Evidence Set 2

Health Scrutiny Committee

Effectiveness of the Suffolk Health and Wellbeing Board

Information in this Appendix was submitted by	
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Title	*Supporting evidence regarding the effectiveness of the Suffolk Health and Wellbeing Board*
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Introduction

1. This paper presents evidence against the questions posed by the Health Scrutiny Committee in pursuit of its objective of considering how the Suffolk Health and Wellbeing Board is working to make a difference to health outcomes for Suffolk people.

2. Evidence is set out in line with the following key questions, set by the Committee:

   a. How does the Health and Wellbeing Board operate, in practice, in Suffolk?
   b. What does the Board see as its key purpose?
   c. What process does the Board use to develop the Joint Strategic Needs Assessment (JSNA)?
   d. How do partner organisations use the JSNA to inform their planning and commissioning?
   e. How do they evidence that they are doing this?
   f. How are strategies and actions agreed at Board meetings communicated and progressed within the various partner organisations?
   g. How does the Board demonstrate that it is accountable, engaged and correctly focussed?

   The Committee also agreed that in order to examine this matter in more detail, it would focus on two key measure from the *Joint Health and Wellbeing Strategy for Suffolk*, in order to investigate how this work was taken forward following agreement by the Board, and what impact they are having on the ground. The chosen key measures were:

   Key Measure 2.1.1 - Decreased smoking prevalence in adults >18 yrs;

   Key Measure 2.4.4 – Less statutory homelessness

h. Following the Board's agreement of these key measures:

i. How were they taken forward?
ii. How does the Board monitor the impact of this work and the progress towards achieving outcomes?
iii. How does the Board work collectively to identify and resolve "blocking points" in achieving outcomes?
iv. What difference has it made to date?

3. Evidence relates to the following organisations, represented on the Suffolk Health and Wellbeing Board:

a. Healthwatch Suffolk
b. Ipswich and East Suffolk Clinical Commissioning Group
c. Suffolk County Council Adult and Community Services
d. Suffolk County Council Children and Young People's Services
e. Suffolk County Council Public Health and Protection
f. West Suffolk Clinical Commissioning Group

Main Body of Evidence

Key Questions Posed by the Committee

How does the Health and Wellbeing Board operate, in practice, in Suffolk?

4. The Health and Wellbeing Board meets six times a year. Each meeting is divided into two sessions – a public meeting followed by an informal meeting for Board partners, which includes: members, providers and members of the Programme Office (the officer support to the Board). Each session lasts for approximately two hours. Individuals, groups and service users are invited to meetings in line with relevant agenda items.

5. The public meeting considers the formal business of the Board, which is very much focussed on improving integrated approaches to support better health and wellbeing across Suffolk. Given the breadth of this agenda, the Programme Office assists Board members in setting their forward plan so that it concentrates on where joint working would provide greatest additional benefit.

6. Often this includes new areas of work or proposals for tackling issues where the health and wellbeing system has failed to provide effective, integrated support to people in need. As such, the Board has provided system-wide leadership in a number of significant areas, for example: Suffolk Family Focus (Suffolk's approach to the Government's Troubled Families programme); the Housing and Health Charter for Suffolk, and, at its most recent meeting on 10th September, the Joint Mental Health Commissioning Strategy for Adults.

7. Since September 2015, the Board has introduced informal meetings directly after its formal business meeting. This is designed to allow the Board to have informal discussions that are more interactive or workshop-based than the formal committee meetings allow. They provide the opportunity for Board members and key partners to explore issues in greater depth, exchange learning and knowledge, and better focus the Board's formal work plan. It is not a decision making forum.

8. The Board also holds four half-day development sessions a year, which include members of the Programme Office. As for the informal meetings referred to above, these events are intended to allow Board members to informally explore

areas of particular interest or concern. However, they are generally longer sessions in order to allow more time for consideration and to make use of different approaches (including inviting external speakers, workshop sessions and outside visits).

9. In addition, the Board holds an annual conference. This is an opportunity for the Board to highlight a particular area of interest and to engage with a wider range of stakeholders. This year's conference, to be held on 20th October 2015 at Wherstead Park, Ipswich will be exploring the theme of neighbourliness. This theme was chosen given the local context of increased emphasis on effective community networks, partnership working with the voluntary sector.

