Health and Wellbeing
SUFFOLK

A prevention strategy for Suffolk to reduce demand in the health and care sector by improving health

2016 - 2021

INTRODUCTION

Health and Care system leaders in Suffolk requested an approach to prevention that would lead to reducing health and care demand in the next 5-10 years. The focus of the 2015 Annual Report of the Director of Public Health was how preventing ill health could decrease health and care demand in the short and medium term. The report provided the needs assessment and evidence base for this strategy which suggests prioritised actions for the system to take forward.

WHY DO WE NEED A PREVENTION STRATEGY?

The Health and Wellbeing strategy is the overarching prevention strategy for Suffolk with the aim of increasing healthy life expectancy and decreasing health inequalities. The four strategic outcomes are: Every child in Suffolk has the best start in life; Improving independent life for people with physical and learning disabilities; Older people in Suffolk have a good quality of life and People in Suffolk have the opportunity to improve their mental health and wellbeing. "Embedding Prevention" is one of the cross cutting themes running through all the outcomes.

Prevention will only lead to sustained decreased demand within the health and care sector if it can decrease the gap between healthy life expectancy and life expectancy. Life expectancy is an estimate of average expected life span; healthy life expectancy is an estimate of the years of life that will be spent in good health. Until 2009 the trend for healthy life expectancy in England for males and females increased approximately in line with overall life expectancy. For example, between 2006 and 2009, healthy life expectancy increased by 0.8 years for females and 0.5 years for males while overall life expectancy grew by 0.6 years for females and 0.7 years for males. This suggested that the extra years of life would not necessarily be years of ill health. However, the King's Fund highlighted that predictions for an increasing proportion of the population having diabetes and other lifestyle related long term conditions may result in healthy life expectancy not keeping pace with increases in life expectancy. More recent figures of healthy life expectancy are available for Suffolk from 2009-11 (three year rolling average). They show that life expectancy continues to slowly increase but for healthy life expectancy the age has decreased. Table 1 shows that the average number of years of disability have increased during the three years. Although the difference could be due to chance and will need to be confirmed with future data, we need to reduce the 16 years of ill health before death in males and 18 years in females. This ill health is not good for the individual and it is also the period when individuals will make the highest demand, and cost the most for the health and care system.

TABLE 1: *The gap between healthy life expectancy and life expectancy in Suffolk*

Year	Males			Females		
	Life Expectancy	Healthy life expectancy	Years of disability	Life Expectancy	Healthy life expectancy	Years of disability
2009-11	**80.3**	**65.6**	**14.7**	**84.0**	**68.3**	**15.7**
2010-12	**80.6**	**66.1**	**14.5**	**84.1**	**68.2**	**15.9**
2011-13	**80.7**	**64.8**	**15.9**	**84.1**	**66.1**	**18.0**

THE SCOPE OF THIS STRATEGY

This strategy will focus on those interventions that the 2015 Director of Public Health's (DPH) Annual Report found to be cost effective in reducing the health and care burden within 5 to 10 years. These should increase healthy life expectancy and decrease the years of ill health before death and are in addition to work already in place within the Suffolk system.
Five to 10 years is a relatively short time frame in terms of prevention and therefore many of the interventions with greatest impact focus on "secondary prevention" with the detection and optimal treatment of some of the illnesses that lead to more serious ill health requiring expensive health care interventions and social care support. The strategy also recognises the need to focus on health inequalities. Those from more deprived and disadvantaged communities have longer periods of ill health before death, despite having higher rates of early death.

This is not an inclusive prevention strategy.
In using the scope of the 2015 DPH Annual Report it does not include mental health or child health, or those interventions that take longer to impact on health. The 2014 DPH Annual Report focused on children, the 2016 report will focus on mental health and the prevention and early detection of cancer is a priority of the Suffolk system and is highlighted in the "system transformation plans".

WHAT CAN WE DO THAT WILL HAVE AN IMPACT ON THE HEALTH AND CARE SYSTEM WITHIN 5-10 YEARS?

The DPH Annual Report looked at emergency admissions to hospital, general hospital activity, NHS programme budgeting, and adult social care spend, to identify types of ill health that contributed the greatest demand, and was preventable. 51% of adult social care money in local authorities is spent on those over 65 and 70% of Health and Care money is spent on long term conditions. Half of us have 2 or more long term conditions during the last 15 years of our lives. The main preventable diseases in Suffolk and their underlying, modifiable causes of ill health and hospital admission are identified in table 2 below.

