Health and Wellbeing in Surrey Heath
Preventing avoidable illness and death
2014/15 – 2015/16

Update: November 2014
November 2014 update

Following comments received at the last Surrey Heath Health and Wellbeing Board, the following updates have been made:

A description of the differences between CCG and BC boundaries has been added.

A new page on Health Improvement campaigns has been added but as campaign calendars for 2015/16 across all organisations have yet to be developed then this remains incomplete.

Descriptions of Health Visiting and Youth Services have been added to the Cross-cutting programmes section.

A section on the aspiration to work in collaboration with primary care has been added to the same section.

The metrics appendix has had some data included but difficulties in collecting pharmacy, exercise referral and child weight management data means these lines are all pending.

A reporting process appendix has been developed. Named leads to be added.

All reporting lines within the Prevention Plan have been updated where possible.

Highlights:

• Currently all secondary schools in Surrey Heath (except Portesbury) have received the Drug and Alcohol and Smoking toolkits.

• The Stoptober and Self-care Campaigns were delivered across SH.

• All but two Practices in Surrey Heath are signed up to the alcohol DES (Lightwater and Old Dean).

• Bin hangars showing advice on keeping warm and keeping well this winter are about to be delivered with refuse collection to those identified as vulnerable.

• Comparative data on GP level flu immunisation uptake was published in the CCG newsletter to practices.

• Public Health have recently met with counterparts in Berkshire to discuss the work going on around fall prevention and the Frimley system. An Action Plan table for falls prevention has now been included in this plan for discussion.

• 23 patients out of 44 identified as being suitable for telehealth are currently receiving this service.

• The first Local Partnership Forum will meet on November 25th. Surrey Public Health, SH CCG and SHBC will be represented. The Forum will discuss how we best strengthen our partnership working in Surrey Heath. Part of this will be identifying what kind of partnership networks already exist locally, and to understand how we can communicate better with other statutory and voluntary sector and share local objectives from each of our organisations.

Lowlights:

• The open-access Stop Smoking Clinic in Park Road surgery has shut due to staff and accommodation issues arising from extended opening hours.

• People setting a quit date with the Surrey Stop Smoking service is at a low.

• A&E alcohol related assault data is regularly uploaded to Surreyi. Feedback from the Community Safety Partnership is that the data is of limited use. Public Health will review the data and information available for licensing decisions.

• Plans to tackle obesity remain under-developed. Public Health have recently appointed to a post specialising in Physical activity and are also developing plans for the whole Healthy Weight Care Pathway.
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  Data/Information Sources
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Why prevention

Health, ill-health and health inequalities are the consequence of a wide range of factors that operate at a number of different levels, as demonstrated in the diagram below.

Ill-health prevention must form the foundation of any strategy to improve health and wellbeing. The Global Burden of Disease 2010 study is the largest study of its kind ever undertaken. According to the survey, the top 5 risk factors are:

- Tobacco smoking
- Raised blood pressure
- Obesity
- Physical inactivity
- Alcohol

Together with improving emotional wellbeing and mental health, this represents a key opportunity to improve health and wellbeing by targeting these behaviours through a prevention strategy.

Prevention can happen at different stages:

**Primary prevention**: preventing healthy people from developing a disease or experiencing an injury in the first place.

**Secondary prevention**: halt or slow the progress of disease (if possible) in its earliest stages.

**Tertiary prevention**: helping people manage complicated, long-term health problems to prevent further physical deterioration and maximizing quality of life.

Prevention can also take place in a variety of settings including:

- Healthcare settings: primary, community or secondary care
- Schools and other educational settings
- Community settings: Community Centres, Leisure Centres etc
- Workplaces

This prevention plans describes services, programmes and activities taking place (or planned) within Surrey Heath that contribute towards prevention of avoidable illness and death. It is a multi-agency plan, contributed to by Surrey County Council, Surrey Heath Borough Council, Surrey Heath Clinical Commissioning Group and wider partners. It will report to the Surrey Heath Health and Wellbeing Group.

The priorities within the plan have been chosen based on assessment of the health and wellbeing needs of the Surrey Heath population. Further information on these needs is given in the appendices of this document (list of resources to be provided).