10. The intention of this year's conference is to raise awareness of the many effective community-led schemes across the county, to consider and unblock any problems that prevent closer collaboration, and to encourage a Suffolk-wide debate on what people value about their communities and what neighbourliness means to them. The aim is to create a balance between local focus and national influence, where we can learn from best-practice examples in Suffolk and elsewhere around the country.

11. Going forward, the Board is looking to:

    - Devise a process for virtual decision-making;
    - Enhance the Healthy Debate newsletter;
    - Consider webcasting its public meetings, and;
    - Consider setting-up or sharing a seminar programme.

What does the Board see as its key purpose?

12. Health and Wellbeing Boards were established as part of the *Health and Social Care Act 2012*. The legislation states that Boards have a "*duty to encourage integrated working*" (*Health and Social Care Act 2012*: Part 2 Chapter 5 section 195) which includes encouraging: "*persons who arrange for the provision of any health or social care services in that area to work in an integrated manner*."

13. This has guided the Board's work as lead strategic body for the local health and wellbeing system. Consequently, it has focussed on issues where partners need to be more joined-up in their approach. This system leadership role for Health and Wellbeing Boards was further consolidated when the government required Boards' agreement of the Better Care Fund. In addition to consolidating the role of Health and Wellbeing Boards, the Fund signalled the importance of better-integrated health and wellbeing services by creating a local single pooled budget to incentivise the NHS and local government to work more closely together to improve keeping people as healthy and independent as possible, and to prevent ill health.

14. The Health and Wellbeing Board also has a duty to prepare a Joint Health and Wellbeing Strategy (JHWS) The Clinical Commissioning Groups (CCGs) have a duty to have regard to the JHWS in their work. Suffolk's Board published its strategy in May 2013, which set the vision that guides the Board's work:

    i. "Our vision is that people in Suffolk live healthier, happier lives. We also want to narrow the differences in healthy life expectancy between those living in our most deprived communities and those who are more affluent through achieving greater improvements in more disadvantaged communities".

15. Although the JHWS is a ten year strategy, in order to ensure the Board is focussed on the most relevant issues, it agreed to review the strategy before it had run for three years. As a result, the JHWS is currently being refreshed and is due for agreement by the Board at its meeting on 19th November 2015. The refreshed strategy will be supported by accompanying action plans and associated monitoring arrangements, which are due to be approved at the Board's meeting on 28th January 2016.

16. CCGs and the County Council have a duty to prepare a Joint Strategic Needs Assessment (JSNA) that is now expected to be executed through the Health and Wellbeing Board. The primary purpose of the JSNA is to help identify the priorities of the JHWS by analysing evidence of need.

17. In preparing the JSNA there is also a duty to involve:

    - Local HealthWatch;
    - People living or working in the area, and;
    - Each relevant district/borough council.

    i. *"By having full engagement of all health and wellbeing board members, wider local partners and the local community, JSNAs will provide a unique picture of local needs and assets."*[1]