TABLE 2: *Preventable diseases causing most health and care demand and their modifiable underlying causes*

	Preventable diseases causing highest health care and demand					
Modifiable risk factor	**Cardiovascular disease**	**Type 2 diabetes**	**Respiratory**	**Frailty**	**Dementia**	**Falls**
Smoking reduction	■	■	■	■	■	
Alcohol consumption	■	■		■	■	■
Healthy weight	■	■		■	■	
Physical activity	■	■		■	■	■
Social isolation and loneliness				■	■	
Vaccination			■	■		
Support for carers				■	■	
Blood Pressure Control	■	■			■	■
Atrial Fibrillation detection and management	■			■	■	■
Type 2 diabetes detection and management	■	■		■	■	■

■ Linked factor and disease

■ Not applicable

□ Currently unlinked

Another measure of the amount of time people spend living in poor health as a result of preventative disease is called the number of “years lived with disability”. Public Health England has very recently published a tool estimating the impact of various risk factors for different areas of England. When this tool is applied to Suffolk it supports the local findings and estimates that 22,665 people in Suffolk are living in poor health that could have been prevented.

Figure 1 shows the underlying, modifiable causes for this poor health.

The distribution of the proportion linked to each risk factors needs to be viewed with caution due to the overlaps, for example that between High Body Mass Index (BMI), low physical activity and dietary risk.

Figure 1:

Number of person years lived with disability in Suffolk per year, by modifiable risk factor