All the prevention activities described here should give consideration to inequalities within Surrey Heath, whether on a socio-economic basis or inequalities between particular population groups. The activities will be linked to other plans that aim to address inequalities such as the Old Dean priority group.
There are boundary differences between Surrey Heath CCG and Surrey Borough Council. The maps below indicate these differences (ward names in bold indicate differences)

**Surrey Heath CCG Ward Boundaries**

Ward Legend:
1. Windlesham
2. West End
3. Lightwater
4. Bagshot
5. Old Dean
6. St Paul’s
7. Parkside
8. Heatherside
9. Mythett and Deepcut
10. Ash Vale
11. Ash Wharf
12. Ash South and Tongham
13. Frimley Green
14. Frimley
15. Watchetts
16. St Michael’s
17. Town

**Surrey Heath Borough Council ward boundaries**


Handling these differences will use the following principle:

1) Actions that fall under the responsibility of the CCG will cover the wards within the CCG boundary e.g including the “Ash” wards but excluding Chobham (which is part of North West Surrey CCG)

2) Actions that fall under the responsibility of the Borough will cover the wards within the Borough boundary e.g including Chobham but excluding the “Ash” wards (which are part of Guildford & Waverly BC)
Cross-cutting programmes that improve health and wellbeing: 1

The following four slides describe services and programmes available within Surrey Heath that address a range of health and wellbeing issues.

**Sure Start Children’s Centres**

The core purpose of Sure Start children’s centres is to improve outcomes for young children and their families, with a particular focus on those in greatest need. They work to make sure all children are properly prepared for school, regardless of background or family circumstances. They also offer support to parents.

There are five Children’s Centres in Surrey Heath (details available [here](#)), including one within the Old Dean Estate, an area with a high proportion of children living in poverty.

Achieving a Healthy Children’s Centre status means meeting standards on:
- Healthy weight (childhood and maternal obesity)
- Improving the oral health of children
- Improving mental health/emotional health and wellbeing
- Reducing teen pregnancy rates and supporting teenage parents
- Reducing alcohol and substance misuse
- Increasing smoking cessation and smoke free homes
- Increasing coverage rate of childhood immunisations

Children’s Centres are provided by Surrey County Council. Public Health are currently working on a pilot with selected Children’s Centre’s (not in Surrey Heath) to achieve Health Children’s Centre status. Once this pilot is complete (due July 2015) then Children’s Centres within Surrey Heath can be identified as being part of the county-wide roll out of this scheme.

**Health Visiting**

Health visitors support and educate families from pregnancy through to a child’s fifth birthday (the Health Child Programme 0-4 years) Common tasks include:
- offering parenting support and advice on family health and minor illnesses
- new birth visits which include advice on feeding, weaning and dental health
- physical and developmental checks
- providing families with specific support on subjects such as post natal depression.

The Health Visiting Service is currently commissioned by NHS England. In October 2015 the commissioning responsibility will transfer to Surrey Public Health. In Surrey Heath, Health Visiting is provided by Virgin Care Ltd.

**School Nursing**

School nurses, with their teams, co-ordinate and deliver public health interventions for school-aged children. The service leads on the delivery of the Healthy Child Programme for 5 – 19 year olds. Public Health priorities for the school nursing service are:
- Emotional health and wellbeing
- Dental decay
- Obesity and weight management
- Teenage Conception
- Sexually Transmitted Infections
- Smoking
- Drug and Alcohol misuse

Public Health commission the school nursing service and in Surrey Heath the school nursing service is provided by Virgin Care Ltd.

**Personal, Social and Health Education in schools**

PSHE is the planned provision in schools for promoting the emotional, social and health development of children and young people. It is a National Curriculum subject which contains several specialist areas:
- Drug Education
- Economic Well-being and Financial Capability
- Emotional Health and Well-being (including [Targeted Mental Health Promotion Service](#) and Social and Emotional Aspects of Learning Programme (SEAL))
- Staying Safe and Sex and Relationships Education (SRE).

**Services for Young People**

Within Surrey Heath there are a range of services for young people (16 to 18 years); from universal programmes such as Youth Engagement or Duke of Edinburgh programme through to the Youth Support Service which uses a case management approach to support vulnerable young people.

There are two youth centres in Surrey Heath, Frimley Green and Old Dean Youth Centre plus Ash Youth Centre in Guildford Borough.

