfolk Clinical Commissioning Group
Cllr. Elizabeth Nockolds	Borough Council of King's Lynn and West Norfolk
Sheila Oxtoby	Great Yarmouth Borough Council
Cllr. Andrew Proctor	Broadland District Council
Chief Insp. Lou Provart	Norfolk Constabulary
Dr. Janka Rodziewicz	Voluntary Sector Representative
Dr. Louise Smith	Norfolk County Council
Jo Smithson	Norwich Clinical Commissioning Group
Dr. John Stammers	Great Yarmouth and Waveney Clinical Commissioning Group
Alex Stewart	Health Watch Norfolk
Cllr. Margaret Stone	Vice Chair, Adult Social Care Committee
Cllr. Vaughan Thomas	Norwich City Council
Dr. Wendy Thomson	Norfolk County Council
Catherine Underwood	Norfolk County Council
Cllr. Brian Watkins (in the Chair)	Norfolk County Council

Also present:

Christine Allen	James Paget University Hospital
David Ashcroft	Norfolk Children's Safeguarding Board
Dennis Bacon	Norfolk Independent Care
Cllr. Richard Bearman	Norfolk County Council
Sam Cayford	South Norfolk District Council
Matthew Cross	Broadland District Council
Cllr. Margaret Dewsbury	Chair, Communities Committee
Adele Madin	Norfolk Community Health and Care
Robert Read	Great Yarmouth Borough Council
Rhiana Rudland	Breckland District Council
Jon Shalom	Community Safety Manager
David Wright	James Paget University Hospital

The Chairman welcomed Chief Inspector Lou Provart, Dr Janka Rodziewicz, Adele Madin and Chris Bean to their first meeting of the Board.

1 Apologies

1.1 Apologies were received from Cllr Roger Smith, Cllr Bill Borrett, Temporary Assistant Chief

Constable Mike Fawcett, Pip Coker (Voluntary Sector), Dan Mobbs (Voluntary Sector), Geraldine Broderick (East Coast Community Health Care), Roisin Fallon Williams (East Coast Community Health Care), John Fry (Norfolk and Norwich Hospital), Mark Davies (Norfolk and Norwich Hospital), James Bullion (Norfolk County Council), Cllr Yvonne Bendle (South Norfolk District Council), Tracy Williams (Norwich CCG), Michael Scott (Norfolk and Suffolk NHS Foundation Trust) and Cllr Paul Claussen (Breckland District Council).

2. Chairman's Opening Remarks

2.1 The Chairman welcomed Cllr Margaret Dewsbury (Chair of Communities Committee) and Cllr Richard Bearman to the meeting as observers.

3. Minutes

3.1 The minutes of the Health and Wellbeing Board (HWB) held on the 21st September 2016 were agreed as a correct record and signed by the Chairman.

4. Declaration of Interests

4.1 There were no interests declared.

5. Urgent Business

5.1 There was no urgent business received.

6. Norfolk and Waveney Sustainability and Transformation Plan (STP)

6.1 The Board received the report from the Managing Director, Norfolk County Council, which provided an update on the development of key aspects of the Norfolk and Waveney Sustainability and Transformation Plan (N&W STP) including governance arrangements, communications and engagement. It also outlined four bids currently under development for submission to the Transformation Fund.

6.2 During the ensuing discussion the following issues were raised:

- Where possible the governance structure for the STP would use existing rather than additional resources.

- With regard to the accountability of the structure for the STP there would be collective ownership and each of the groups would be responsible for electing their own leads.

- The Board discussed the advantages of localism and the importance of District Councils in understanding local needs was recognised. It was stressed that in order to meet local needs, local variations needed to be understood.

- The Board considered the need for engagement with colleagues in the Waveney area. It was noted that Great Yarmouth and Waveney CCG and East Coast Community Healthcare were represented in STP groups and Waveney District Council was represented on the newly established Stakeholder Board. In response to an issue raised regarding joint working with the Suffolk Health and Wellbeing Board, the Director of Public Health said that in the past the Board had

invited representatives when there was a pertinent item on the agenda and this approach would be continued.

6.3 The Board **Resolved** to:

- Note the progress on the key aspects of the STP and identified any actions that Board member organisations could take at this stage to support its developments.

7. Better Care Fund Plan 2017-19: Progress and Future Planning

7.1 The Board received the report which provided a summary of the progress of the Better Care Fund for 2016/17 and an overview of the strategic direction for the 2017-19 Plan.

7.2 In introducing the report Catherine Underwood said that detailed BCF guidance was still awaited and it was expected that this would be available shortly. It was hoped that the BCF 2017 -19 could be brought to the April meeting of the Board for final sign off if timings allowed.

7.3 The Board's attention was drawn to the proposed BCF schemes for 2017-19 and the progress being made with those schemes that were already committed to. The need to fully understand the impact of the 2016-17 BCF to inform future planning was recognised as was the need to align the developing BCF Plan with the STP.

7.4 The Board agreed that if it was not possible for the final BCF Plan for 2017-19 to come to the April meeting, that the decision would be delegated to the BCF Sub-Group (the Chair and Vice Chairs). In these circumstances, the final draft submission would be sent to all HWB members for comments.

7.5 The Board resolved to:

- Note the overall strategic direction of the BCF Plan, in particular noting that it should be aligned with the Norfolk and Waveney STP.

- Agree that, if deadline timings allow, the final submission should be brought to the full Health and Wellbeing Board meeting in April for approval. If timings do not allow then this will be circulated to all members of the Board for comment with the final decision delegated to the BCF Sub-Group (the Chair and Vice Chair).

8. Norfolk's Response to Domestic Abuse

8.1 The Board received a report which summarised the strategic direction of work to improve how Domestic Abuse is tackled in Norfolk and suggesting how the Health and Wellbeing Board could contribute.

8.2 In introducing the report Jon Shalom reminded the Board that responsibility for tackling Domestic Abuse did not rest with just one agency but required a whole system approach.

8.3 The Board highlighted that the impact of Domestic Abuse on children was particularly important because of the inter-generational consequences. Attention was drawn to the report undertaken by the Children's Services Committee regarding the Emotional Wellbeing and Mental Health of Children in Norfolk. The importance of working with schools to discuss Domestic Abuse was emphasised, as was the importance of

discussing behaviour in relationships, particularly for teenagers. It was noted that work was being piloted in Great Yarmouth schools to identify when a DA incident had occurred in a child's home in order that the child involved could be properly supported in the school environment.

8.4 David Ashcroft, Independent Chair of the Norfolk Children's Safeguarding Board (NCSB), reinforced the message that Domestic Abuse cut across different services and acknowledged that while there was still work to do to integrate support it was a high priority of the NCSB.

8.5 It was noted that the Safe Lives project had approached the County Council to put forward funding, however this did not undermine or cut across the work of other agencies.

8.6 The need to highlight issues in workplaces surrounding Domestic Abuse was raised. It was noted that Public Health England had developed a toolkit for employers and suggested that this could be looked at being rolled out to other employers in Norfolk. Board members, who were employers, were also encouraged to look at the toolkit. In addition all partners not already actively engaged in the DA awareness raising campaign were encouraged to commit to do so.

8.7 **RESOLVED to:**

- Confirm that partners endorse the approach being taken to tackle DA in Norfolk through the partnership with SafeLives for MASH development, and the piloting of Penta interventions.

- Assist in building awareness of our approach and influencing the alignment of strategy between partners

- Consider the role that partners could play, both collectively and individually, in ensuring the practical implementation and embedding of our approach.

- Consider how integrated care pathways for DA are commissioned.

- Identify major risks or barriers and how these might be addressed.

9. Developing our Future Strategy - a draft Framework

9.1 The Board received a report which provided a draft Framework for developing future Strategy based on the Board's three longer term goals or themes. It was noted that for each of the longer term goals, the draft Framework outlined the Board's overall purpose and principles involved, and a high level statement about how the Board would go about addressing the challenges facing the system.

9.2 During the ensuing discussion the following issues were raised:

- The importance of developing integration between health and social care was highlighted by the Board. The Board stressed that there was a need to be clear as to what was meant by integration, what was trying to be achieved and the most appropriate time to move forward with any new approaches.

- Targets needed to be focused on prevention in order to delay the onset of

dementia particularly for older people in deprived areas.

- There was a commonality with the proposed themes and those of the STP and it was important that the Board challenged the STP regarding these themes.

- It proposed that the Engagement event for wider stakeholders would receive contributions from outside experts to highlight examples of successes both nationally and in Norfolk as well as breakout discussions regarding the strategic direction of the Board's themes.

The Board noted the date for the Stakeholder Engagement event of Wednesday 21st June 2017.

9.3 **RESOLVED to:**

- Consider and comment on the contents of the paper
- Agree the draft Framework as the basis for developing the next Joint Health and Wellbeing Strategy
- Approve the outlined proposals for an engagement event with wider stakeholders on the developing Strategy to be held in the summer.
- Identify any key factors that should inform the next stages of its development.

10. Prevention and Promoting Independence. Creating wellbeing and improving health and social care - a District Council perspective

10.1 The Board received the report and presentation (attached) which had been prepared with the aim of developing a shared vision of the role District Councils have in supporting residents across Norfolk to live independently in their own homes, promote independence and prevent ill health.

10.2 During the ensuing discussion the following issues were discussed:

- The importance of District Council work within communities was recognised and it was suggested that there might be an opportunity to explore the role of the District Councils in supporting integration as part of the proposed engagement event around developing the Joint Health & Wellbeing Strategy. District Councils had a key role in developing stronger, more resilient communities through developing affordable homes, supporting businesses, leisure services, adapting homes, etc.

- The initiatives outlined were welcomed and it was highlighted that they linked with the priorities of Adult Social Care that people live their lives as independently as possible with access to services within communities.

- From the perspective of the STP, prevention had originally been a separate workstream but was now a key part of the work of the Prevention, Primary and Community Care workstream and this connectivity was crucial. There were opportunities to build upon the framework in place and a real 'win' for Norfolk people would be for all partners to make sure that prevention opportunities were being recognised and realised.

10.3 **Resolved to:**

- Support the joint working initiatives, recognising the importance of locality working and the role played by District Councils, alongside other partners, in building stronger communities, creating wellbeing, early help and prevention and the potential to integrate services.

- Identify any actions that Board Member organisations could take to support its development.

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The meeting closed at 11.50 after which it continued into a workshop.

Chairman

Norfolk Health and Wellbeing Board

Item 8

Report title:	**Norfolk Integration and Better Care Fund 2017-19: Planning and Approval**
Date of meeting:	**Wednesday 26th April 2017**
Sponsor (H&WB member):	**James Bullion, Executive Director of Adult Social Services**

Reason for the Report

The Health & Wellbeing Board has a duty to promote integration and Board members have agreed that driving integration is one of its three strategic goals in its Joint Health & Wellbeing Strategy. It is the body responsible for developing and implementing the strategic plan for the Norfolk Integration and Better Care Fund (BCF) and is accountable, overall, for the Norfolk BCF

NHS England (NHSE) has now released the Integration BCF Policy Framework document, though further more detailed guidance documents and allocations are awaited.

This report provides an overview of the key points addressed in the BCF Policy framework and outlines the draft content of the formative BCF plan.