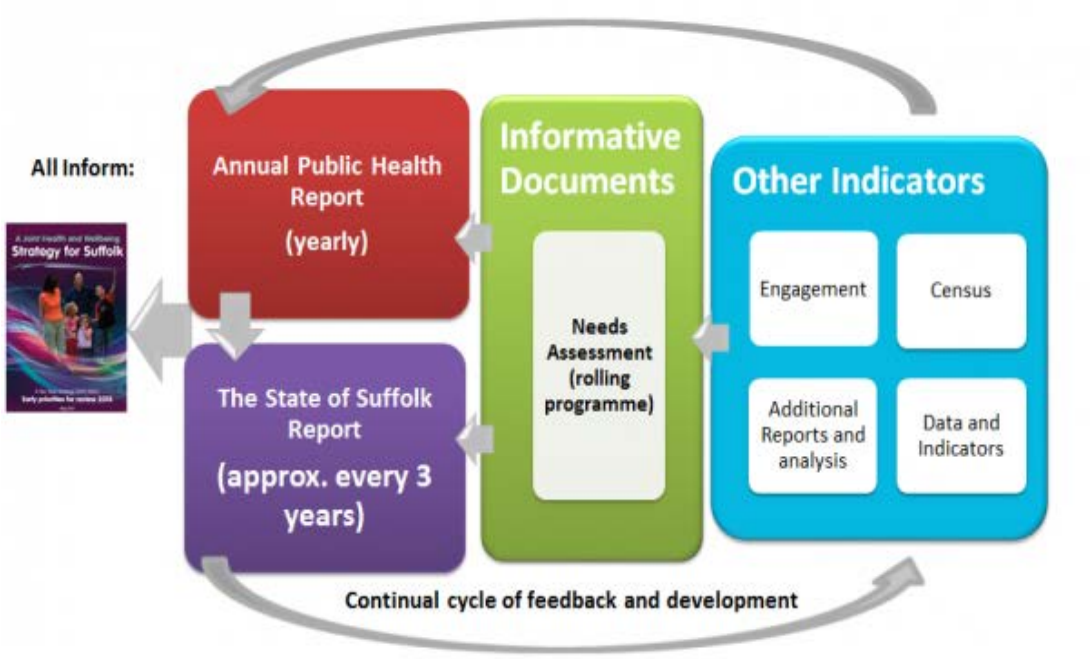
18. The process for developing the JSNA is explained in response to the next question.

What process does the Board use to develop the Joint Strategic Needs Assessment (JSNA)?

19. Suffolk's Health and Wellbeing Board has taken the view that the JSNA is not a single document but a suite of dynamic resources to inform the commissioning of health and care. This means that the JSNA constitutes a rolling programme of documents as a central resource for health in Suffolk.

20. The evidence base for the JSNA is built from a range of quantitative and qualitative sources and using a number of different tools. These include detailed local needs assessments and evidence of outcomes collected from local commissioners, providers and service users.

i. [1] Section 8, Page 8, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies – Consultation. 31 July 2012.



21. JSNA outputs are produced in a variety of different formats, including written documents, presentations and videos, in order to support accessibility and encourage engagement.

22. The process for producing Health Needs Assessments (HNAs) is set out below:

    - The need for a HNA arises in order to inform an upcoming commissioning decision or service redesign. This request could come from a Clinical Commissioning Group (CCG) or a County Council team, but this process is not exclusive to them.
    - A completed HNA Application Form is submitted to the JSNA Programme Manager.
    - The application form goes to the JSNA Task Group for addition to the rolling programme.
    - At the same time the requestor sets up a steering group for the HNA.
    - The HNA then officially starts and work commences.
    - Upon completion, the requestor self-assesses their completed HNA using the QA Form, which is then double-checked by the JSNA Task Group.
    - At this point, the HNA is complete and is added to the Healthy Suffolk website.
    - A review of the document is scheduled for two years from this date.

23. It is important to note that not all reports are HNAs – for example, some can be called profiles, when the content is not as thorough as that suggested in the HNA Template, or if there are no actionable recommendations within the document. This type of report is added to the Additional Reports section of the JSNA website when complete.

How do partner organisations use the JSNA to inform their planning and commissioning?

Evidence from Suffolk County Council Adult and Community Services (ACS)

24. ACS has used JSNA information to inform commissioning of home care, learning disability, and housing-related support services.

Evidence from Suffolk County Council Children and Young People Services (CYP)