**We are Surge** is a Surrey based group of young people, online in a forum, sharing things that are interesting and important to them. The site also has advice and information on issues young people care about.
Cross-cutting programmes that improve health and wellbeing: 2

<table>
<thead>
<tr>
<th>Healthy Work places</th>
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<tbody>
<tr>
<td>The <strong>Workplace Wellbeing Charter</strong> is an opportunity for employers to demonstrate their commitment to the health and well-being of their workforce. There is also strong evidence to show how having a healthy workforce can reduce sickness absence, lower staff turnover and boost productivity - this is good for employers, workers and the wider economy.</td>
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<tr>
<td>Surrey Public Health and Surrey Heath Borough Council are represented on the Surrey Workplace Wellbeing Charter implementation group.</td>
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<tr>
<th>NHS Healthchecks</th>
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<tr>
<td>The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. Successfully implementing NHS Health Checks may help reduce chronic illnesses and avoidable premature mortality, as well as the health and social care costs related to long-term ill health and disability.</td>
</tr>
<tr>
<td>The NHS Healthcheck is currently available in three pharmacies and three GP practices within Surrey Heath (including Torchwood Pharmacy within the Old Dean Estate). More GP Practices are signed up and preparing to deliver the service. There will also be a focus on workplace health checks and groups most at risk of CVD (including carers, BME groups, smokers, and people in areas of socioeconomic deprivation).</td>
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<tr>
<th>Primary Care</th>
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<tr>
<td>Primary care health professionals, including GPs, practice nurses, and pharmacists have many opportunities to offer brief interventions to support behaviour change, such as smoking cessation or reducing alcohol consumption. They encounter patients at times when they may be open to change – before an operation, after a health scare, when they are feeling ill, or are pregnant. There are several priority areas within this prevention plan that depend on the support of primary care, including:</td>
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<tr>
<td>➢ Delivering NHS Health Checks</td>
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<td>➢ Delivering and referring to Smoking Cessation</td>
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<td>➢ Alcohol misuse Early Identification and brief advice</td>
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<td>➢ Identifying physical inactivity and obesity</td>
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<td>➢ Delivering immunisations</td>
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<td>➢ Identification of domestic abuse</td>
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<td>➢ Early identification of mental health issues including suicide risk and self-harm</td>
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<tr>
<td>➢ Falls prevention</td>
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<tr>
<td>➢ Self-care and Carer’s health</td>
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<tr>
<td>The individual actions surrounding each of these areas are described in each section but all will be supported by the general principle of the CCG, Public Health and Primary Care working together to ensure primary care professionals have the understanding, capacity and motivation to fully engage in the prevention agenda.</td>
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</tbody>
</table>
Health Improvement Campaigns

Surrey Public Health support three major Public Health England campaigns (Change 4 Life, Stoptober and NHS Health Check) that aim to raise awareness amongst the general public about healthy lifestyles and other preventative activities. Borough councils and CCGs can also promote healthier lifestyles, by signposting local support services and encouraging residents to take greater responsibility for their own wellbeing. The Surrey Health and Wellbeing Communications Group have produced a Communications toolkit to support these organisations in doing this. The minor campaigns supported within Surrey Heath are also shown below.

Text on minor campaigns (with weblinks) to be added
# Cross cutting services: Action Plan 1

<table>
<thead>
<tr>
<th>Cross-cutting area</th>
<th>Action(s)</th>
<th>Who will do this (Lead / Organisation)</th>
<th>When will we do this by (Milestones / Timescale)</th>
<th>Current progress (Nov 2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PSHE / School Nursing</strong></td>
<td>Ensure that teachers and school nurses have access to health improvement training including the Drug and Alcohol toolkit, Smoking toolkit and healthy weight information.</td>
<td>Public Health / Education Area Officer / Providers (Babcock4S &amp; Virgin Care)</td>
<td>Ongoing activity</td>
<td>Currently all secondary schools in Surrey Heath (except Portesbury) have received the Drug and Alcohol and Smoking toolkits.</td>
</tr>
<tr>
<td><strong>Increase the number of NHS Healthchecks offered and delivered</strong></td>
<td>Support GP practices and pharmacies with training, documentation, POC testing equipment and guidance. Deliver workplace and targeted community healthchecks. Deliver communications campaign</td>
<td>Public Health / Primary Care / SHBC</td>
<td>HC delivery: Ongoing activity Campaign: summer 2015</td>
<td>See metrics section</td>
</tr>
<tr>
<td><strong>Health Improvement Campaigns</strong></td>
<td>Use guidance available from Surrey Health and Wellbeing Communications Group toolkit and meetings to support campaigns including Healthchecks, Stoptober and Change4Life.</td>
<td>SHBC and SH CCG Communications leads</td>
<td>Ongoing activity</td>
<td>The Stoptober and Self-Care week campaigns have been supported locally.</td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
<td>To work in partnership to identify barriers and opportunities for primary care to become fully engaged in the prevention plan. Engagement meetings to be held with General Practitioners, Practice Nurses and allied health professionals, Practice Managers.</td>
<td>SHCCG and Public Health</td>
<td>Meeting dates to be confirmed</td>
<td></td>
</tr>
</tbody>
</table>
Section 1: Healthy Lifestyles
Why is smoking a public health problem?