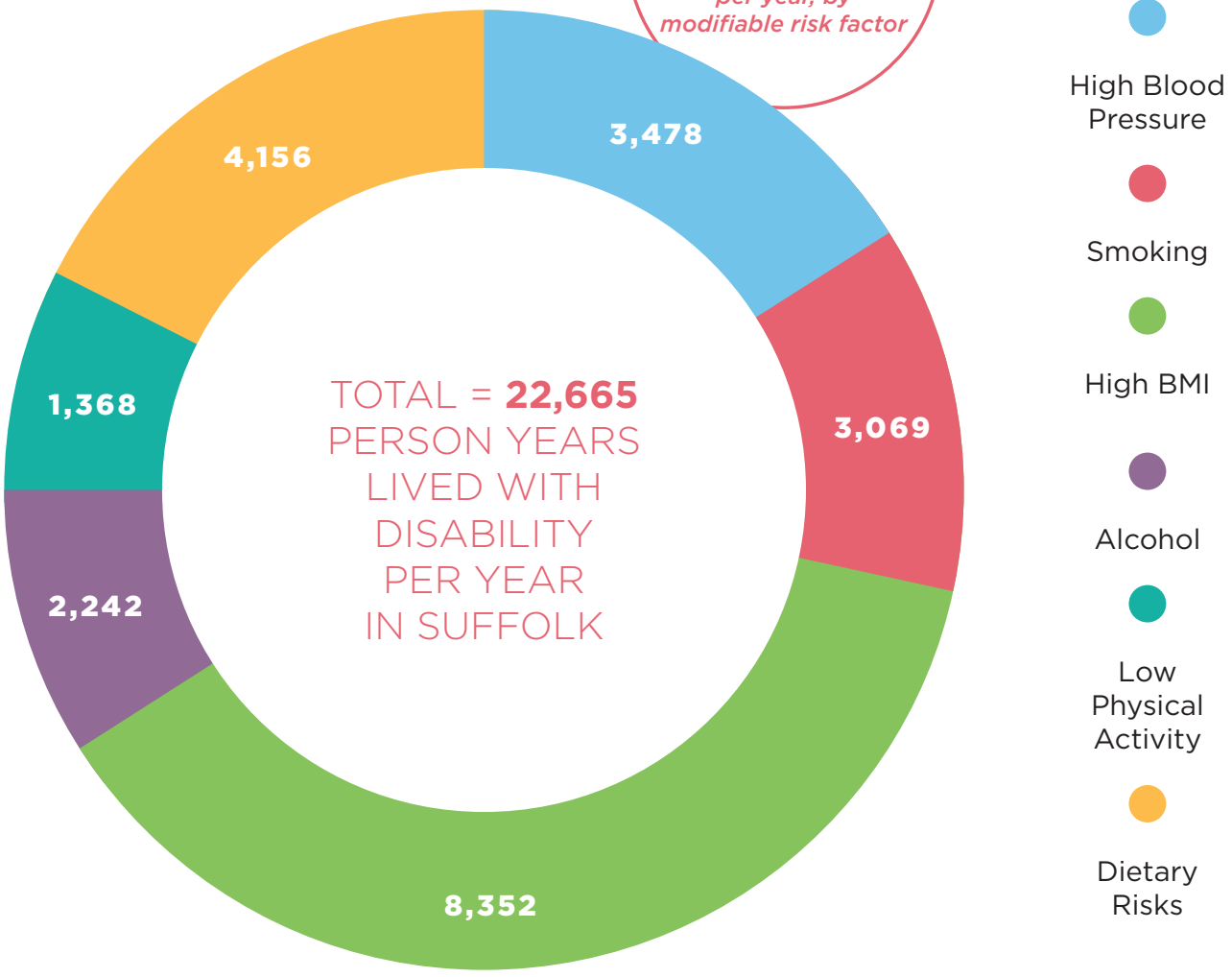

Table 3 summarises the actions identified in the DPH Annual Report that would decrease ill health, through acting on the above modifiable risk factors, as well as other elements identified in the report. It shows the potential savings that can be achieved in Suffolk by modifying these risk factors.

TABLE 3: *: Actions on modifiable risk factors that can decrease ill health and estimates of potential cost savings*

Modifiable factors	Action we can take in Suffolk	Major illness prevented over 5 years	Net costs prevented over 5 years – health care (£m)	Net costs prevented over 5 years – social care (£m)	Return on Investment (ROI)
Hypertension detection and management	Improve the number of people diagnosed with hypertension by 15%.	255 strokes, 171 heart attacks	4	3	1:2.4 at five years
	Improve the care of those already diagnosed so that 15% more adults achieve good blood pressure control (equal to or lower than 150/90 mmHg).	58 strokes, 39 heart attacks	1.1	0.7	1:3 at five years
Atrial fibrillation detection and management	Improve the number of people diagnosed to the highest level already being achieved by similar CCGs.	267 strokes	0.8	3.3	1:1.6 at five years
	Improve the care of those already diagnosed so that all people clinically suitable for anti-coagulation are treated optimally.	180 strokes	0.6	2.2	
Smoking reduction	Implement the wider actions agreed by the Health and Wellbeing Board which focus on preventions, protection and support for smoking cessation.	Risk of cancer of the mouth, throat, oesophagus and bladder is halved. Risk of cervical cancer falls to that of a non-smoker. Risk of stroke falls to that of a non-smoker.	Full saving unknown but the first year after the smoke free legislation saw 1,200 fewer emergency admissions for heart attacks across England equating to a saving of £10.5 million per year. For 5 years this would equate to £0.5m for Suffolk.	Specific cost savings not identified.	The stop smoking quit based service taken in isolation will give a return of 1:1.1 at 2 years and 1:1.24 at 5 years. However this includes the financial benefits of wellbeing to the individual. Savings to the public purse do not deliver until 10 years when the return on investment is 1:1.2. The return on investment for other areas is not known but likely to be higher.

Modifiable factors	Action we can take in Suffolk	Major illness prevented over 5 years	Net costs prevented over 5 years – health care (£m)	Net costs prevented over 5 years – social care (£m)	Return on Investment (ROI)
Weight management	Increase scale of intervention - support 6,000 adults each year with weight loss programmes which will include dietary advice and increased physical activity. ROI seems low but interventions do not result in large weight loss (i.e. 3%).	Reduce the significant contribution of excess weight to diabetes, heart disease and some cancers.	Cost savings do not materialise until year 10.	Specific cost savings not identified.	At 10 years 1:1 At 25 years 1:1.9 for obese and 1:2.8 for overweight.
Physical activity	Increase the proportion of those physically active in the population by offering a programme for 3000 most at risk adults each year. Implement and promote broad strategies that increase activity as part of daily living and focus on Suffolk's ambition to become the most active county in England.	Reduce the significant contribution of physical inactivity to cancer, heart disease and diabetes.	Impact across society is evident at 2 years (£3.6million) however only 0.7% of these savings accrue directly to health and social care, the rest being productivity and transport benefits.	Specific cost savings not identified.	The NICE ROI tool at 2 years suggests returns of 1:8.84 for cost savings, and 1:18.5 for benefits including personal wellbeing. However returns for health and social care are minimal in comparison to productivity and transport savings. Transport calculations may be based on an urban area.
Alcohol reduction	10% of the population to receive alcohol screening (and brief intervention where required) at next GP appointment.	Reduce the number of people who use alcohol by 1034 individuals will reduce their drinking as a result of intervention.	For care costs on these interventions ROI of 1:2.36 (over lifetime) Healthcare cost savings only.	Specific cost savings not identified.	Much larger cost savings across public sector. Quasi-societal: ROI of 1:198.92 over 5 years.
	30% of alcohol-related admissions to A&E to receive screening (and brief interventions where required).	1.44% (43 individuals) will reduce their drinking as a result of intervention.	ROI of 1:4.22 healthcare costs over lifetime.	Specific cost savings not identified.	Quasi-societal: ROI of 1:355.95 over 5 years