25. The JSNA is used to inform the strategic commissioning intentions of the Children's Trust, which are published annually.
26. The JSNA was used to inform the *Special Educational Needs and Disability (SEND) Strategy*:
    a. With a number of priorities maintaining a focus on narrowing the attainment gap and supporting Raising the Bar ambitions;
    b. Informing the Strategy's priority focus on moving into adulthood, in support of the SEND reforms 0-25 agenda, and;
    c. Supporting implementation of the SEND Strategy, deploying a national framework of objectives to meet local priorities and need.
27. The JSNA also supported commissioning decisions:
    a. Through robust commissioning arrangements increasing the local Alternative Provision population capacity by 20%, to enable more vulnerable learners to access targeted, small group environment support;
    b. Commissioning of sixth form provision at the Bridge Special School, to keep more vulnerable young people aged 16-24 engaged in education, training and learning in order to help narrow the attainment gap, support the transition into adulthood and reduce the need for this cohort having to leave their local area to access provision.
    c. Other examples include:
        i. Development of locality assessment centre models to identify the barriers to learning and wellbeing, to inform the individual learning programme for vulnerable learners and those most at risk of poor outcomes;
        ii. The Carers JSNA commissioned by ACS informed the *Young Carers Supplementary Report*, which in turn informed the *Young Carers and Young Adult Carers Strategy 2015-18* and service commissioning to support both young carers and young adult carers.
        iii. Public Health produced a Speech and Language Therapy (SALT) JSNA in 2014 and have been commissioned to update this document to in turn inform the *SALT Strategy 2015-18* (to be drafted this year) and the *Joint Commissioning of SALT Services* to be contracted 2017.
        iv. The Disabled Children and Young People's JSNA drafted this year will be used to inform the commissioning of short break services for disabled children and young people where there are gaps in provision.
28. *Suffolk County Council:* Both service specific and corporate teams use the JSNA. For example: The State of Suffolk report, The Annual Public Health Report, the Environment report and information and data on the Suffolk

observatory. These documents/data are used to: support funding bids, when writing reports, inform advice, assist in benchmarking and inform strategy and policy.

29. *CCGs:* utilise the JSNA and reference it in Operational Plans.

Place based Evidence: Haverhill Needs Assessment

30. There was growing concern amongst the population of Haverhill that their health needs were not being met and that the West Suffolk CCG was not addressing their concerns in planning health services for Haverhill. To allay their fears and to plan appropriate services, Public Health Suffolk was asked by West Suffolk CCG to undertake a health needs assessment.

31. From this work, it was found that people were not aware of their health status and how they compared to the rest of the borough, the county and the country. There was also a lack of knowledge of available services.

32. This led to practical action, involving the local community, to present the findings and come up with local solutions. These included:

    a. A Haverhill-specific directory of health services, with the town council agreeing to fund and distribute this to local residents. This has already helped establish good links between the community and statutory sectors.

    b. Engagement events held with the Haverhill community to discuss the results. These were very well attended and generated a lot of positive local press coverage of the report and its outcomes.

33. As a result of this work, the relationship between the West Suffolk CCG and the Haverhill community has improved, with local people feeling they are being consulted with, and engaging in addressing the health needs of their locality.

Issue based Evidence

34. *Mental Health Concordat*: Partner organisations of the Suffolk Mental Health Crisis Concordat utilise findings from the Mental Health Needs Assessment, which also informed the development of the Concordat.

35. *Adult Autism:* The JSNA will drive much of the agenda for the new joint partnership board (in relation to Autism Spectrum Disorder), and has already helped shape the rewrite of the *Adult Autism Strategy*.

36. *Dementia:* The Dementia Needs Assessment has helped underpin redesign of the Dementia Pathway. It validated a number of messages that commissioners had been seeking to respond to in terms of confirming the demographics, and confirming a critique of the existing arrangements. As a result, ACS has been working with CCG commissioners to address this situation, feeding off the recommendations in the Needs Assessment.

Evidence from Healthwatch Suffolk

37. Healthwatch is not involved in commissioning health or social services. However, it has recently commissioned seven small projects intended to allow it to better reach people whom it finds more difficult to reach. These include:

    a. A project to engage with the Muslim community associated with the horse racing industry in Newmarket - who often feel isolated despite providing an essential and skilled workforce for the industry.

b. A project submitted by 4YP to allow better understanding of the health and wellbeing needs of children and young people in Suffolk across diverse communities. This is a countywide project looking to include 12-25 year olds including: Black and Minority Ethnic young people, Lesbian, Gay, Bisexual and Transgender, young carers, young offenders, refugees, young people not in education, employment or training and young parents mapping and highlighting health and wellbeing issues.

c. A project (the smallest of the seven) by the Multicultural Women's Group in Bury St Edmunds, which is attempting to attract more women from outside the limits of the town.