Smoking is the primary cause of preventable illness and premature death, accounting for approximately 100,000 deaths a year in the United Kingdom. As a result, reducing tobacco use is the single most effective means of improving public health. For every death caused by smoking, approximately 20 smokers are suffering from a smoking related disease. The top three smoking related conditions are; respiratory disease, lung cancer and heart disease.

Public Health England has set a national ambition to achieve a smoking prevalence of only 5% amongst those aged 11-15 years by 2025.

Effective prevention

NICE guidance recommends brief stop smoking interventions, behavioural support and pharmacotherapy as cost effective interventions. Evidence shows that people who access Stop Smoking Services and pharmacotherapy are 4 times more likely to quit than attempting quitting alone. Although the health benefits are greater for people who stop at earlier ages, quitting smoking is beneficial at all ages.

It is recommended that all GPs and Practice nurses provide very brief stop smoking advice (VBA) to all patients aged over 16. When time is very limited, 30 seconds of advice from those who have regular contact with people who smoke is effective in triggering a quit attempt. Brief advice from a healthcare practitioner can double the natural quit rate for smokers (West R, 2000). A VBA training module is available on the National Centre for Smoking Cessation and Training website [http://www.ncsct.co.uk/publication_very-brief-advice.php](http://www.ncsct.co.uk/publication_very-brief-advice.php)

There is evidence that ASSIST (a school-based smoking prevention programme) could reduce adolescent smoking prevalence.

Services available in Surrey Heath

Surrey Stop Smoking Service (SSS) offer intensive face-to-face, group support and telephone support and advice, over a number of weeks, to any smoker wanting to stop. Behavioural support, along with the use of stop smoking pharmacotherapy, is provided by an advisor who has received training and supervision that complies with the DH ‘Standard for training in smoking cessation treatments’.

The public health team commissions stop smoking services via Public Health Agreements from General Practice and Pharmacies. Nine GP Practices and 4 Pharmacies have signed up to the PHA. There is currently one specialist one-to-one stop smoking clinic running at Frimley Green GP practice.

GP practices can also prescribe pharmacotherapy without referral to Surrey Stop Smoking services but the patient is much less likely to be able to quit without behavioural support.
Smoking: Action Plan
Health and Wellbeing Outcome: A reduction in smoking prevalence in Surrey Heath

<table>
<thead>
<tr>
<th>Objective (what do we want to happen)</th>
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<th>When will we do this by (Milestones / Timescale)</th>
<th>Current progress (Nov 2014)</th>
</tr>
</thead>
</table>
| Local implementation of Smoke Free legislation                                                      | • Ensure SH representation on Surrey Tobacco Control Alliance  
• Local promotion of SF campaigns  
• Underage sales: mystery shopping  
• Smoking litter fines  
• Smokefree work vehicles  
• Provision of evidence-based info on NV                                                                 | Surrey Tobacco Control Alliance supported by local environmental health, trading standards and police. | Ongoing work                                      | Richard Haddad represents Surrey Heath on the Surrey TCA. Work on smoking litter fines and smokefree work vehicles is pending the results of pilots on both within Woking BC. Statement on NV published. A Smokefree playgrounds project is being developed |
| Reduce the update of smoking amongst children                                                       | • Ensure Stop Smoking training is available for professionals working with children  
• Review and update Smoking Toolkit and ensure distribution to SH schools | Public Health Babcock 4S                                                                          | Ongoing work                                      | Stop smoking training is readily available to front-line professionals including school nurses. Nurses offer brief intervention alongside the smoking toolkit delivered in PSHE lessons. Smoking toolkit being updated. Nurses can not deliver pharmacotherapy. |
| Increase provision of Stop Smoking Services within primary care                                      | • Increase provision of brief advice training for primary care staff  
• Ensure patients offered pharmacotherapy are also offered referral to SSS | Public Health Primary Care                                                                       | Ongoing work                                      | See metrics sections for activity data. The open-access Stop Smoking Clinic in Park Road surgery has shut due to staff and accommodation issues arising from extended opening hours. |
| Increase Stop Smoking Services in areas with high smoking prevalence                                | Deliver Stop Smoking services within areas identified with a high smoking prevalence (Old Dean and St Michaels) | Public Health                                                                                     | To be confirmed                                   | There is a pharmacy within the Old Dean that is signed up to the smoking PHA. Delivery of specialist clinic within the area is currently an aspirational objective. |
Alcohol