Report summary

Norfolk's BCF programme is a key mechanism for the delivery of integration in Norfolk - it provides a vehicle not only for furthering integration between health and social care, but to support the transformation required to address the sustainability of the system set out in 'In Good Health', Norfolk's Sustainability and Transformation Plan (STP)

This reports sets out the key areas for consideration contained within Norfolk's BCF Plan for 2017-19 in addition to summarising national guidance.

Key questions for discussion

a) Does the Board have any comment on the vision, ambition and integration plan contained within the BCF Plan?

b) How can the Board/individual members support and influence development and delivery of the BCF Plan?

c) How can the Board/individual Members support the integration agenda within the context of the BCF/STP?

Action/decisions needed:

The Health & Wellbeing Board is asked to:

a) Note the overview of the key points addressed in the BCF Policy and Framework provided (Section 4)

b) Comment and note the proposed content of the plan (section 5)

1. Background

1.1 Since the Better Care Fund Plan for 2016/17 was approved for Norfolk, substantial work has been invested in delivering the overarching objectives within the Plan.

1.2 The Sustainability and Transformation Plan (STP) has also been developed during 2016/17 and sets out a vision for Health and Social Care for the next five years. The overall direction of travel in the BCF Plan aligns to that of the STP

1.5 At its meeting on 8th February 2017, the HWB was tasked with considering the overall strategic direction of BCF for 2017/19, particularly noting the alignment with the Norfolk and Waveney STP, and the challenges that this may bring as its footprint does not align with that of the BCF Plan.

1.7 Following an ongoing delay, NHS England published the BCF Policy Framework on 31st March 2017, with further detailed planning requirements and allocations to be published. The deadline for submission has yet to be confirmed.

2. BCF in the wider context

2.1 People need health, social care, housing and other public services to work seamlessly together to deliver better quality care. More joined up services help improve the health and care of local populations and may make more efficient use of resources.

2.2 The challenges across health and care continue to have a high profile nationally, as does the need to address system sustainability, drive up quality and promote independence. A clear policy focus on integration of health and social care remains and is described and emphasised in the development of STPs. The programmes and services formulated through the BCF will support the achievement of these ambitions and are a key mechanism for delivering integration.

2.3 The County Council and Norfolk CCGs have well developed collaborative arrangements which maximise resources and impact on the health and social care system. While the local health and care system in Norfolk is facing significant financial challenge integrated structures between CCGs, the County Council and community health providers provide a sound basis through which to deliver the objectives of the BCF. Improvements in performance and outcomes combined with more efficient delivery will continue to be sought through this programme.

3. Overview of BCF 2016/17

3.1 In its second year of operation BCF plans are starting to have a demonstrable impact on the overall health and social care system with a number of both countywide and locality schemes for 2016/17 making significant progress. Local partnerships have been strengthened by the imperative to collaborate on complex issues and more integrated care delivery is benefiting customers/patients.

3.2 Stakeholders at local integrated care boards were key in driving forward progress and these boards were supplemented and bought together in the Norfolk-wide BCF Programme Board.

3.3 Norfolk has achieved the following positive impact on national metrics:

a) We remain above our Delayed Transfers of Care (DTOC) target at all three Norfolk acute hospitals

b) Countywide we are now under target against our Non-Elective Admissions metric, although performance in Great Yarmouth and Waveney is above target

c) Norfolk has remained above target for the effectiveness of re-ablement measure

d) Performance in permanent admissions to residential and nursing care have improved consistently over the last three years. A scrutiny process has been implemented to continue and sustain the improvement against the permanent admissions to residential care

4. Planning for the 2017/19 Integration and BCF

4.1 BCF 2017-19 Policy Framework

4.1.1 The Integration and BCF Policy Framework has now been published and provides guidance to improve and continue to develop the integration journey in Norfolk. As the only mandatory policy to facilitate integration it brings together health and social care funding with a major injection of social care money announced in the Spring Budget 2017.

4.1.2 The Policy Framework for the Fund covers two financial years to align with the NHS operational plan timetables and to give areas the opportunity to plan more strategically. For 2017-19 there are four national conditions, rather than the previous eight:

1. Plans to be jointly agreed
2. NHS contribution to adult social care is maintained in line with inflation
3. Agreement to invest in NHS commissioned out of hospital services, which may include 7 day services and adult social care
4. Managing transfers of care (a new condition to ensure people's care transfers smoothly between services and settings)

Beyond this, areas have flexibility in how the Fund is spent over health, care and housing schemes or services but need to agree how this spending will improve performance in the following four metrics:

1. Delayed transfers of care
2. Non-elective admissions (general and acute)
3. Admissions to residential and care homes
4. Effectiveness of reablement

4.1.3 Partners will need to develop, and the HWB approve:

a) An agreed narrative including details of how national conditions will be addressed
b) Confirmed funding contributions from each partner organisation
c) A spending plan which sets out funding of each of the BCF schemes
d) A plan detailing how health and social care integration will be achieved by 2020
e) Quarterly plan figures to meet the national metrics
f) Engagement with stakeholders in formation of the plan
g) Progress a new nationally produced 'High Impact of Change' Model template

4.1.4 DFG funding has again been included in the Fund so that the provision of adaptations and associated funding can be incorporated in the strategic consideration and planning of

investment. The statutory duty on local housing authorities to provide aids and adaptations under the DFG, to those who qualify, will remain and funding will be transferred accordingly as for the current year however, it will be important to also consider how adaptation delivery systems can help meet wider objectives around integration. There is a real opportunity here to form stronger and more influential partnerships with housing to promote DFGs and other areas where closer joint working and integration could reap benefits for citizens.

5. The vision, ambition and integration plan

5.1 Areas are required to describe their vision and integration plans through the mechanism of BCF and in Norfolk, we are seeking to align our BCF Plan with the vision and guiding principles already established within the Norfolk and Waveney STP.

These principles comprise:

a) Preventing illness and promoting wellbeing
b) Care closer to home
c) Integrated working across physical, social and mental health
d) Sustainable acute sector
e) Cost effective services

5.2 Our ambition is to include services within BCF which support the delivery of the guiding principles.

5.3 **Integration plan**

5.3.1 Integration continues to be a key priority for Norfolk, as it is recognised that integrated health and social care services promote better outcomes for citizens/patients and are likely to more financially sustainable. The BCF provides a vehicle not only for furthering integration between health, districts and social care, but to support transformation and demand management which is required to address the sustainability of the system.

5.3.2 Norfolk is reviewing its integration plan in conjunction with council members and CCGs. The review will consider operational and commissioning arrangements with a view to aligning them to emerging STP themes. Key goals for 2020 are envisaged as follows:

a) Fully integrated health and care teams in each locality
b) Strong support and prevention in every community
c) Effective 24/7 support in a crisis
d) One efficient commissioning team
e) A clear health and care budget for each area
f) A sufficient, capable and flexible workforce
g) One set of data on citizens and population
h) Governance which supports our outcomes

5.3.3 Agreement has been sought on the overarching areas of work that have been identified within the Plan. These areas will contain a number of local schemes and initiatives, and are areas which benefit from both health and social care funding and oversight. These comprise:

a) Locality Integrated Care Programme Infrastructure – building on the operational integration already in place and improving pathways across all parts of health and social care

b) Care Homes – including incorporating key elements of the Vanguard Enhanced Health Care in Care homes (EHCH) framework

c) Housing Adaptations (to include DFGs) – including maximising flexibilities provided in DFG regulations, the Regulatory Reform Order and a new Grant Regulation Letter which the BCF Policy Framework says will be published in April 2017

d) Out of Hospital – including an interim care strategy covering integrated reablement, discharge to assess and homecare

e) Crisis Response – including rapid response and integrated services to support admission avoidance

5.4 **Finance**

5.4.1 The policy framework provides some guidance for 2017-19, however at the time of writing the detailed allocations for the BCF were not available. In 2016-17 NCC agreed two S75s with all Norfolk CCGs to govern overall BCF finance and a three year agreement for the protection of social care. The Section 75 for Protection of Social Care will remain until the end of 2018/19. In 2017/18 and 2018/19 the national conditions include a requirement that the NHS minimum contribution to adult social care is maintained in line with inflation.

5.4.2 CCGs and NCC have yet to detail the schemes, and consequently funding, that will form part of the BCF. This will need to be detailed swiftly following the publication of the planning templates and mandated contributions to the pooled fund.

5.5 **New Grant for Adult Social Care (Improved Better Care Funding)**

5.5.1 The Chancellor's Budget in March 2017 announced £2bn additional non-recurrent funding for social care, of which Norfolk can expect £18m in 2017/18, followed by £11m in 2018/19 and £6m in 2019/20. This additional funding is required to be pooled through the BCF and should be spent on unmet social care need. The conditions also stipulate that the additional funding for adult social services paid directly to local authorities does not replace, and cannot be offset against, the NHS minimum contribution to adult social care.

5.4.3 The new improved BCF grant will be paid directly to local authorities from the Department for Communities and Local Government. The grant will be included in the BCF however can only be used for the purposes of meeting social care needs, reducing pressures on the NHS and ensuring that the local social care provider market is supported.

While the additional funding will need to be pooled within the BCF and principles agreed as part of the overall plan, plans for investment of this element of the fund will need to be agreed by NCC Adult Social Care Committee rather than the Health and Wellbeing Board.

5.4.4 Policy direction for NCC for the additional funding will support management of overall system pressures and will be subject to NCC agreement. In conjunction with partners, funding will be agreed in line with the following priorities:

a) Protection of social care
b) Sustaining the social care framework
c) Investing in social care

5.4.5 Initiatives that are being explored include:

1. Work with provider markets to expand capacity where it is needed, providing 7 day care and exploring new models of care
2. Strengthening social work to assist people at discharge and to help prevent admissions

3. Support discharge from hospital increasing capacity of short term care beds and accommodation based reablement to help people who can't go straight home from hospital to get back home quickly
4. Manage and reduce unmet need for social care including the need for carers support
5. Expand voluntary and community schemes that enhance the prevention offer and help to ensure that people don't require social and hospital care unnecessarily

5.5 **Governance**

5.5.1 In the future it is proposed that the STP Prevention, Primary and Community Care workstream will provide some oversight of Programme delivery for integration, and ensure wider engagement with health and district council colleagues.

5.5.2 The Plan will be taken to the STP Executive Board for information purposes, with the aim of securing a wider understanding and buy-in of health providers.

5.5.3 The HWB Group will continue to provide formal governance and sign off of the BCF plan, with the subgroup providing scrutiny of quarterly data collection forms and other any business, as required.

5.6 **Strategic fit**

5.6.1 Norfolk's BCF Plan will have a strategic fit with Adult Social Service's Promoting Independence Strategy, emphasising prevention, reduction and delay of the need for formalised care and support.

5.6.2 As stated in section 1.4 there is a clear alignment between STP and BCF.

5.6.3 There is a clear link with district councils, particularly their role in delivering DFGs, and a wider recognition of the role DFGs play in reducing admissions to and facilitating discharges from hospital. Work will continue with partners, including Districts, to further develop plans for integration and explore synergies in service delivery.

6. Decision/Action

6.1 The Health & Wellbeing Board is asked to:

a) Note the overview of the key points addressed in the BCF Policy and Guidance framework provided (section 4)

b) Comment and note the proposed content of the plan (section 5)

6.2 Key questions for discussion:

a) Does the Board have any comment on the vision, ambition and integration plan contained within the BCF Plan?
b) How can the Board/individual members support and influence development and delivery of the BCF Plan?
c) How can the Board/individual Members support the integration agenda within the context of the BCF/STP?