Table Continued Overleaf

Modifiable factors	Action we can take in Suffolk	Major illness prevented over 5 years	Net costs prevented over 5 years – health care (£m)	Net costs prevented over 5 years – social care (£m)	Return on Investment (ROI)
Loneliness and Social isolation	Reduce the estimated 23,000 older people who feel lonely, and 19,000 older people who feel isolated in Suffolk.	Loneliness has an impact estimated to be equivalent to smoking and obesity.	Specific cost savings not identified.	Specific cost savings not identified.	Befriending schemes estimated to have a ROI of 1:4; Community Navigator Schemes have an ROI of 1:2
Being a carer / requiring support from a carer	Support the estimated 77,000 people in Suffolk who provide unpaid care, worth £277m each year.	Carers are likely to have poorer health and wellbeing than non-carers.	Specific cost savings not identified.	Specific cost savings not identified.	Social impact assessment suggests ROI of 1:4 with benefits to health and social care.
NHS health checks	Increase coverage to over 60% (currently 59%) and complete over 20% of the health checks in the most deprived areas of the county.	22 heart attacks/ strokes prevented each year. 56 people each year prevented from getting diabetes. Identifies people at risk of disease so that they can then access services for weight management, exercise and smoking cessation.	The estimated savings to the NHS budget nationally are around £57 million over four years, rising to £176 million over a fifteen-year period. However costs to SCC are ~£3.6 million over four years.	Increases opportunity to realise all the above.	Health gain at £1,976 per quality adjusted life year (QALY).
Make Every Contact Count (MECC)	MECC is an opportunity for interactions between health and care staff and those from other organisations to increase referral to HLS and deliver brief interventions.	Increases opportunity to realise all the above. 650,000 opportunities to change lifestyle behaviour over 5 years.	Increases opportunity to realise all of the above.	Increases opportunity to realise all of the above.	Increases opportunity to realise all of the above.
Acute respiratory conditions prevention and management	Ensure vaccine coverage of vaccines is as high as possible. Improve the number of people diagnosed to the highest level already being achieved by a similar CCG (suggests that an additional 1,312 diagnoses could be made in Suffolk). Ensure that COPD diagnoses are accurate and confirmed with spirometry; and that resulting prescribing is optimal.	Prevent a quarter of current hospital admissions for exacerbation of COPD in patients who do not have a previous diagnosis of COPD.	0.3 from reduction in late stage admissions in previously undiagnosed people.	Specific cost savings not identified.	Not possible to estimate at present, but likely to realise significant savings across health and social care.

Modifiable factors	Action we can take in Suffolk	Major illness prevented over 5 years	Net costs prevented over 5 years – health care (£m)	Net costs prevented over 5 years – social care (£m)	Return on Investment (ROI)
Type 2 diabetes prevention and management	Reduce the number of people diagnosed with Type 2 diabetes in Suffolk each year by 750 -1500 through adoption of the national diabetes prevention programme.	Prevent 750-1500 people in Suffolk from developing diabetes.	0.7 – 1.3, only considering costs of avoided medication and assuming the prevention programme starts in year 3. It is estimated that 80% of the costs of diabetes arise from the need to treat complications, which often take longer than 5 years to develop. Evidence suggests that managing high blood pressure in the diabetic population reduces complications more than managing blood glucose alone.	Specific cost savings not identified.	The return on investment from preventing or optimally treating diabetes is extremely complex, as a number of risk factors such as blood pressure, cholesterol and blood glucose all have an effect on the eventual development of the clinical complications of diabetes, and their associated costs. Clearly, given that spending on diabetes is nearly equal to 10% of total NHS spending, there are significant potential gains from both preventing the disease, and reducing later complications.
Vascular dementia	Support Suffolk residents to make lifestyle changes which reduce vascular dementia, including managing cardiovascular risk, smoking, alcohol, diet.			5.5 – 8.9	
Reduce osteoporosis & falls	Effective identification of at–risk people leading to Optimal prescribing, and the use of evidence-based strength and balance training.	Evidence base suggests that appropriate interventions can reduce the number of falls by 50%. Assuming the number of resulting hip fractures also reduces by 50%, this would prevent approximately 500 hip fractures per year in Suffolk.	It is assumed that the cost of providing additional services will offset the gross savings to healthcare of £17m over 5 years. As some services are already in place, in reality costs may be lower than this, leading to net savings for health services.	4.5	Minimum of 1:1.3 at five years.