Evidence from Community Action Suffolk

39. The Voluntary and Community Sector (VCS) comes together in various forum in the County to network, exchange good practice and intelligence and develop its response to issues that it faces. Community Action Suffolk facilitates a significant number of such forum.

40. The JSNA is seen as a key document for VCS organisations when applying for funding. Alongside the State of Suffolk report it provides important evidence of need in the County and provides part of the evidential base that helps the VCS lever additional funding into the County. Organisations say that it is important in helping them more closely align their services with county-wide priorities.

How do they evidence that they are doing this?

Evidence from Suffolk County Council

41. Data from the JSNA is embedded in the Home Care Market Position Statement, which is used by providers for planning purposes and to support tenders. JSNA data is also embedded in the specification for the Housing Related Support tender.

Evidence from Healthwatch Suffolk

42. The projects listed earlier are Healthwatch's attempt to engage with some of the more difficult communities in Suffolk to obtain their views of their health and wellbeing needs. Healthwatch is driven not just by the Health and Wellbeing Board's intentions but also by the requirements of commissioners.

Evidence from Community Action Suffolk

43. No work has been undertaken to assess or quantify the use of the JSNA in funding applications and development of strategy, but feedback is strong.

Other Evidence

44. Voluntary and Community organisations and the Suffolk Congress ensure they keep up-to-date with the JSNA and share information regarding findings through their network meetings.

45. West Suffolk CCG uses information from the JSNA to inform the development of the West Suffolk CCG's ambitions, priorities and outcomes, expressed in its Operational Plan. It also ensures a link between the Health and Wellbeing Strategy and its own priorities:

Health and Wellbeing Strategy	CCG Clinical Priorities
Vision; People in Suffolk live healthier, happier lives. We also want to narrow the differences in healthy life expectancy between those living in our most deprived communities and those who are more affluent through greater improvements in more disadvantaged communities.	The CCG, with strong clinical leadership, will continue to work closely in partnership with other stakeholders, to ensure that the significant changes to the way that services are delivered continue to provide value for money and meet the needs of the local population.
Priorities:	**Priorities**
• Every child in Suffolk has the best start in life • Suffolk residents have access to a health environment and take responsibility for their own health and wellbeing • Older people in Suffolk have a good quality of life • People in Suffolk have opportunities to improve their mental health and wellbeing	• To develop clinical leadership • To demonstrate excellence in patient experience and patient engagement • To improve the health and care of older people • To improve access to mental health services • To improve health and wellbeing through partnership working • To deliver financial sustainability through quality improvement

46. Ipswich and East Suffolk CCG uses findings from the JSNA to inform its Integrated Plan, which is a key document for holding the CCG to account and that sets out the things it wants to achieve, how it plans to achieve them, who will lead, manage and be engaged, and by when improvements will be delivered.

How are strategies and actions agreed at Board meetings communicated and progressed within the various partner organisations?

Evidence from Suffolk County Council

47. The Children's Trust Board is accountable to the Health and Wellbeing Board and is responsible for Priority Outcome 1 from the *Joint Health and Wellbeing Strategy for Suffolk* – 'Every child in Suffolk has the best start in life'. For CYP, this is the main route for communication and progression with partner organisations.
48. The relevant Suffolk County Council Cabinet Member is provided with a health and wellbeing briefing for every meeting of Full Council.
49. Information is circulated to the CYP Directorate Management Group regarding key Health and Wellbeing Board decisions.
50. Information is shared and progress discussed with partners as appropriate. For example, the *Housing Charter* is discussed at meetings of the Children's Trust, the Suffolk Corporate Parenting Board, and the Suffolk Safeguarding Children Board.
51. Strategies and actions are also communicated through the Health and Wellbeing Board newsletter and progressed through CYP's Business Plan.
52. Through the relevant Programme Office member, what the Board agrees is communicated back to appropriate individuals within the directorate or the ACS

Directorate Management Team for further discussion or action. Examples include the *Learning Disability Strategy* paper and the *Dementia Friendly Communities* paper.