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

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IN TRAN communication for all

If you need this Report in large print, audio, Braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Norfolk Health and Wellbeing Board

Item 10

Report title:	**Suicide Prevention in Norfolk**
Date of meeting:	**26 April 2017**
Sponsor(s):	**Dr Jane Sayer, Director of Nursing and Quality, Norfolk and Suffolk NHS Foundation Trust** **Dr Louise Smith, Director of Public Health, Norfolk**

Reason for the Report

Suicide is an important public health issue and a priority for Norfolk given our relatively high local rate. Evidence suggests that preventing suicide is achievable and in 2016, government nationally set out an ambition to reduce suicide by 10% from 2016 to 2021. In response to this, and in line with Public Health England advice, a suicide prevention strategy and action plan for Norfolk has been developed using a multi-agency approach. No one agency is responsible for suicide prevention – it involves collective commitment and responsibility and is therefore a whole system issue. A key partner in the development and implementation of this Norfolk-wide strategy and action plan is the Norfolk and Suffolk NHS Foundation Trust (NSFT), which has recently approved its Suicide Prevention Strategy 2017-2022. The Health and Wellbeing Board has a direct interest in the work carried out by partners to reduce suicide which contributes directly to the Board's strategic theme of prevention and reducing inequalities.

Report summary

This report outlines the work being carried out by partners to reduce the number of suicides in Norfolk. It presents the county-wide Suicide Prevention Strategy and action plan 2016-2021, which has been developed in consultation with a range of agencies and service users, having researched national and local activities. The Strategy is wide ranging but has two key themes – population level wellbeing actions and activities, and targeted actions for people with (emerging or existing) mental health issues.

The report also provides the Suicide Prevention Strategy 2017-2022, recently agreed by the NSFT. This Strategy complements the action plan of the county as a whole and effective joint working has ensured that actions have been aligned. The NSFT Strategy commits the Trust to do all that it can to avoid the loss of life to suicide and has three core goals:

1. Improving quality and achieving financial sustainability
2. Working as one Trust
3. Focussing on prevention, early intervention and promoting Recovery.

Finally, the report includes information on the Norfolk suicide prevention audit 2016 - a comprehensive review of suicides in the last ten years, undertaken by Public Health, in line with national guidance.

Key questions for discussion

Q.1 How are Board members - or the organisations they represent - engaged in tackling suicide prevention in Norfolk?

Q.2 What opportunities are there for partner organisations to be further engaged in delivering the county-wide actions?

Q.3 What are the barriers faced in delivering the priorities and what can HWB members do, as system leaders, to address them?

Action needed:

The Health & Wellbeing Board is asked to:

- Endorse the Norfolk Suicide Prevention Strategy and action plan
- Note the Suicide Prevention Strategy developed and agreed by the Norfolk and Suffolk NHS Foundation Trust
- Consider how HWB partners are participating in the work to reduce the number of suicides in the county and identify what else can be done

1. Background

1.1 There is a national expectation that Public Health departments lead local initiatives on suicide prevention with some strategic support provided regionally by Public Health England. No one agency is responsible for suicide prevention - it involves collective commitment and responsibility. Responding to suicide requires a system-wide approach; local authorities, health services, police, fire and rescue, mental health services and voluntary and community groups all have a role to play in reducing suicide in Norfolk.

1.2 In line with national guidance, the County Council's Public Health team is leading multi-agency working on the regular audit of suicides, the development of the strategy, and the implementation of the action plan. The Norfolk suicide prevention strategy and action plan was approved by the County Council's Communities Committee in January 2017. (The strategy and action plan are attached as **Appendix 1**)

1.3 A suicides audit was published in December 2016, and the strategy and action plan are due for publication in the spring of 2017. Suicide prevention activities are designed to support vulnerable people, and our local plan with targeted approaches to reduce health inequalities for men will have a positive impact on gender equality. Reducing stigma around mental health will evidently have a positive impact on disability equality.

1.4 The Norfolk and Suffolk Foundation Trust is a key partner in the development and implementation of this county-wide Strategy. The NSFT's own Suicide Prevention Strategy was approved by the Trust Board in March 2017.

2. The national context

2.1 In 2012, a cross party **National Suicide Prevention Strategy** was issued calling for further action to tackle suicide prevention, including the inequalities involved. Suicides are more likely to occur in areas of low social and economic prosperity, in under-served communities and amongst those experiencing a range of challenges to their health, employment, finances, social and personal lives. The national Strategy has been updated several times, most recently via the **3rd Annual Report** in January 2017.

2.2 The 3rd Annual Report updated the 2012 strategy to meet the recommendations of the Five Year Forward View for Mental Health as relevant to suicide prevention: to reduce the number of suicides by 10% by the year ending March 2021 and for every local area to have a multi-agency suicide prevention plan in place by the end of 2017. It updated the original strategy in 5 main areas:

- expanding the strategy to include self-harm prevention in its own right
- every local area to produce a multi-agency suicide prevention plan
- improving suicide bereavement support in order to develop support services
- better targeting of suicide prevention and help seeking in high risk groups
- improve data at both the national and local levels

2.3 A recent **Health Select Committee (HSC) inquiry** into suicide prevention has also made a number of initial recommendations for improving the National Strategy in its report of 16 Match 2017. Based on the evidence of their inquiry, the HSC report states that the clear message heard throughout their inquiry is that suicide is preventable, that the current rate of suicide is unacceptable and that it is likely to under-represent the true scale of this avoidable loss of life.

2.4 The findings include that the government's underlying strategy is essentially sound but that the key problem lies with inadequate implementation, and the need for a clear, effective quality assurance process and implementation at both national level and local level. Provision of funding for implementing suicide prevention is also cited as an issue and the report calls for government to set out how it will make sure that funding is available for the actions outlined in the strategy.

2.5 The findings include recognition of the need to reach people who are at risk of suicide but not in contact with any health services, and particularly welcomes the role of the voluntary sector and the importance of those working in non-clinical settings. It states that a "joined-up approach is essential and local authorities' suicide prevention plans should include a strategy for reaching those who are unlikely to access traditional services, particularly men." It also recognises the importance of ongoing work to tackle stigma and build public confidence to discuss mental health.

2.6 Other recommendations are around data issues which can hamper suicide prevention and the difficulty of reliably assessing which public health initiatives are the most effective without consistency in the recording of suicide. Better guidance for coroners is considered essential to reduce the number of 'hard-to-code' narrative conclusions and calls for rapid communication between all agencies so that local public health teams are aware of possible clusters or new methods so that early preventative action can be taken.

2.7 The **full recommendations of the HSC inquiry** can be found at this link.

3. Suicide Prevention in Norfolk

3.1 Norfolk has an average of 12.4 suicides per 100,000 people, which is higher than the national average of 10.1, equating to around 77 suicides in Norfolk each year. In 2016, a comprehensive review of suicides in the last ten years was undertaken and it identified the groups most at risk and the factors which may influence. It identified that 76% of suicides in 2015 were male, with a significant proportion being aged 45-59. It also found that 30% lived in the most deprived areas. (The audit is available at the following link: Suicide in Norfolk).

3.2 This audit has enabled us to target activities such as engaging better with men and farming communities. The intention is to encourage all professionals to take a strengths based approach to safety planning, and reducing access to the means of suicide. These methodologies are based on current preventative practice promoted nationally, and in keeping with safeguarding principles in Norfolk. Targeted approaches to reduce health inequalities for men will have a positive impact on gender equality and reducing stigma around mental health will evidently have a positive impact on disability equality.

3.3 When people decide to take their own lives, there are complex variables which influence their actions. In attempting to reduce stigma, making tools more accessible and promoting a consistent approach across and within organisations, we intend for resources to be available for professionals and members of the public.

The strategy and action plan

3.4 The Norfolk Suicide Prevention Strategy and action plan includes preventative actions designed to help at an earlier stage such as:

- Enhancing the skills of non-medical or mental health professionals
- Rolling out training and raising awareness
- Developing a web resource and guidance
- Sharing learning and resources through a multi-agency conference
- Working to develop community activities with men's and farmers network (including peer mentor support)
- Ensuring crisis pathways are robust and working with Norfolk and Suffolk foundation trust to support the delivery of their strategy on suicide prevention

3.5 A key partner in the development and implementation of this strategy and action plan is the Norfolk and Suffolk NHS Foundation Trust (NSFT), which as a provider of mental health services plays a critical role within the community. Other agencies such as Norfolk Constabulary, British Transport police, and the Office of Police and Crime Commissioner have actions they will be leading on specific to their functions or responsibility.

3.6 The Norfolk Safeguarding Adults Board has also identified suicide prevention as a priority, and will work closely with the local multi-agency suicide prevention group to promote learning and workforce development across agencies in Norfolk. The Coroner's office is a leading voice for suicide prevention in Norfolk, encouraging multi-agency learning to better support communities. It is, however, recognised that measuring the impact of our actions and assessing whether they contribute to reducing the number of suicides in the county will be difficult.

NSFT strategy and action plan

3.7 In February 2017, the NSFT Board of Governors approved a Suicide Prevention Strategy 2017-2022 (**Appendix 2**). The NSFT strategy and action plan complements the action plan of the county as a whole, and effective joint working has ensured aligned actions for the Trust in order to maintain consistency for the organisation and its actions across the area. The overall focus for agencies working with people in crisis will be on appropriate pathways, ways in which to intervene earlier, safety planning and supporting families and carers.

3.8 NSFT's strategy commits the Trust to do all that it can to avoid the loss of life to suicide, acknowledging its complexity and the need to work with partners in the community. The strategy has three core goals:

1. Improving quality and achieving financial sustainability
2. Working as one Trust
3. Focussing on prevention, early intervention and promoting Recovery

3.9 Through its strategy, the Trust commits to ensuring that it delivers the fundamentals of safe care consistently, applying the evidence for suicide prevention across all care pathways. These fundamentals include: training; providing safe environments; providing services that meet the needs of people in the community; following up on people discharged from in-patient care within seven days; providing medication in safe amounts; and learning from events.

3.10 There will be a focus on a defined number of priorities with actions which are reviewed on a yearly basis. These priorities have been formed through talking with service users, carers, staff and other partner organisations and groups, by information from national and local sources about new approaches to working, and through the Trust's own information and learning from deaths by suicide of people in their care about what needs to improve. The key priorities are:

- Clinical Pathways
- Working with family and carers
- Supporting staff with the most up to date skills and knowledge
- Innovations
- Working with partners to deliver countywide actions

3.11 The strategy recognises that actions to prevent suicide require partnership and collaboration and the Trust is working with both Norfolk and Suffolk multi-agency suicide prevention groups and commits to playing a key role in supporting countrywide actions.

Norfolk wide governance

3.12 A local, multi-agency, Norfolk Suicide Prevention Implementation Group has been established to lead the implementation of the county-wide strategy in order to meet the government ambition to reduce the number of deaths from suicide by 10% by 2021. Led by Public Health, the Group includes representation from the Clinical Commissioning Groups, voluntary sector, NSFT, Coroner, Criminal Justice Board, Fire Service, Norfolk and Suffolk Constabulary, Office of the Police and Crime Commissioner, and the County Council's Children's services. There will also be a wider network of stakeholders the group may wish to engage with either through membership of task and finish groups or by invitation as appropriate, and including service users.