PRIORITIES FOR ACTION

A stakeholder group including the NHS, Adult Social Care, Public Health, Districts and Boroughs and the voluntary sector examined the findings of the DPH Annual Report and agreed priorities for action across years 1 and 2 of this strategy based on the evidence. These were refined during a 3 month consultation period where presentations were made across health, adult social care and the wider public and voluntary sector. Three priorities were identified with specific areas for actions. The strategy was then discussed and further refined in a workshop with the Health and Wellbeing Board.

PRIORITY 1: IMPROVE EARLY DETECTION AND TREATMENT OF HYPERTENSION, ATRIAL FIBRILLATION, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, DIABETES AND "FRAILTY"

- Increase the number of individuals diagnosed with hypertension, atrial fibrillation, Chronic Obstructive Pulmonary Disease (COPD) and type 2 diabetes
- Optimise treatment of individuals with these conditions
- Ensure NHS Health checks are delivered in a way that maximises impact
- Support healthy ageing, improve the detection and minimise deterioration in frail people

Please note that the early detection and treatment of cancer is also a priority for the Suffolk system and all the areas included in Priority 2 will contribute to the prevention of cancer.

PRIORITY 2: IMPROVE DIRECT AND INDIRECT SUPPORT TO THOSE WHO WISH TO CHANGE THEIR LIFESTYLE

- Decrease tobacco use in Suffolk by continuing to drive forward the actions agreed as part of ***Aspiring to a Tobacco Free Suffolk***
- Increase the proportion of those who are physically active in Suffolk with the specific focus on the priorities agreed by the HWB: active aging, a physical activity habit for life, walking, cycling and increasing activity amongst those with disability
- Increase the proportion of the Suffolk population with healthy weight by providing opportunities for the Suffolk population to improve their diet and increase the support available to those at risk who wish to decrease their weight
- Decrease excessive alcohol consumption by continued multiagency support to deliver the ***Suffolk Alcohol Strategy***
- Support the public and voluntary sector workforce to fully understand their role in promoting healthy lifestyles including the promotion of the ***Making Every Contact Count*** programme

PRIORITY 3: CREATE COMMUNITY AND PERSONAL CAPACITY AND ENHANCE COMMUNITY AND PERSONAL RESILIENCE

- Increase and improve interventions which address social isolation and loneliness and ensure interventions are either evidence based or locally evaluated
- Improve support to carers in Suffolk
- Improve the connections of individuals and families with their neighbours and local community
- Encourage and support community groups to focus on supporting healthy lifestyles and the wider prevention agenda

WHAT WILL SUCCESS LOOK LIKE?

The action plan in Appendix 1 prioritises actions to moderate those risk factors that have the strongest evidence base and information on return on investment. They are actions that have background evaluation to show that if implemented they will have an effect in both decreasing ill health and also cost to the system.

Success in terms of seeing decreased demand and costs for the health and care sector in the short term is unlikely as currently there is increasing demand due to the aging population, and the suggestion that years of ill health experienced before death is also increasing. However, if successful the actions in this strategy should lead to a "flattening" of the increasing demand, costs and years of ill health seen in the Suffolk population.

As the majority of actions suggested have an evidence base supporting the outcomes required by the strategy, the delivery of process measures will be a good indication that progress is being made. Where there is a lack of strong evidence behind the action an evaluation will be built into the work.

The action plan in Appendix 1 identifies the work programme for the first 2 years.