Evidence from Healthwatch Suffolk

53. Strategies are communicated to managers within Healthwatch and actions are agreed.

54. As a result of the Dementia Friendly Communities initiative, a member of staff has been trained as a Dementia Champion and the intention is that all staff and as many volunteers as possible become dementia friends. Already members of the Enter & View team have received this training and are now dementia friends, as are at least two Board members.

55. The organisation's Operations Manager has attended a dementia event and sits on the Health and Wellbeing Board's Priority Outcome 3 Panel ('Older people in Suffolk have a good quality of life'), in order for Heathwatch to be a part of the Older People initiative.

56. Healthwatch has published for the public an explanation of the *Care Act*.

57. As part of the Move More Project, Healthwatch has a group of staff who take part in the effort to walk 10,000 steps a day, and who regularly challenge each other to see who can take the most steps over a weekend. To this end, they have all purchased electronic pedometer devices (known as Fitbit) which allows them to monitor each other's performance.

58. As a part of the Warm Homes Initiative, one of the organisation's directors has signed up to have solid wall insulation installed and has installed an electricity generating solar panel on their roof.

Evidence from Community Action Suffolk

59. Community Action Suffolk provides support to the VCS representatives on the Health and Wellbeing Board. It has developed clear mechanisms through which organisations can discuss upcoming Health and Wellbeing agenda items and emerging strategies to help and inform the representatives These are:

    a) A VCS Health and Wellbeing Network, which operates as a sub committee of Suffolk Congress, meets before each Health and Wellbeing Board to consider issues from the Board

    b) A Health and Wellbeing newsletter is distributed to VCS organisations requesting it (189)

    c) Through Suffolk Congress single issue meetings have been convened where more detail discussion and feedback is merited

    d) Suffolk Congress receives presentations on key issues, in the last year this has included the Health and Housing Charter, the Alcohol Strategy, New Model of social care – adult assessment and the GP Federation

    e) Community Action Suffolk facilitates locality meetings throughout Suffolk. These network meetings enable smaller VCS organisations to come together. Key health and wellbeing items have been taken to the locality meetings including the new service model for health and social care.

60. These mechanisms are becoming embedded in the work of the VCS, increasing communications both from and into the Health and Wellbeing Board.

How does the Board demonstrate that it is accountable, engaged and correctly focussed?

Evidence from Suffolk County Council

61. The Board demonstrates that it is clearly focussed by basing its strategy on needs highlighted by the JSNA and by calling for updates on papers it has previously discussed and on decisions it has previously made.

62. The Health and Wellbeing Board meets the standards required of a public body. Meetings are open to the public and agendas, papers and minutes are published as appropriate.

63. The Board operates with a wider membership than is strictly required (e.g. it is open to providers) and works beyond its statutory responsibilities. This is also supported by the way it works (as outlined in the response to the first question) such as informal meetings and the annual conference that allow wider stakeholder engagement and ensure that the Board is well networked.

64. The Board's Programme Office ensures that links to members are maintained and that agendas are planned inclusively.

Evidence from Healthwatch Suffolk

65. Healthwatch Suffolk represents the views of the people of Suffolk, as appropriate, to the Health and Wellbeing Board. In addition it is represented in the Programme Office as well as the Priority Outcome 3 Panel and on the Communications Group as a part of its commitment to ensure communications support the Board's initiatives. In doing this, Healthwatch relies on the *vox populi* it receives through a variety of channels, including its Community Development Officers and its new Feedback Centre website.

66. However, Healthwatch feels it could do more, for example looking ahead at future agendas to see to what extent it can provide feedback on proposals rather than after strategies and projects have been launched. Unfortunately, this is often difficult as the intention of a strategy or project needs to be explained prior to its approval by the Board and at a time when proposals are not fully set out. But Healthwatch still believes it is a sensible way forward.

In order to consider the above questions in more detail, the Health Scrutiny Committee agreed to focus on two key measures from the Joint Health and Wellbeing Strategy for Suffolk, in order to investigate how work was taken forward following agreement by the Board and what impact it is having on the ground. The chosen key measures are:

Key Measure 2.1.1 – Decreased smoking prevalence in adults >18 years, and;

Key Measure 2.4.4 – Less statutory homelessness

Following the Board's agreement of these key measures:

i) How were they taken forward?