3.13 The Group reports to the Mental Health Strategic Board which oversees the existing Mental Health Crisis Care Concordat, bringing those with key actions and responsibilities together to implement the action plan. The Strategic Board will provide annual updates on progress to the Norfolk Health and Wellbeing Board which has agreed mental health as a key ongoing priority.

3.14 In addition, there is a commitment to working with Suffolk County Council to share targets, resources and ideas, an alignment which will benefit the local mental health trust in ensuring consistency as it works across the two areas. We also recognise

that the voluntary and community sector has an important role to play, especially in preventative work and engaging with specific groups.

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2016

Norfolk Suicide Prevention Strategy 2016-2021

Norfolk Suicide Prevention 2016-21

Norfolk County Council is committed to working with partners to reduce the number of suicides in the county. The local multi-agency Suicide Prevention Group is tasked with implementing and monitoring the suicide prevention action plan. Norfolk County Council's Public Health department has undertaken an audit of suicides in Norfolk which provides an understanding of the evidence base including the people it affects and the agencies that could help.

Local knowledge

In Norfolk there are on average 77 suicides per year (2016) which is higher than the national average. The most recent statistics (over the last ten years up to 2016) identify that 76 percent were male, and a significant proportion of them were aged 45-59. We know that 30 percent lived in the most deprived areas, and 35% were economically inactive. This builds a picture which implies a loss of hope and purpose mainly affecting men in poverty or near it. For further information on local statistics, please refer to the Norfolk Suicide Prevention Audit (2016) published on the Norfolk Insight website.

The government's Preventing Suicide in England (2012) strategy states that it is often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity.

Suicide is not inevitable, and preventing it is everyone's responsibility

Target

The government Mental Health Five Year Forward View (2016) has set the ambition to reduce the number of deaths from suicide by 10% from 2016-2021. Our suicide prevention group has adopted this target with a view to reducing the suicide rate further in later years, to as close to zero as possible.

Who we think it affects the most

The national strategy identifies the following groups as priorities for prevention:

- young and middle-aged men
- people in the care of mental health services, including in-patients
- people with a history of self-harm
- people in contact with the criminal justice system
- specific occupational groups e.g. doctors, nurses, veterinary workers, farmers and agricultural workers

The Norfolk picture reflects the national one with an additional potential focus on people with substance misuse issues. As a rural county, there is a particular interest in ensuring that individuals experiencing isolation and stress are identified and supported effectively, such as farmers for example. Norfolk has an older population which is growing, and older people with complex physical health issues are identified in the suicide audit as an area of focus for improving quality of life and pain management. There is also a work stream which has identified activities on reducing suicides of children and young people, further details are outlined in Child Suicide Audit (2016) and the suicide prevention action plan attached to this document.

Working together

The Suicide Prevention Implementation Group reports to the Mental Health Strategic Board which oversees the Mental Health Crisis Care Concordat, bringing those with key actions

and responsibilities together to implement the action plan. The strategic board will provide annual updates on progress to the Norfolk Health and Well-Being Board which has agreed mental health as a key ongoing priority. There is a commitment to working with Suffolk County Council to share targets, resources and ideas, an alignment which will benefit the local mental health trust in ensuring consistency as it works across the two areas. We also recognise that the voluntary and community sector has an important role to play, especially in preventative work and engaging with specific groups.

Norfolk county council has launched a campaign to address loneliness 'In good company', and we will ensure that the suicide prevention campaign will complement that and other existing messages on reducing social isolation. The Norfolk Safeguarding Adults Board has also identified suicide prevention as a priority, and will work closely with the suicide prevention group to promote learning and workforce development across agencies in Norfolk. The Coroner's office is a leading voice for suicide prevention in Norfolk, encouraging multi-agency learning to better support communities.

We have set out the Norfolk suicide prevention action plan to reflect government priorities to:

- Reduce the risk of suicide in key high-risk groups
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support research, data collection and monitoring
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour.

What we are going to do

We intend to develop educational guidance to promote strengths based interventions such as safety planning rather than risk assessing, and preventative activities for professionals to support them to identify and encourage individuals contemplating suicide to make a different decision.

We will develop a multi-agency training framework which sets out the levels of awareness and knowledge expected across professions, what the training should include, and how it could be delivered – setting the quality standard for Norfolk. This will be enhanced by the knowledge of experts by experience.

We plan to raise awareness of suicide and campaign to reduce stigma so that people are confident in coming forward to find the right support. This could range from self-help well-being tools, finding meaningful employment, or participating in an activity which reduces social isolation. Campaigns will include messages tailored to carers, friends and family who might otherwise consider themselves powerless to effect change.

We also have commitments from agencies to undertake activities which improve services as well as ideas for innovation and support for community and voluntary sector agencies.

We are going to

	Milestone	When by
✓	Deliver a campaign to raise awareness and reduce stigma across the county	September 2017
✓	Publish guidance which emphasises safety planning and making the environment safe and distribute it online	September 2017

✓	Make a website resource available listing local and national support for people in crisis – putting it all in one easily accessible place	June 2017
✓	Make sure that training on suicide prevention is available for professionals in the county	June 2017
✓	Deliver a carers pack for families and carers supporting loved ones	tbc
✓	Hold a multiagency conference to disseminate learning and resources as near to world suicide prevention day (10 September) as possible	September 2017

How will we know we have made a difference?

	Indicator	When by
✓	Feedback from training which will include a follow up 3 months later	January 2018
✓	An increase in the number of hits on the website	January 2018
✓	People use safety planning and share their learning experiences	January 2018
✓	Public Health Outcomes Framework Indicators such as number of suicides per 100,000 begin a downward trend	September 2018
✓	The number of unexpected deaths reported by the local mental health trust goes down	September 2017

Further details of planned activities are outlined in the suicide prevention action plan below.

	NORFOLK SUICIDE PREVENTION ACTION PLAN 2016-2021

	Recommended action	Lead organisation	when by
1	**Reduce the risk of suicide in key high-risk groups**		
1.1	Develop a training framework and identify key professional groups that should receive it and at what level. Should include how to spot the signs, safety plan and refer on to suitable pathways.	NSFTand partners with input from Adult Learning and Improvement Policy sub group (reports to the Adult Safeguarding board)	2016
1.2	Produce comprehensive and concise guidance on how to ask, how to safety plan and what next for all front line staff including healthcare workers, Jobcentre Plus staff, drug and alcohol services etc. (online)	Norfolk and Suffolk Foundation Trust (NSFT)/Norfolk Clinical Commissioning Groups (CCGs)/ Norfolk Public Health/Suffolk Public Health	2017
1.3	Implement the College of Policing Approved Professional Practice for 'Suicide and Bereavement Response' (currently out for consultation) and National Police Chiefs Council guidance 'Suicide Prevention Risk Management Perpetrators of Child Sexual Exploitation and Indecent Images of Children (IIOC)'	Norfolk Constabulary	

	Recommended action	Lead organisation	when by
1.4	Review guidance and pathways for people with complex needs such as substance misuse and mental health problems.	Norfolk Public Health/CCGs/ Norfolk Recovery Partnership(NRP)/NSFT	2017
1.5	Review current provision of well-being services for men. Consider jointly commissioning and encouraging male specific interventions and support (third sector groups reducing social isolation such as MENSHEDS and VETERANS CENTRE)	Norfolk Public Health/NSFT	2017
1.6	Offenders: Review the possibility of release planning sooner (in some cases this may be at point of entry into custody), for those who are subject to ACCT within the prison community.	OPCC coordinate - Prisons/Probation	

	Recommended action	Lead organisation	when by
1.7	Offenders: More emphasis to be placed on suicide prevention when going through the gate i.e. greater liaison with community mental health teams, more established release planning (accommodation, employment, signposting and appointments to support agencies such as including Samaritans, drug and alcohol agencies, family support, finance and debt advice);	OPCC coordinate - Prisons/Probation	
1.8	Audit compliance with relevant best practice guidelines to ensure good pathways and support on discharge from psychiatric inpatient care to decrease patients' risk of suicide.	NSFT	2016
1.9	Promote good mental health among target group (men in high risk occupational groups) Engage with NFU/Farming community network/You are not alone (YANA) - rural norfolk farming support Oil and gas industries unions/employers Football club Adnams	MIND - and Norfolk Public Health	2018
1.10	Review guidance for hospitals including discharge policies for people who have self-harmed or attempted suicide (specifically the need to contact family or friends to collect them). Consider a follow up plan where appropriate.	Acute Trusts/NSFT	2017
1.11	Psychiatric liaison	Acute Trusts/NSFT	2018
1.12	Children and young people's action plan	Norfolk Safeguarding Children's Board partners	
	6.1 Raising resilience in children and young people		
	6.2 Providing for the long term needs of children and young people who have experienced bereavement		

	Recommended action	Lead organisation	when by
	6.3 Guidance for staff		
	6.4 Training for Tier 1 Staff to support children with Self-Harm/suicide ideation		
	6.5 Mental health awareness for children and young people		
	6.6 Better information sharing and gathering information about 'near misses'		
2	**Tailor approaches to improve mental health in specific groups**		
2.1	BAME – Men from Eastern European backgrounds are disproportionately more affected. Guidance and Campaigns around self -management or accessing support earlier should be accessible for diverse communities.	County Community Cohesion network	2017
2.2	Raise the visibility of current national/local suicide prevention self-help tools through development of a web resource based in the Wellbeing service website	Suffolk Public Health/Norfolk Public Health/ Samaritans/NSFT Wellbeing service	2017
2.3	Social marketing suicide prevention campaign - focus on men's mental health and delivering key messages to men in midlife experiencing disadvantage	Suffolk Public Health/ Norfolk Public Health	2017
2.4	Embed suicide prevention in workplace health initiatives - ensure employers understand their responsibility for the well-being of employees	Norfolk Public Health	2018

	Recommended action	Lead organisation	when by
2.5	Implement Public Health England guidance and masterclasses on suicide prevention	Norfolk Public Health	2017
3	**Reduce access to the means of suicide**		
3.3	Approach railway services or British transport police for guidance on training received by their staff and how to maximise impact of campaigns, particularly in rural areas.	BTP	2017
3.4	It should be a routine part of all safety planning to ask about access to guns including ownership.	Norfolk Constabulary / CCGs - GPs	2017
3.5	Car Parks and Malls – Advise on reducing access to methods.	districts - designing in safety features in new structures.	2017
3.6	Provide education materials for GPs and mental health clinicians to use the safest prescribing options for people at risk of self-poisoning	CCG CSU prescribing advisors/NSFT	
3.7	Inpatient mental health, and prison services to regularly review and monitor access to means when individuals are in their care.	NSFT/Prisons	2018
4	**Provide better information and support to those bereaved or affected by suicide**		
4.1	Improve awareness of resources and support for families of people who die by suicide	NSFT/Norfolk Public Health	2018
4.2	Engage with SOBs and Samaritans on support services available for families	Suicide Prevention Group	2018

	Recommended action	Lead organisation	when by
4.3	Design a support care pack for families	NSFT	2017
5	**Support research, data collection and monitoring**		
5.1	Improve information sharing and referral pathways between organisations in contact with vulnerable people. In particular, GP and mental health services.	CCGs and NSFT	
5.2	Improve information sharing pathways between different teams within organisations in contact with vulnerable people.	Public Protection Forum	
5.3	Particular consideration should be given to how assessments and safety plans are recorded and to ensuring that the future commissioning of IT systems supports the sharing of information	Public Protection Forum	
5.4	Investigate if there is a link between suicide and being a member of the armed forces, and if this link is stronger for offenders.	Armed forces covenant	
5.5	Conduct further research into female released prisoners and suicide. As the sample size of female released prisoners is so much smaller than males a much larger geographic area should be studied. This could form part of a national piece of research using similar methods and investigating other prisoner characteristics, such as sentence length.		
5.6	Partner agencies commit to seeking opportunities for research and evaluation of impact	all partners	