PRIORITY 1

Outcome:

Improve early detection and treatment for hypertension, atrial fibrillation, Chronic Obstructive Pulmonary Disease (COPD), diabetes and "frailty"

Aim	Specific Actions	How it will be measured	Lead Organisation	Timescale
Increase the number of patients diagnosed with hypertension by 15%	Increase opportunistic testing of blood pressure within primary care (GP and pharmacy), the IHLS and the wider community	QOF IHLS KPI	NHSE/CCGs SCC-PH	April 2017
	Improve the uptake of the NHS Health check in 40-74 year olds to 66% of those offered a check	PH contract monitoring and PHOF	SCC-PH	April 2017
	Ensure appropriate referral if hypertension suspected at health check	KPI in contract	SCC-PH	April 2016
	Encourage the use of BP monitors in GP waiting rooms and other venues both health and community sector	Survey	CCG PH	June 2016
Improve the care of those already diagnosed with hypertension, baseline to be assessed	Assess baseline within practices	QOF	NHSE/CCGs	April 2016
	Encourage call recall in primary care	Audit	NHSE/CCGs	April 2017
	Support adherence to treatment and lifestyle by increasing self-monitoring of BP	Audit	NHSE/CCGs	April 2017
Improve the detection of those with Atrial Fibrillation to the highest level already achieved by similar CCGs	Raise awareness of underdiagnoses of atrial fibrillation within primary care for example via CCG shut down training sessions	QOF	NHSE/CCGs	April 2017
	Train staff and audit inclusions of pulse rhythm check (as per specification) and ensure appropriate referral if irregular as could be AF	Audit for primary care and HLS provider KPI	SCC-PH	Dec. 2016
	Scope potential for assessment as part of other programmes for example flu vaccination	Scoping complete and plan produced	SCC-PH/CCGs	June 2016
	Scope potential for self-assessment within community	Scoping complete and plan produced	SCC-PH	June 2016
Improve the care of those already diagnosed with Atrial Fibrillation, baseline to be assessed	Encourage GPs to use the available stroke assessment tool	Audit	NHSE/CCGs	April 2017
	Ensure that those with Atrial Fibrillation who could benefit from anticoagulants have been offered treatment.	QOF	NHSE/CCGs	April 2017

Aim	Specific Actions	How it will be measured	Lead Organisation	Timescale
Improve the prevention and detection of those with type 2 diabetes	Increase the uptake of the NHS health check to 66% Scope the potential for screening those at high risk attending the IHLS	PH contract monitoring Proposal developed and considered	SCC-PH SCC-PH	April 2017 April 2016
Improve the management of type 2 diabetes	Increase proportion of patients with optimal treatment to national good practice levels	QOF National Diabetes survey	NHSE/CCG	April 2017
Improve the prevention and detections management of those with chronic obstructive pulmonary disease (COPD)	Ensure high risk smokers identified at NHS Health Check have spirometry Support people with COPD to stop smoking Improve coverage of flu vaccination for those with COPD Ensure appropriate referral to and sufficient capacity in local pulmonary rehabilitation services	Primary care audit PH contract monitoring PHE coverage information CCG contract monitoring	CCG/SCC-PH SCC-PH NHSE/PHE CCG	April 2017 April 2017 April 2017 April 2017
Maximise the impact of the NHS Health check	Increase uptake in those called for a health check to 66% Monitor uptake in deprived and at risk communities to ensure uptake at least as high as the Suffolk average	PH contract monitoring and PHOF Audit	SCC-PH	April 2017
Support older people to achieve a healthy lifestyle to delay the onset of frailty	Ensure older people have access to the IHLS to support them to stop smoking, be more physically active, improve their diet, achieve, gain/maintain a healthy weight, and reducing alcohol intake	PH contract monitoring	SCC-PH	April 2017
Prevent falls and fragility fractures in older people	Scope options to ensure that all older people are routinely asked whether they have fallen in the past year whenever they see a health or care professional and systematically offered: • falls and osteoporosis risk assessments • bone sparing agents • access to an individualised multifactorial intervention as appropriate e.g. strength and balance training, home hazard assessment	Contract monitoring – KPIs, PHOF indicators	CCGs, SCC-ACS	April 2017

PRIORITY 2

Outcome:

Improve direct and indirect support to those who wish to change their lifestyle

Aim	Specific Actions	How it will be measured	Lead Organisation	Timescale
Decrease tobacco use in Suffolk by continuing to drive forward the actions agreed as part of ***Aspiring to a Tobacco Free Suffolk*** (see Appendix 2)	Improve the effectiveness of the Suffolk Tobacco Alliance though completing the Public Health England facilitated cLeaR self-assessment and make appropriate changes	Completion of self-assessment with recommended changes for implementation	SCC-PH and Tobacco Alliance	Dec. 2015
	Alliance to agree an action plan including measures and timescales	Action plan completed and agreed by all organisations on Tobacco Alliance	Member organisations of Tobacco Alliance	Feb. 2016
	Action plan to go to HWB March meeting	Action plan considered by Board	SCC-PH	March 2016
Increase the proportion of those who are physically active in Suffolk with the specific focus on the priorities agreed by the HWB: active aging, a physical activity habit for life, walking, cycling and increasing activity amongst those with disability	Implement the Suffolk Walking Strategy 2015-2019	Dept for Transport walking statistics	SCC – MAC districts and boroughs	2019
	Implement the Suffolk Cycling Strategy	Dept for Transport cycling statistics	SCC – MAC districts and boroughs	2020
	Implement the Suffolk Disability Sport and Physical Activity Strategy	Sport England Active People Data	SCC – MAC districts and boroughs	2019
	Increase physical activity among older people by: Making “fit Villages” programme in rural villages sustainable	UEA evaluation	SCC - MAC districts and boroughs	April 2017
	Scope integrations of physical activity into the commissioning intensions of mental health commissioners	Sport England	SCC - MAC districts and boroughs	Sept. 2016
	Develop evidence based programmes through the healthy lifestyle service for increasing numbers to 3000 individuals at high risk each year	PH contract monitoring	SCC-PH	April 2017 - developed April 2018 delivered to 1000 people

Aim	Specific Actions	How it will be measured	Lead Organisation	Timescale
Increase the proportion of the Suffolk population with healthy weight by providing opportunities for the Suffolk population to improve their diet and increase the support available to those at risk who wish to decrease their weight	Agree a Suffolk Food charter across the public, voluntary and private sector with actions that can be monitored	PH contract monitoring - KPI	SCC-PH	1,660 people seen 2016/76 7,500 people seen 2019/20
	Establish a Healthy Food Award Scheme	Endorsement of the charter and monitoring through the Suffolk HWB	SCC-PH	May 2016
	Offer a programme to support increasing numbers of at risk people each year to reach a healthy weight	Award scheme embedded into District and Borough Council Environmental Health assessment of food outlets.	District and borough Councils	April 2017
Decrease excessive alcohol consumption by continued multiagency support to deliver the ***Suffolk Alcohol Strategy***	Complete the over 50s Alcohol Needs Assessment	NA available on JSNA site	SCC-PH	March 2016
	Refresh Alcohol Strategy Action plan in view of new CMO guidance and the NA . Include actions to increase identification of excessive intake and increase alcohol screening and brief interventions	Acton plan agreed by JCG for MH/LD and D&A	SCC-PH	April 2016
	Action Plan and progress report to HWB	Agreed by Board	SCC-PH	July 2016
Support the public and voluntary sector workforce to fully understand their role in promoting healthy lifestyles including the promotion of the ***Making Every Contact Count*** programme	Encourage staff to complete the training programme provided through the IHLS	PH contract monitoring	IHT/WSH/JPH/ SCH/ACS/Vol Sector	April 2016
	Increase appropriate referral to the IHLS for advice and support	PH contract monitoring	IHT/WSH/JPH/ SCH/ACS/Vol Sector	April 2017
	Promote healthy lifestyle champion training within the public sector, voluntary sector and within communities	PH contract monitoring	SCC-PH	Dec 2016
	Develop and test “prevention link workers” between HLS and GP practices across Suffolk	PH contract monitoring	SCC-PH	Dec 2016

PRIORITY 3

Outcome:

Create Personal and Community Capacity and enhance Personal and Community resilience

Aim	Specific Actions	How it will be measured	Lead Organisation	Timescale
Increase and improve interventions which address social isolation and loneliness	Increase social connectivity and befriending by: • Supporting and promoting the development of Dementia Friendly Communities across Suffolk • Promoting and supporting grant making through the Dementia Fund • Ensuring all Connect site activity commissioned by Neighbourhood Networks work stream have focus to address social isolation and loneliness • Ensuring Community Strategies include elements to address social isolation and loneliness	Monitoring of numbers of Dementia Action Alliances constituted. Outcomes from successful bids monitored for evidence. Monitored through NN group in various ways District an Borough Community Strategy action plans	SCC - ACS Suffolk Community Foundation SCC - ACS Districts and boroughs	April 2017 April 2017 Dec 2016 Dec 2016
Improve the Support to Carers in Suffolk	Reduce social isolation by providing : • opportunities for Carers to provider peer to peer support and advice • Target specific targeted opportunities for carers to actively participate in leisure activities Increase opportunities for Carers to have a break from caring role by: • Improving range and access of respite for the Cared for • Better use of and access to technology that creates safe home environments allowing Carers to leave the Cared for	Take up of the opportunities provided Qualitative assessment of Carers experiences and outcomes Market measurements of available provision and qualitative assessment of experience Carers support plans	SCC and Suffolk Family Carers SCC and district and borough Councils SCC–ACS CCGs SCC-ACS	April 2017 Dec 2016 Sept 2016 April 2017