Evidence against Key Measure on Smoking

67. The recommendations of the Board are being taken forward by all the member organisations. This is being overseen by the reconstituted Suffolk Tobacco

Control Alliance, which in itself was a recommendation of the Board. Critical to the success of this approach is the appropriate membership of the reformed Alliance.

68. An Action Plan has been proposed, based on the agreed recommendations of the Board. It is expected that the Plan will develop and be refined as the Alliance matures and settles into its role.

69. The Alliance will conduct a self-assessment using an evidence-based improvement model that will help develop local action to reduce smoking prevalence and the use of tobacco. It will ascertain whether the Alliance is fit for purpose and to enable benchmarking of Suffolk's work both over time and against others.

70. This development work will be facilitated by Public Health England and is scheduled for November 2015.

Evidence Against Key Measure on Homelessness

71. Each district and borough council has a homelessness element within their housing strategy. These strategies reflect projected need, emerging pressures and current demands. They also reflect the objectives of the Health and Wellbeing Board.

72. The Board recently agreed the Housing and Health Charter for Suffolk (9th July 2015). The Charter has preventing homelessness as a key objective and to tackle this, partners are prioritising where to focus. This is likely to include: provision of free housing advice; how to ensure that the right short term accommodation is commissioned for Marginalised Adults threatened with being 'street homeless'; providing good quality temporary accommodation for homeless families; working with private landlords on accreditation schemes and 'myth-bust' the issues of Housing Benefit claimants; developing a pathway approach that leads from street homelessness to secure independent accommodation and more joined up approaches to supporting high risk groups.

73. Partners will develop an action plan in accordance with the Housing and Health Charter Commitments, which are:

- A whole lifespan approach that considers the housing needs of all;
- Enabling people to take responsibility for their own health and wellbeing, by providing access and information on housing choices;
- Developing a shared approach to investment in housing, health and social care with a focus upon prevention and reablement;
- Establishing a culture of shared understanding;
- Improving outcomes that ensure equality of access to services;
- Co-producing innovative models that ensure the needs and views of individuals and communities are taken into account;
- Working together to develop, deliver and maintain a fully integrated approach to housing, health and social care, and;
- Using our resources flexibly and creatively to improve collective impact and resilience.

74. In addition, CYP has established a multi-agency group focussed on prevention of homelessness for young people. This will look to focus efforts on identifying

where in the system young people are at risk and develop appropriate interventions to help them before they become homeless.

How does the Board monitor the impact of this work and the progress towards achieving outcomes?

Evidence Against Key Measure on Smoking

75. The Alliance will report regularly on progress to the Health and Wellbeing Board. The first step towards this is for the Board to endorse the Action Plan and approve the membership of the Alliance.

Evidence Against Key Measure on Homelessness

76. Monitoring of the impact of statutory homelessness is carried out at a local level. The Suffolk Strategic Housing Partnership (SSHP) provides the forum for each local council to raise emerging issues and adjust local approaches to meet any changes in demand. Developing programmes such as 'Warm Homes Healthy People' ensure people stay in their homes for longer and have access to good quality housing as a priority. Enabling people to remain housed fundamentally improves their life outcomes.

How does the Board work collectively to identify and resolve 'blocking points' in achieving outcomes?

Evidence Against Key Measure on Smoking

77. The Board allows scope and space for expression of varied viewpoints on the pace of progress, whilst reiterating the direction of travel and agreed outcomes. It is recognised that Board members represent organisations and constituencies with a range of perspectives and priorities which, on occasion, need time and space to allow a shared point of view to be reached.