	Recommended action	Lead organisation	when by
5.7	For suicide data collection of offenders to be standardised so that when the police notify the Coroners' office of a death they are also notifying them whether or not that person was an offender, if this is known. The Norfolk Constabulary should already be notifying the Prison and Probation Ombudsman if the individual who had taken their own life had been released from prison within 28 days.	Norfolk Constabulary /Coroner's Office	
5.8	Produce an annual briefing on the suicide audit, and undertake a refreshed review after three years.	Norfolk Public Health	2017 2019
6	**Support the media in delivering sensitive approaches to suicide and suicidal behaviour**		
6.1	Contact local media to disseminate use of and awareness of the Samaritans guidance on responsible report, this includes using supportive language and working together to reducing stigma.	Work in partnership with Samaritans/Healthwatch? – Norfolk Constabulary or Norfolk Public Health	
6.2	Develop a campaign for world suicide prevention day 10 September 2017	Norfolk Public Health	2017
6.3	Organise a conference in September 2017 to review progress and raise awareness	Norfolk Public Health/Chris Copsey	2017

Norfolk Health and Wellbeing Board

Item 11 a)

Report title:	**Norfolk Tobacco Control Strategy and Action Plan**
Date of meeting:	**26 April 2017**
Sponsor:	**Dr Louise Smith, Director of Public Health, Norfolk**

Reason for the Report

Smoking is the single greatest cause of premature death and disease in our communities. Reducing smoking in our communities significantly increases household incomes and benefits the local economy. Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities. The Health and Wellbeing Board (HWB) has a direct interest in the work carried out by partners to address the harm caused by smoking and in addressing those health inequalities.

Report summary

This report is about the work of the Norfolk Tobacco Control Alliance, which brings together partners across Norfolk to address the causes of tobacco use, raise the profile of the harm caused by smoking to our communities, reduce smoking prevalence, monitor progress and publish the results. It outlines the key elements of the Tobacco Control Alliance Strategy, including the vision and the 3 priorities, and the action plan developed to deliver progress against the priorities.

Key questions for discussion

Q.1 To what extent are Board members, for example the CCGs, involved in the work of the Alliance and engaged in promoting and pursuing its strategic priorities?

Q.2 What opportunities are there for partner organisations to be further engaged in the delivering the action plan and to help drive improvement? (For example, by taking an active role in the 'Saving Babies Lives' Action group or E- cigarette Action Group).

Q.3 What are the barriers faced in addressing the priorities and what can HWB members do to help?

Action needed:

- The HWB is asked to endorse the Norfolk Tobacco Control Strategy and action plan
- Board members are asked to commit to promoting the strategic priorities within their organisations and to identifying what actions their organisations can take to help drive improvement in the wider community.

1. Background

1.1 The Tobacco Control Alliance leads work to reduce smoking in Norfolk and in 2016 the Alliance developed Norfolk's Tobacco Control Strategy & Action Plan. The strategy sets out a **vision to 'make smoking history for the people of Norfolk'** by preventing young people from starting smoking, helping people quit and protecting people from second hand smoke and illicit tobacco. A review of the strategy has been undertaken, including advice from national experts, and an action plan that addresses the gaps identified has been drawn up.

1.2 Tobacco Control and Stop Smoking services are core public health services addressing one of the most preventable causes of early death, ill health and health inequalities. The Norfolk Tobacco Control Strategy and action plan was approved by the County Council's Communities Committee in September 2016. It includes goals specific to children and young people as well as actions that are intended to reduce the number of children who start smoking and reduce the impact on children from adults smoking. In the circumstances, in January 2017, the County Council's Children's Services Committee endorsed the recommendations of the Alliance, particularly in relation to children and young people.

1.3 The Health and Wellbeing Board (HWB) has a direct interest in the work carried out by partners to address the harm caused by smoking and in addressing the health inequalities. The Norfolk Tobacco Control Strategy and action plan contribute directly to the Board's strategic themes of Reducing Inequalities and Prevention.

2. The evidence and the position in Norfolk

2.4 Smoking is the single greatest cause of premature death and disease in our communities. Reducing smoking in our communities significantly increases household incomes and benefits the local economy. Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities.

2.5 National legislation supports the work to drive down prevalence of smoking starting with the smoking ban (2007), point of sale display in shops (2012), smoke free cars (2015) through to standardised packaging legislation introduced in May 2016. The 2007 Smoke-free legislation in England was associated with 1,200 fewer emergency admissions to hospital for heart attacks (a reduction of 2.4%) in the 12 months following implementation.

2.6 Supported by legislation, increased public knowledge, and more recently stop smoking services, smoking prevalence in England has halved over the last 35 years. Now fewer than 1 in 5 adults smoke. However, smoking is still a cause of excess deaths.

2.7 About 1 in 6 people in Norfolk smoke, and in the most deprived areas this rises to 1 in 3. About 1 in 10 children aged 15 years also smoke. Smoking rates are highest in deprived areas, and people working in routine and manual occupations. Data on the prevalence and impact of smoking in Norfolk are shown in **Appendix 3.**

2.8 The Tobacco Control Alliance leads work to reduce smoking in Norfolk and in 2016 the Alliance developed Norfolk's Tobacco Control Strategy & Action Plan. The strategy sets out a vision to 'make smoking history for the people of Norfolk' by preventing young people from starting smoking, helping people quit and protecting

people from second hand smoke and illicit tobacco. A review of the strategy has been undertaken, including advice from national experts, and an action plan that addresses the gaps identified has been drawn up. The Strategy is at **Appendix 1** and the Action Plan is at **Appendix 2.**

2.9 Through the Tobacco Control Alliance, partners have the opportunity to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence. Norfolk's Tobacco Control Strategy has **3 strategic priorities** to:

- 'Turn off the tap' of young people who become smokers
- Assist every smoker to quit smoking
- Protect families and communities, especially children, from tobacco related harm.

2.10 The **key proposals** in the action plan are to:

- Provide strong leadership for tobacco control
- Target stop smoking services towards target groups through providing good quality stop smoking services
- Continue to work with trading standards to tackle illicit tobacco and under age sales, and
- Promote smoke free messages through a comprehensive communications plan

2.11 Norfolk County Council's Public Health team commissions Specialist Stop Smoking services for the county. In 2014/15 the services helped about 6,400 smokers set a quit date and confirmed that 3,400 had stopped smoking. Recent years have seen significant reduction in smoking prevalence however there remains work to do. Stop smoking services face increasing challenges, with falling footfall and more hardened smokers. It is becoming harder to deliver smoking quits in the numbers achieved historically. Thus the strategy and action plan propose a number of changes in strategy to target key groups.

2.12 To inform our future strategy we have reviewed our services, with national experts against a nationally recognised framework approved by Public Health England - the CLeaR tool. The action plan addresses areas identified and a review of progress will be undertaken in 12 months.

(All prevalence data from Tobacco Control Profiles, Public Health England)

3. Action

- The HWB is asked to endorse the Norfolk Tobacco Control Strategy and action plan
- Board members are asked to commit to promoting the strategic priorities through the work of their organisations and to identifying what actions partner organisations can take to help drive improvement in the wider community.

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Norfolk Tobacco Control Strategy 2016 -2020

By: Norfolk Tobacco Control Alliance.

Revised summer 2016.
The action plan remains to be a live document and is reviewed annually by the Norfolk Tobacco Control Alliance.

Foreword

Smoking remains the biggest cause of preventable deaths in Norfolk and increases health inequalities between socio-economic groups. Consequently, the Tobacco Control Alliance has set itself the strategic vision "to make smoking history for the people of Norfolk".

The Alliance's Tobacco Control Strategy recognises that in Norfolk smoking prevalence has reduced from 20% in 2010, to 18% in 2013. Yet despite this welcome reduction, smoking continues to have a detrimental effect on health and economic well-being in the County. The Strategy therefore contains three goals:

- To 'Turn off the tap' of young people who become smokers
- To assist every smoker to quit smoking
- To protect families and communities, especially children, from tobacco related harm

The various organisations which make up the Tobacco Control Alliance allow it to pursue these agreed Strategic goals through multi-agency efforts that encompass prevention, education, cessation and recovery. By establishing common strategic priorities among the many members of the Alliance, the Strategy should enable increased and more effective Tobacco Control partnerships across Norfolk, and it will be updated in the light of best practice. It is hoped, therefore, that the rejuvenated Tobacco Control Alliance will make real progress toward making 'smoking history for the people of Norfolk.

PAUL SMYTH
Chair of the Norfolk Tobacco Alliance and
Chair of the Communities Committee, Norfolk County Council

Foreword

Over the past 35 years, smoking prevalence in England has halved. Now fewer than 1 in 5 adults smoke. However, smoking is still a cause of excess deaths. Evidence has shown that strategies designed to tackle tobacco need to be comprehensive and can only be delivered by multiple partners. The Tobacco Control Alliance has therefore come together as a partnership with a drive and strategic vision "to make smoking history for the people of Norfolk".

I am pleased that the new Tobacco Control Strategy focuses on the key influences and help to direct the work at locality level by 'turning off the tap' of young people who become smokers, assisting every smoker to quit smoking and protecting families and communities, especially children, from tobacco related harm.

Within Norfolk, I have prioritised Public Health action to deliver the strategy and I encourage all partners to do so too. By making every contact count and signposting smokers to quit through brief interventions, we can make Norfolk a better place for our future generations and support us in achieving our vision to make smoking history in Norfolk.

DR LOUISE SMITH
Director of Public Health
Norfolk County Council

Introduction

Smoking Tobacco has been identified as one of the biggest contributors to inequalities in life expectancy and causes of death and disability within Norfolk. Smoking prevalence has shown to be affected by a number of demographic factors. For example:

- Age
- Deprivation
- Gender
- Mental Health problems
- Pregnancy
- Prisoners
- Socio-economic status

The smoking prevalence in England and Norfolk has been decreasing during the most recent 4 year period. However the health inequality gap remains.

This strategy provides a clear pathway to improve the inequalities gap in Norfolk. It details an overarching 10 year vision and clarifies the first steps required to progress the Tobacco Control agenda in Norfolk. The strategy specifies recommendations which have been informed by the Health Needs Assessment, and including public opinion via the Your Voice questionnaire as well as regional, national and international trends in tobacco control.

The 3 priority areas have been developed through the work of the Tobacco Control Alliance, are informed by the Health Needs Assessment and are aim to have a greater influence on health inequalities and tackle Tobacco Control issues faced within Norfolk. The purpose of this strategy is to ensure that the Alliance members have a structure to follow and activities are monitored whilst being completed within a multi-agency approach

Our Vision

“To make smoking history for the people of Norfolk.”