Aim	Specific Actions	How it will be measured	Lead Organisation	Timescale
Improve the connections of individuals and families with their neighbours and local community	Appoint Local Area Coordinators in Connect integration site to facilitate individual's connections with their neighbours and local community Explore other areas of Suffolk where Local Area coordination could be implemented Ensure there is collaboration and communication across organisations involved in community development work to improve connections in and with the community	Evaluation criteria will feed into Connect metrics. Social Return on Investment also under consideration	SCC–ACS Districts and boroughs, CAS SCC-PH	March 2017
Encourage and support community based groups to focus on supporting healthy lifestyles and the wider prevention agenda	Work with Patient Groups in primary care to encourage focus on healthy lifestyles and the wider prevention agenda Support the community, through towns, parishes and other routes, to take control of their own health and wellbeing	Survey Survey	SCC-PH CCG SCC-PH, districts and boroughs Congress	March 2017 Oct 2016

ACS: Adult and Community Services

AF: Atrial Fibrillation

BMI: Body Mass Index

BP: Blood Pressure

CCG: Clinical Commissioning Group

HLS: Healthy Lifestyle Service

IHLS: Integrated Healthy Lifestyle Service

IHT: Ipswich Hospital Trust

JPH: James Paget University Hospitals

KPI: Key Performance Indicator in contracts

MAC: Most Active County

NHSE: NHS England

PH: Public Health

PHOF: Public Health Outcome Framework

QOF: Quality outcome framework for General Practice

SCC: Suffolk County Council

SCH: Suffolk Community Healthcare

WSH: West Suffolk Hospital

ASPIRING TO A TOBACCO FREE SUFFOLK:
Towards a tobacco free generation

PREVENTION: CREATING AN ENVIRONMENT WHERE YOUNG PEOPLE CHOOSE NOT TO SMOKE

1. Support young people to develop and implement smoking prevention programmes for schools and youth organisations (Lead agencies Public Health, Children & Young People, SCC).
2. Take every opportunity to ensure staff do not smoke around children and vulnerable adults. (Lead agencies: All members of the HWB).
3. The focus on illicit tobacco should be maintained, including intelligence gathering for HMRC and underage sales (Lead agencies: All members of HWB).
4. Sponsor a strengthened Tobacco Alliance to work across the system ensuring that the membership is appropriate for delivery of the strategy (Lead agencies: All members of HWB).

PROTECTION: PROTECTING PEOPLE FROM SECOND-HAND SMOKE AND SUPPORTING TOBACCO CONTROL INTERVENTIONS

5. Ensure Suffolk is ready to implement the legislation making it illegal to smoke in a car where children are present, by October 2015 (Lead agencies: Public Health Suffolk, Suffolk Fire & Rescue, SCC).
6. Work towards establishing a smoke free homes movement in Suffolk (Lead agencies: Local Authorities and the Suffolk Strategic Housing Partnership).
7. Continue to use our political and economic influence to support Tobacco Control initiatives (Lead Agencies: Local Authorities).

CESSATION: SUPPORTING AND ENABLING PEOPLE TO QUIT SMOKING

8 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 (Lead agencies: Public Health Suffolk).

9 NHS organisations should implement NICE guidance concerning tobacco use including:

- Ensuring buildings and grounds are smoke free.
- Routinely offering Nicotine Replacement Therapy (NRT) to those admitted to hospital and to those visiting out-patients and clinics if appropriate.
- Signposting patients to stop smoking services especially elective surgical patients who will need an anaesthetic (Lead agencies: All NHS members of the HWB and their service providers).

10 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 (Lead agencies: All members of the HWB).

11 Place greater contractual emphasis on supporting prisoners to stop smoking and work with Prison Governors to gain support (Lead agencies, Public Health Suffolk).

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