78. This was demonstrated when the *Tobacco Control* paper was first presented in January 2015 ("Aspiring to a Tobacco Free Suffolk: Moving towards a Tobacco Free Generation"). At that time, the Board agreed the issues and respected the intentions placed before it, but was unable to agree the exact wording of recommendations. The relevant members were asked to take the challenge back to their organisations to deliberate and reach agreement on modified recommendations. This was done successfully and the following amended recommendations were ratified in March 2015:

    a. Develop a smoking prevention programme for schools and youth organisations.
    b. Confirm that there are organisational smoke-free policies in place that ensure staff do not smoke around children and vulnerable adults.
    c. The focus on illicit tobacco should be maintained, including intelligence gathering for HMRC and underage sales. Sponsor a strategic Tobacco Control Group with clear reporting structure and appropriate senior leadership.
    d. Develop a smoke free homes initiative within Suffolk. Such an intervention could also be linked up with the Fire Service for provision of free fire safety checks, or could be extended to include smoke free cars.
    e. Establish smoke free terms within Local Authority tenancy agreements.
    f. Continue to use political and economic influence to support legislation to strengthen Tobacco Control initiatives. This could include: Prohibiting

smoking in and within close range of children's play areas; Supporting legalisation and campaigns that de-normalises tobacco use.

g. Ensure robust evaluation of the service changes agreed with the stop smoking service which aim to deliver a more comprehensive system based on population need NHS facilities should implement the NICE recommendations on smoke-free building and grounds and routinely offer Nicotine Replacement Therapy to those admitted to hospital.
h. Ensure front line staff are trained across the public sector to deliver MECC (Make Every Contact Count). There should be a particular emphasis on referrals from our most vulnerable communities.
i. Place greater contractual emphasis on supporting prisoners to stop smoking and work with Prison Governors to gain support. In a similar way, it is anticipated that the Board will address any blocking points escalated to it from the Tobacco Control Alliance.

79. The Public Health team have advised that as they were agreed only in March 2015, it is too early to evaluate the impact of these recommendations.

Evidence Against Key Measure on Homelessness

80. Each district and borough council maintains access to housing stock, either retained as their own, or via a housing association or third sector organisation. This ensures that each applicant, if deemed suitable, can be housed even temporarily before moving on to more permanent accommodation. The SSHP works on behalf of the Health and Wellbeing Board to identify emerging issues, tackle challenges to the efficient operation and delivery of the policies in each area, and reports to the Board on key issues.

What difference has it made to date?

Evidence Against Key Measure on Smoking

81. The Health and Wellbeing Board has made several significant differences to the Tobacco Control agenda, particularly in its profile, its reach, and the adoption of evidence on the issue.

82. The Board has raised the profile of the tobacco control agenda in Suffolk and broadened its reach by emphasising opportunities beyond the health sector. In particular, it has encouraged Suffolk's district and borough councils to be bold in their duty to their residents' health by exerting influence on levers within their control, e.g. housing.

83. The Board has affirmed that preventing children from taking-up smoking is the most effective way to reduce the prevalence of adult smokers. It does this through its commitment to addressing tobacco control through prevention programmes for young people, enforcement of smoke free cars where a child is present, and the sustained focus on illicit tobacco.

84. The Board has secured commitment from local NHS organisations to make progress in implementing evidence-based guidance on tobacco use. This includes smoke-free buildings/grounds (e.g. Ipswich Hospital Trust is to become a tobacco-free site from October 2015) and the offer of nicotine replacement or cessation services for patients who smoke.

85. In addition, Board members have exerted political and economic influence within their organisations to challenge the status quo and support tobacco control initiatives.

Evidence Against Key Measure on Homelessness

86. Statutory homelessness remains at a low level. The advent of the Spare Room Subsidy has seen a shift into smaller accommodation, thereby freeing other stock. The SSHP maintains a brief to monitor progress against the key measure by implementing plans that maintain tenancies and support vulnerable people in accommodation.

Supporting Information

Suffolk Health and Wellbeing Board Papers:

A Housing and Health Charter for Suffolk, Suffolk Health and Wellbeing Board 9th July 2015: Item 6
http://committeeminutes.suffolkcc.gov.uk/meeting.aspx?d=09/jul/2015&c=Suffolk Health and Wellbeing Board

Aspiring to a Tobacco Free Suffolk: Moving Towards a Tobacco Free Generation, Suffolk Health and Wellbeing Board 15th January 2015: Item 10
http://committeeminutes.suffolkcc.gov.uk/meeting.aspx?d=15/jan/2015&c=Suffolk Health and Wellbeing Board

Housing and Health Charter Commitments, Suffolk Health and Wellbeing Board 9th July 2015: Item 6 Appendix 2
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