The main reasons for setting our ambitious vision are highlighted below:

- Smoking is the highest cause of preventable death in England in comparison to other leading causes of preventable death e.g. alcohol, accidents, non-communicable diseases and drug misuse.
- Smoking has been identified as one of the biggest contributors to inequalities in life expectancy and causes of death within Norfolk.
- Smoking in pregnancy has shown to be more prevalent in women who have never worked or are routine and manual workers, a prominent issue in Norfolk.
- Long-term or persistent smokers bear the heaviest burden of morbidity and mortality related to their smoking habit. Persistent smokers are disproportionately drawn from lower socio-economic groups.
- Evidence has shown that most adult smokers start smoking at a young age, around 66% start before they are 18. It is a common misconception by young people that they can experiment with cigarettes without getting addicted but they often shows signs of addiction after 4 weeks of smoking.
- In a year it is estimated that 2,861 children will start smoking in Norfolk, this means that each day 8 children will begin smoking that is 56 children start smoking every week. This is equal to having two classroom full of children becoming smokers every week- a clear call to action.
- Illicit tobacco is easily accessible to young people as it is made cheap and available through unofficial & unregulated outlets. This is a health protection concern.

- Reducing exposure to second hand smoke including exposure to young children travelling in cars is a public health priority

Tobacco Control

Tobacco Control is an evidence-based approach to tackling the demand for tobacco use and harm caused by the use. Tobacco control is made up of the following sections:

- Enforce the minimum price of tobacco
- Ensure non-price measures such as advertising restrictions, smoke free laws and health warnings are in place
- Provide information and advocacy
- Provide effective stop smoking programmes
- Restrict underage sales
- Control the illicit trade.
- Reduce health inequalities

To ensure effective tobacco control, it is important to take a multi-faceted and comprehensive approach which includes working with local and national colleagues. Effective tobacco control is more than providing stop smoking services or enforcing smoke free legislation but assists to eliminate the health and economic burden of tobacco use.
To drive tobacco control forwards in Norfolk, the Alliance was rejuvenated to ensure all required organisations were involved to galvanise the actions decided.

The harms of Tobacco Use

Tobacco is the only legal drug that kills many of its users when used as exactly as intended by manufacturers and is a global health threat. Smoking is the primary cause of preventable illness, premature death and is strongly associated with socio-economic disadvantage. Smokers in disadvantaged groups typically start at a younger age, smoke more cigarettes per day and take in more nicotine – this highlights that smoking exacerbates health inequalities between communities.
Smoking has shown not only affect the smoker but those around them in the form of second-hand smoke. Second-hand smoke can cause respiratory complications such as Asthma, wheezing and lung cancer.

Cost of smoking to Norfolk

In Norfolk, it estimated that smoking costs the society £203.9 million each year, the majority of that results from the estimated output lost from smoking breaks at £74.2 million. It is not only the cost to the NHS, businesses and wider economy but financial impacts upon individuals especially those from a deprived area. Based on the cost of an average packet of cigarettes (around £8), a person who smokes 20 a day could spend up to £2,920 a year. This cost of cigarettes disproportionally affects the lower-income groups as on average they smoke more frequently and have less disposable income to spend on perceived luxury products. This highlights an opening in health inequalities between social-economic groups that still exists.

Prevalence of smokers in Norfolk

Smoking has been identified as one of the biggest contributors to inequalities in life expectancy and causes of death within Norfolk. The integrated household survey demonstrated that the general population of over 18's national has a smoking prevalence of 16.7%. The smoking prevalence in the routine and manual socio-economic status is considerable higher than the general population at 25.3%.
Looking at the neighbouring regions within East of England, Norfolk at 14.1% the worst for smoking status at time of delivery. It is to be noted that the data collected is not particularly accurate or consistent as the questions asked (if at all) are often not asked

at the time of delivery but most often at the first antenatal visit. This is perhaps before any pregnancy influenced behaviour change has taken place and, as it is self-reported, women may fear judgement so their responses may not be reliable. This highlights that further work needs to be explored to achieve the national SATOD target (11%) which could be achieved through the Tobacco Control Alliance, although it is a responsibility for NHS England.

Norfolk Tobacco Control Strategy

In September 2013 it was agreed that a Health Needs Assessment on Tobacco Control was required. The needs assessment included;

- An understanding of the prevalence of smoking and its affect within different population and community groups
- Review of national and researched best practice
- Service mapping of current practice in Norfolk
- Stakeholder feedback through a Tobacco Control Conference/ workshop held in June 2014 and researching public opinion using Your Voice survey. This questionnaire highlighted triggers why young people initiated smoking and people's perception of the stop smoking service.

For the purpose of validating the findings of the HNA and translating the needs assessment into a strategy, a Tobacco Control conference was held in June 2014. The aim of the conference was to recruit members from appropriate organisations such stop smoking services and develop priorities for the strategy going forwards.

The Tobacco Control Strategy Priorities

The priorities as set out in the UK Tobacco Control Alliance a toolkit for London were adapted to the Norfolk Tobacco Control priorities following discussion at the conference. These priorities are:

- Turning off the tap for young people recruited as smokers
- Assisting every smoker to successfully quit
- Protecting families and communities from tobacco related harm, especially children

A leadership and communications section ensures that the 3 strategic priorities act as one seamless set of activities and that partnerships share information with all relevant colleagues. The Tobacco Control Alliance will act as the driver for the overall strategy and will be responsible for monitoring the progress of the 3 priorities.

Strategic Priority 1: Turning off the tap for young people recruited as smokers

The HNA highlighted the following:

- Evidence has shown that most adult smokers start smoking at a young age with around 66% of smokers starting before they are 18. It is a common misconception by young people that they can experiment with cigarettes without getting addicted but they often shows signs of addiction after 4 weeks of smoking.
- In a year it is estimated that 2,861 children will start smoking in Norfolk, this means that each day 8 children will begin smoking, 56 every week. This is equal to having two classroom full of children becoming smokers every week- a clear call to action.
- Illicit tobacco being cheap and available is easily accessible to young people and is a health protection concern

For the above stated reasons, preventing young people from becoming smokers is seen as a high priority.

Strategic Priority 2: Assisting every smoker to successfully quit

The HNA highlighted the following:

- Smoking is the highest cause of preventable death in England in comparison to other leading causes of preventable death e.g. alcohol, accidents, non-communicable diseases and drug misuse.
- Smoking has been identified as one of the biggest contributors to inequalities in life expectancy and causes of death within Norfolk.
- Smoking in pregnancy has shown to be more prevalent in women who have never worked or are routine and manual workers, a prominent issue in Norfolk.

In addition, the evidence tells us that two out of every three smokers wishes to quit and that smokers are much more likely to have a successful quit attempt if supported by a smoking cessation service. For the above stated reasons, assisting every smoker to successfully quit is seen as a high priority.

Strategic Priority 3: Protecting families and communities from tobacco related harm, especially children

The HNA highlighted the following:

- Long-term or persistent smokers bear the heaviest burden of morbidity and mortality related to their smoking habit. Persistent smokers are disproportionately drawn from lower socio-economic groups.
- Illicit tobacco being cheap and available is easily accessible to young people and is a health protection concern.
- This is found to be purchased by young adults and children who are often unaware of the health implications.
- Reducing exposure to second hand smoke including exposure to young children travelling in cars is a public health priority

For the above stated reasons, protecting families and children from tobacco related harm is seen as a high priority.

Core functions of the alliance e.g. communications and evaluations.

Good communication is the key to the development of a Tobacco Control Alliance, raising awareness of the harms of tobacco use and ensuring that a clear and consistent message is relayed to the public and partners. It is important to have a shared communications plan, identifying opportunities for tobacco control work, key actions to achieve the priorities and named leads, which can include organisations. The communications plan will include Stoptober, Non-smoking day and possibly the "Take 7 Steps out" campaign originating from Tobacco Free Futures.

Implementing the Strategy

The Norfolk Tobacco Alliance was revitalised following the Health and Social Care Act. The Health and Wellbeing Board agreed that the Alliance meets again to set out its strategy and develop the work of Tobacco Control in Norfolk.

The membership of the Tobacco Alliance consists of;

Matthew Project	Keystone Trust
LPC – Local Pharmacy Committee	South Norfolk YAB
UEA	Breckland District Council
Healthy Schools	South Norfolk District Council
NCC Communications	Broadland District Council
Momentum	Norwich City Council
Stop Smoking service – ECCH and NCH&C	Public Health
	Trading Standards
	Fire and Rescue Service
	Action for Children
	School governor

Tobacco Control Conference was organised to validate the findings of the Health Needs assessment and begin to set the priorities for a Tobacco Control Strategy for Norfolk. The strategy is a result of a commitment to partnership approach to tackling the impact

of Tobacco in Norfolk. The partnership chaired by the Councillor Chair of the Communities Committee and is accountable to the Health and Wellbeing Board.

CONTACTS:
For further details on the Strategy, to discuss how your organisation can contribute towards the work of Tobacco Control in Norfolk or if you would like to be a member of the Norfolk Tobacco Alliance, please contact Alice Vickers on 01603638306/ alice.vickers@norfolk.gov.uk or Dr Augustine Pereira on 01603638470 or augustine.pereira@norfolk.gov.uk

Tobacco Control Norfolk: Action Plan

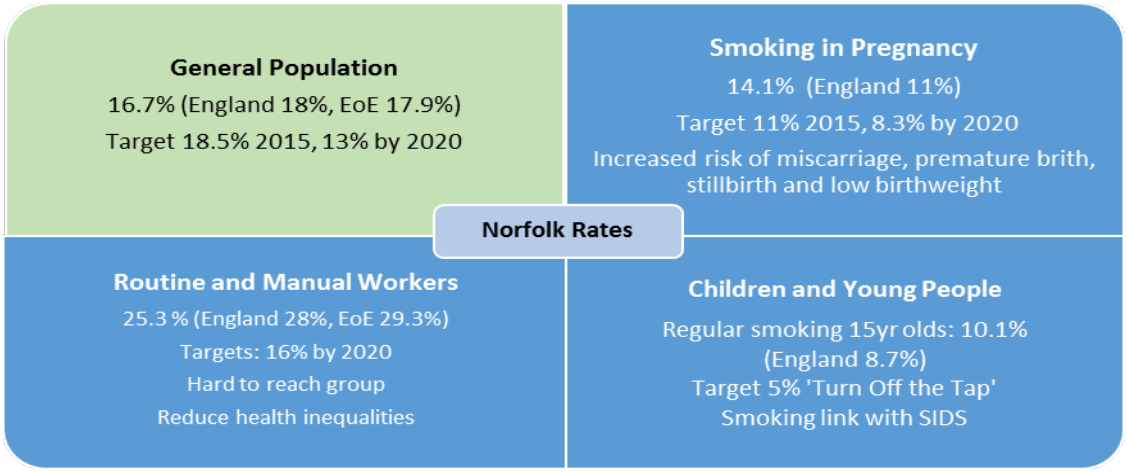
Background
Over the past 35 years, smoking prevalence in England has halved. Now fewer than 1 in 5 adults smoke. However, smoking is still a cause of excess deaths. In 2013, 1 in 6 deaths over the age of 35 were caused by smoking, approximately 200 deaths per day [1].
The 2015 targets set by Healthy Lives Healthy People have been largely reached in our region, with the exception of smoking in pregnancy. The five year strategy set out in the Government's Tobacco Control plan came to an end in 2015 and further targets for reduction were proposed in 'Smoking Still Kills' produced by Action on Smoking and Health in 2015[2]. The government undertook a high profile marketing campaign for tobacco control including Smokefree, Stoptober and Quitkit campaigns. However, the recent reduction in resources put into mass media means there is a need for local authorities to continue the impetus of smoking cessation campaigns to keep on target for the reduction in smoking prevalence in our communities.

Norfolk: How we compare

In Norfolk, smoking in adult population is 16.7 % [3] and is following the general decline reflected in the national data. Work by the Norfolk Tobacco Control Strategy 2016[4] defined 3 key strategic priorities to continue the decline in smoking in Norfolk. These are:

- To 'Turn off the Tap' of young people who become smokers
- To assist every smoker to quit smoking
- To protect families and communities, especially children, from tobacco related harm

Targets



The three strategic priorities set out below helps define the aims within our Action plan to achieve our overall vision for Tobacco Control in Norfolk.

Vision: To make Smoking History for the people of Norfolk

'Turn off the tap' of young people who become smokers:

- Engage with providers of smoking prevention services commissioned by the Healthy Child Programme
- Explore alternative ways to engage with young people

To assist every smoker to quit smoking

- Increased promotion of the Smoking Cessation Service locally
-
- Increased working with the service in joint events, sharing of promotional materials

To protect families and communities, especially children, from tobacco related harm

- Reinvigorate the Take 7 Steps campaign, increase awareness, family perspective
- Increased focus on Smoking in Pregnancy – focus on family and young women rather than just mother
- Increase awareness of legislative changes around smoking environments (e.g. smoking in cars)
- Develop an approach to communicate the role of e-cigarettes in smoking cessation

CLeaR	Aims	Lead	Outcome/ Action	Timescale
Leadership	**To ensure tobacco control is part of mainstream**	**Senior responsible officer**	• **To ensure tobacco control is part of mainstream public health work and commit Norfolk County Council to taking comprehensive action to address the**	**July 2016 - January 2017**

CLeaR	Aims	Lead	Outcome/ Action	Timescale
	public health & County Council work and its ambition. To promote that NHS partners sign the NHS statement of support for tobacco control.		harm from smoking, we recommend the council to endorse the core set of principles developed by the PH team. • To support the council and its members to assert a clear ambition for Tobacco Control by endorsing the Norfolk Tobacco Control Strategy with its overarching priorities • To support Health Scrutiny to examine the role of Smoking Cessation and the NHS support to reduce smoking across Norfolk, including highlighting the role of clinical leadership champions • To support Prisons in the process of becoming voluntary Smokefree	
Challenge Services	To improve the health outcomes of mothers and their babies through the saving babies lives task and finish group.	Senior responsible officer and key professionals who have an interest and skills in maternity services or smoking cessation.	• For CO monitoring to be done routinely at 36 weeks of pregnancy. • Review the midwives script to encourage better compliance with CO monitoring • review of the CO monitors and training available • To make CO monitoring a standard health check. • level 2 smoking cessation training to be mandatory • To review the op out/in referral to the stop smoking service. • To develop a e-cigarette policy for use during pregnancy • achieve the 10 % year on year reduction amongst Smoking in Pregnancy • To engage with Childrens centres, health visiting and FNPs in this work	June 2016 – February 2018

CLeaR	Aims	Lead	Outcome/ Action	Timescale
			• Increase number of smoking in pregnancy referrals	
	To improve the health outcomes of those with mental conditions through the mental health and smoking task and finish group.	Stop Smoking service, Public Health and Mental Health lead.	• Incorporate harm reduction into future service offer (specialist service). • Better partnership working between organisations. • Collaborative development of smoking cessation and mental health strategy. • Promote SSS through organisations. • To include NRP within discussions ensuring a clear referral pathway. •	August 2016 – June 2017
	Support and advocate the regional illicit tobacco project and promote campaign/events.	Trading Standards with support from Public Health.	• Roadshows to have been delivered across the region • Referrals to the stop smoking service • Improved knowledge of illicit tobacco. • Improved intelligence of illicit tobacco traders leading to further raids.	December 2016
	For the stop smoking service to share their practice with the alliance.	Specialist Stop smoking Service	• To review the primary care contract list and offer the contract to organisations working with vulnerable groups. • To have a clear pathway for referrals for organisations not fitting the PCC criteria. • To demonstrate how the specialist service work with other organisations in regards to referrals or training. • Demonstrating how the specialist service adheres to the NICE guidance.	August 2016- January 2018
Communications	To be prepared for all campaigns and utilise all media methods through the use of the	Comms lead for Public Health	• To ensure that Tobacco control messages go beyond promotion of activity and support the wider work programme	July – September 2016

CLeaR	Aims	Lead	Outcome/ Action	Timescale
	communications plan.		• To ensure the plan has specific & measurable outcomes which help us to monitor impact of each campaign. • To coordinate between all comms leads so that consistent messages are shared across organisations in Norfolk.	
	To monitor the implementation of the comms plan.	Comms lead for Public Health & NTCA	• To ensure that the comms plan has adequate support from all agencies and messages are shared by all organisations	Ongoing
Results	To raise awareness and support the performance data dashboard at NTCA To have an improved data monitoring system for level 2 stop smoking service.	Senior responsible officer	• To develop an efficient dashboard to take reports of performance to NTCA and monitor progress • To have an efficient system to support pharmacies to input their quit data • To have an efficient system to support GP's to input their quit data	July – October 2016

NTCA CLeaR Communications Plan

Projects/ Area	Aims	Key Message/ #	Action Plan	Timescale
National Campaigns, Legislation & Environment StOptober Standardised packaging	Increase awareness Distribute materials	Become #Smokefree	Promotion of QuitPacks – pharmacy /GP promotion Promotion of Web resources: OneYou Promotion of SmokeFree App – 28 day programme via phone	Continuous
	Local awareness/ media/ events Distribute Quitpacks		Social media, posters for GP/Pharmacy, Local radio promotion, newspaper advertising Small city based events Norwich, KL, Thetford, GY	Active Sept – October 2016
	Increase awareness of changes and rationale	'Increased health warnings, no more misleading information'	Press releases around legislation Local newspaper advertising quarterly – strong use of image	Ongoing 2016-2017 Repeat May 2017
Supporting Smoking Cessation Services	Promote access to and engagement with the local services	Support available for everyone	Social media: FB media management, Twitter retweets General Practice Advertise and promote joint projects Reciprocal support of events	Continuous
Children and Young People Take 7 Steps out	Aim to Reduce regular and occasional smoking among 15 year olds to 9% by 2020	'66% of regular smokers start before the age of 18yrs' [5] #yourfuturesnotpretty	School based channels HCP: Contracted to Cambridge Community Services (Helen Smith) Focused social media campaign – 'Smoking selfie filter'	From autumn 2016
	Investigate other school based projects		Involvement of school nurses with smoking cessation messages Spotify Adverts	Autumn 2016
	Promote understanding of the dangers	#take7steps 'Children exposed to second-hand smoke have higher rates of	Social media – Twitter/FB message/website Use of Interactive website – promote locally Norwich / GY event – family focus Bus station screens	Summer 2016 to Spring 2017

Projects/ Area	Aims	Key Message/ #	Action Plan	Timescale
	of second hand smoke	infant mortality, wheezy illness, and psychological problems' [6]	Norfolk Library screens	
Smoking in Pregnancy	Decrease % of pregnant women smoking to 8% by 2020	#loveyourbump 'Smoking while you are pregnant can lead to miscarriage, premature birth, stillbirth and illness, and it increases the risk of cot death by at least 25%'[6]	Video campaign FB Campaign for young women SmokerSelfie FB/Twitter Antenatal Clinics – posters / videos Update Midwife team on 'BabyClear' campaign NNUH JPH QEH Stickers for SCS on maternity booklets (NNUH)	Autumn 2016 2017 Autumn 2016
Routine and Manual workers	Decrease smoking prevalence	'Smoking increases sickness and reduces productivity' (Men) 'Smoking can cause male impotence, damage sperm, reduce sperm count and cause testicular cancer'[6]	Workplace interventions: Development of approach for small/medium sized businesses Use of Workplace Health Practitioner	2016-2017
e-Cigarette Approach	Investigate role of increasingly popular e-cigarettes Engage with e-cigarette providers to foster links to SCS	#95%safer	Production of myth buster postcard (Alice) Discussion with e-cigarettes shops – will they take smoking cessation materials Liaise with Smoking Cessation services – use of only e-cigarettes should count as a quit.	Start Autumn 2016

References

1. **Healthy Lives, Healthy People: A Tobacco Control plan for England (2011) Department of Health, available via https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england Last accessed 16th June 2016**
2. **Smoking Still Kills: Protective Children, Reducing Inequalities 2015, published by Action on Smoking, available via http://www.ash.org.uk/current-policy-issues/smoking-still-kills Last accessed 16th June 2016**
3. **Data from Public Health outcomes Framework, available via http://fingertips.phe.org.uk/search/smoking last accessed 16th June 2016**
4. **Norfolk Tobacco Control Strategy (2016) Norfolk Tobacco Control Alliance , Norfolk County Council, via *www.norfolkinsight.org.uk/resource/view?resourceId=1279***
5. **Smoking and drinking among adults. General Household Survey 2006. ONS, 2007**
6. **NHS SMOKEFREE website, accessible at www.nhs.uk/smokefree Last accessed 28th June 2016**

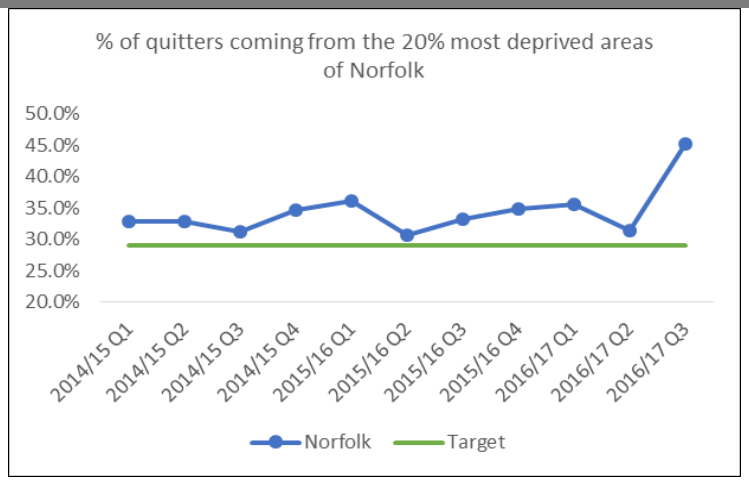
Reducing inequality in smoking prevalence

Why is this important?

Smoking is the most important cause of preventable ill health and premature mortality in the UK. Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in the lip, mouth and throat.

Because smoking is so harmful, differences in smoking prevalence across the population lead to big differences in death rates and illness, making smoking the single most important driver of health inequalities. Smoking is more common among unskilled and low income workers than among professional high earners. The more disadvantaged someone is, the more likely they are to smoke and to suffer from smoking-related disease and premature death.

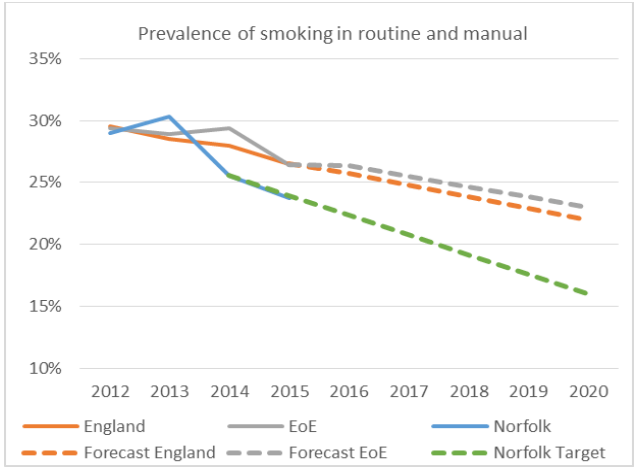
Performance



Source: Public Health – Norfolk County Council
*2016/17 Q2 only includes Specialist smoking services. GP and Pharmacy data not available.

What is the story behind current performance?

- In 2016/17 Q3 the percentage of people that quit smoking coming from the most deprived areas in Norfolk was 45.2% vs target of 29%.
- The prevalence of smoking in the routine and manual group in Norfolk has decreased from 29% in 2012 to 23.8% in 2015.
- This is due to targeting stop smoking services to those from deprived areas and the subsequent use of the service by smokers from those areas



Source: Public Health Outcomes Framework (PHOF)

What will success look like?

- Decrease the prevalence of smoking in the routine and manual group to 16% by 2020.
- The percentage of people that quit smoking coming from the most deprived areas in Norfolk is above the target of 29%.

Action required

- Ensure Stop Smoking Services prioritise and target manual workers in delivery of services.
- Working with local businesses / workplaces to promote stopping smoking
- Provision of advice within the workplace for routine and manual workers and train workers to provide this to their peers.

Responsible Officers	Lead: Diane Steiner – Deputy Director of Public Health	Data: Alice Vickers - Public Health Officer

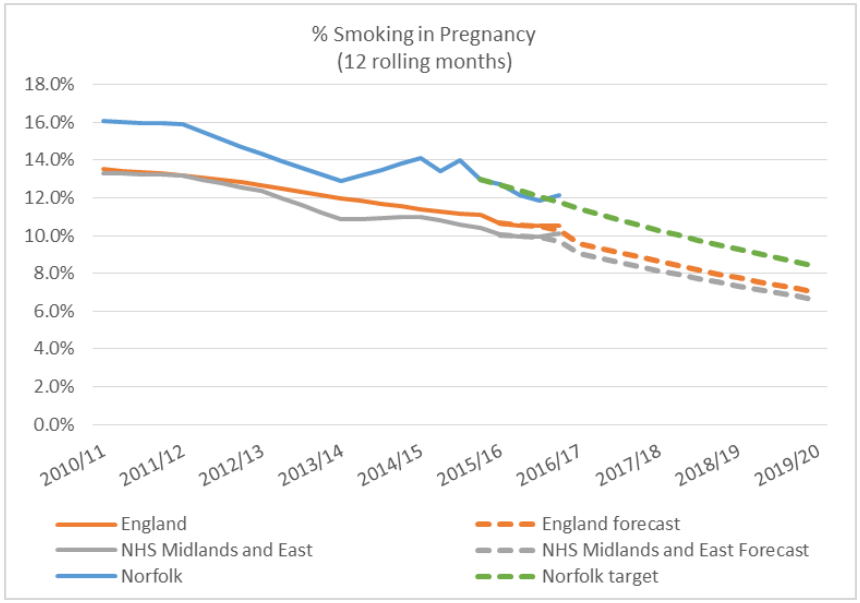
Smoking Status at Time of Delivery / Smoking in pregnancy

Why is this important?

Smoking in pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy.

Potential harms to the child include the increased chance of attention difficulties, increased chance of breathing problems and increased chance of poor educational attainment. Smoking in pregnancy is five times more likely in deprived areas so disproportionately impacts on deprived communities.

Performance



Source: NHS Digital quarterly data (at CCG level, Norfolk value estimated).

What is the story behind current performance?

- The rate of woman smoking in pregnancy is 12.2% for December 2016 against our target of 11.7. It compares well to rate for the same period last year of 13%.
- From January 2016 to December 2016 approximately 1,050 mothers were smoking during pregnancy out of 8,632 maternities.

There is inequality in smoking in pregnancy. The highest smoking in pregnancy rates are in Great Yarmouth CCG and Norwich CCG.

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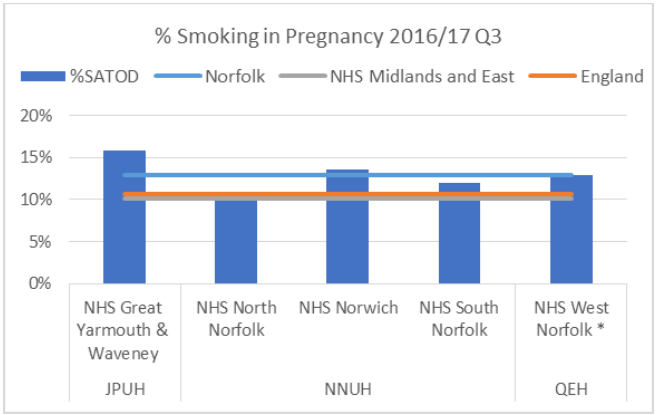

What will success look like?

- For Norfolk as a whole a 10% reduction year on year through to 2020.
- The gap in smoking in pregnancy between mothers from more deprived areas of Norfolk and the rest of Norfolk is halved by 2020.

Action required

- Carbon monoxide monitoring of all pregnant women at booking and referral to Norfolk stop smoking service, based on an opt-out system.
- Training and awareness for midwives and other health professionals.
- Partnership work to develop a good referral pathway.
- Shared accountability by partners.

Responsible Officers	Lead: Diane Steiner – Deputy Director of Public Health	Data: Sandra Davies - Public Health Officer.

Report title:	**NHS Smoke Free initiative**
Date of meeting:	**26 April 2017**
Sponsor:	**Dr Louise Smith, Director of Public Health, Norfolk**

Reason for the Report

Smoking is the single greatest cause of premature death and disease in our communities. Reducing smoking in our communities significantly increases household incomes and benefits the local economy. The Health and Wellbeing Board (HWB) has a direct interest in work carried out to address the harm caused by smoking.

Report summary

This report outlines the NHS Smokefree initiative - a public health campaign initiated and supported by Public Health England which has recently called for a complete ban on smoking in all NHS buildings and grounds.

Key questions for discussion

Q.1 What are HWB partner organisations doing in relation to smoke free policies?

Q.2 What are the barriers faced in addressing the Smokefree initiative in partner organisations and what can be done to address them?

Action needed:

The HWB is asked to:

- Consider the issues arising from the report
- Request that the Norfolk Tobacco Control Alliance review smoking policies across the HWB system with a view to co-ordinating and aligning approaches

1. Background

1.1 On 1 July 2007, England introduced new laws to make virtually all enclosed public places and workplaces in England smokefree. The primary aim of the legislation was to protect workers and the general public from exposure to the harmful effects of secondhand smoke.

1.2 Medical and scientific evidence shows that exposure to secondhand smoke increases the risk of serious medical conditions such as lung cancer, heart disease, asthma attacks, childhood respiratory disease, sudden infant death syndrome (SIDS) and reduced lung function. Scientific evidence also shows that ventilation does not eliminate the risks to health of secondhand smoke in enclosed places. The

only way to provide effective protection is to prevent people breathing in secondhand smoke in the first place.

1.3 A report by the Chief Medical Officer one on year on presented a review of the legislation covering compliance, public opinion, businesses' experience of implementing smokefree law in the workplace and academic research into the health benefits of a smokefree England. Smokefree legislation was introduced to create a healthier environment for everyone to work, socialise, relax, travel and shop in, free from secondhand smoke. One year on, the evidence suggested that the nation had quickly adapted to, and was benefiting from, a smokefree England.

1.4 NHS Smokefree is a public health campaign initiated and supported by Public Health England (PHE). It provides support and information for those that want to quit smoking and can be accessed at the following link: https://www.nhs.uk/smokefree

1.5 On 26 February 2017, PHE called for a complete ban on smoking in all NHS buildings and grounds and NHS organisations are working towards this.

2. NHS Smokefree

Why should the NHS go smokefree?

2.4 Smoking remains the leading cause of premature death in the UK and is responsible for half of the health gap between the poorest and most affluent communities. Health services have the reach of thousands to promote and deliver smoking cessation services and support.

2.5 Developing a smokefree NHS is about creating a "new normal", reducing the social norm of smoking in public places. Since 2007, people have not been able to smoke within hospital buildings and would not expect to be allowed to. From this movement it has been discussed that NHS trusts should look at making all areas smokefree.

2.6 It is recognised that hospitals are health promoting environments for everyone and cannot support a behaviour which causes numerous illnesses and can lead to death. There are many reasons for the NHS to go smokefree with the potential outcomes influencing individuals, families, patients and NHS staff.

What are other areas doing?

2.7 **Guy's and St Thomas' Hospitals** went smokefree in June 2015 which meant all cigarettes and e-cigarettes are prohibited from use on their site and is continuously communicated through signage on the grounds. Through this process all staff were given the responsibility to:

- ensure that smoking cessation referrals are offered to all smokers,
- take part in the very brief advice training
- Are advocates of the smokefree policy

2.8 St Thomas' Hospital security staff have the responsibility to implement and advocate the smokefree policy across the site. St Thomas' complies with the four-pronged approach to identifying and treating tobacco dependence (known as 'CO4') required by the London Clinical Senate to ensure its reaches the obligation of a smokefree status which details:

- **COnversations** with every patient and staff member who smokes so they have the chance to quit, referring if necessary to Stop Smoking Services.

- Make routine desktop exhaled carbon monoxide **(CO)** monitoring by clinicians possible.
- **COde** the intervention so can be evaluated for effectiveness – including death certification
- **COmmission** the system to do this right

2.9 **Derby Teaching Hospital site** is smokefree and developed a campaign called "think again" to support this move. The campaign focuses on reminding patients and visitors that the hospital is smokefree and ensure that everyone takes part in making every contact count by offering NRT and support information/services. To spread the message about going smokefree, leaflets were inserted with any patient letters from the hospital and staff handed out cards to visitors to reconfirm the message.

What are we doing locally?

2.10 Since autumn last year, Norfolk and Suffolk Foundation Trust began the movement to go smokefree. To ensure that this is a smooth and effective process, a Nicotine Management Group was set up with sub groups underneath to pick up specialist areas. The group and sub groups are made of various organisations including:

- Norfolk and Suffolk Foundation Trust (NSFT)
- Public Health from Norfolk and Suffolk
- University of East Anglia (UEA)
- Specialist Stop Smoking Services from Norfolk and Suffolk

2.11 Over the past few months, NSFT have held a consultation with staff and patients. It is aimed for NSFT is to be smokefree in 31 December 2018 and NSFT have looked to other areas for best practice towards going smokefree and best ways to communicate with patients and staff.

How could we approach going smokefree across the HWB system?

2.12 Best practice and learning from across NHS organisations who have pursued smokefree environments has produced the following key learning points:

- To have a clear focus on staff and patient support
- Pull together a steering group with relevant colleagues
- Allocate areas of work to each organisation
- Advance preparation and clear and continuous communication regarding smokefree hospitals
- Removal of smoking shelters
- Clear signage
- Consultation between staff and patients to receive their views.
- Ensure that supporting services to go smokefree are in place and accessible
- Whilst deciding on a date to go smokefree, ensure that plenty of notice is given to allow culture to change.

3. Action

3.1 The HWB is asked to:

- Consider the issues arising from the report

- Request that the Norfolk Tobacco Control Alliance review the smoking policies across the HWB system with a view to co-ordinating and aligning approaches

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

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