Why is drinking too much alcohol a problem?
Liver problems, high blood pressure, increased risk of various cancers, heart attack and mental health problems are some of the numerous harmful effects of regularly drinking more than the recommended levels. There is also a social cost due to anti-social behaviour, drink driving and domestic violence.

How much is too much?
Men should not regularly drink more than 3-4 units a day and women not more than 2-3 units a day. To find out more about safe drinking levels please visit the Healthy Surrey website

Prevalence of harmful alcohol consumption in Surrey Heath
Surrey Heath hospital admissions for alcohol related conditions have been increasing at a faster rate than the national average and are higher than the regional average.

It has been estimated that the annual cost of harmful alcohol consumption to Surrey Heath Clinical Commissioning Group is nearly £7.3 million.

Evidence of effective prevention
One of the most effective approaches to reducing alcohol harm is to reduce the availability and affordability of alcohol at a national level. However, at a local level the National Institute for Health and Clinical Excellence state that the most effective strategies to reduce alcohol related harm are multi-agency, delivered in partnership and cover the three domains of:

- Prevention and early identification
- Treatment and Recovery (including Integrated Care Pathways for alcohol)
- Safer communities.

Further information on the evidence base for preventing alcohol-related harm is available in the Surrey Substance Misuse Strategy

Current alcohol-misuse prevention and treatment services available in Surrey Heath
Current services range from prevention activities (e.g. awareness campaigns or alcohol education within PSHE curriculum), Tier 1 activities such as early identification and brief advice within primary care, Tier 2 services (more targeted advice and extended brief interventions) through to Tier 3/4 services which are treatment and recovery services for those with more serious alcohol-related problems.
<table>
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<tr>
<th>Objective (what do we want to happen)</th>
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<th>Who will do this (Lead / Organisation)</th>
<th>When will we do this by (Milestones / Timescale)</th>
<th>Current progress</th>
</tr>
</thead>
</table>
| Ensure early identification of alcohol misuse among the general population through delivery of alcohol identification and brief advice (IBA) within primary care | • Promotion of Dry January and implementation of Don’t Bottle it up, a web-based screening tool  
• Interrogate current provision of alcohol Directly Enhanced Scheme to understand activity and make service improvements  
• Develop and implement a new Public Health Agreement for delivery of alcohol IBA in primary care | Public Health / SH CCG / SH BC Primary Care | DES: 2014/15 PHA: 2015/16 | All but two Practices in Surrey Heath are signed up to the DES (Lightwater and Old Dean). So far only 1 practice has submitted data for Q1-Q2 (Frimley Green: 300 assessments) |
| Ensure there is effective management of people who misuse alcohol | • Work with partners on commissioning alcohol liaison services within Frimley Park Hospital  
• Support the development of a care pathway for alcohol-related repeat attenders to FPH A&E  
• Map current pathway for alcohol patients requiring detox and make service improvements | Public Health / SH CCG / Frimley Park Hospital / SABP | AL nurse: 2014/15 Care pathway: 2015/16 Detox pathway: 2015/16 | Hampshire PH and NE Hants and Farnham have both proposed joint funding of alcohol nurse services at Frimley. Surrey PH reviewing alcohol liaison models across Surrey and considering priorities before deciding on local model. |
| To prioritise public health in licensing decisions | Ensure health data (including A&E assault data) is shared with Surrey Heath Community Safety Partnership and used as intelligence in police licensing reviews, representations and targeted community safety activity | Public Health / FPH / SHBC Community Safety Officer | Ongoing activity | The data is regularly uploaded to Surreyi. Feedback from the CSP is that the data is of limited use. Public Health will review the data and information available for licensing decisions. |
| To ensure compliance with law on under-age sales | Mystery shopper programme | SHBC Environmental Health | Ongoing activity | 44 premises tested and 4 failed the test. Fixed penalty fine issued and re-training offered. Follow-up visits planned. |
Healthy weight: Physical Activity

Why is Physical Inactivity a public health problem?

According to the 2013 Global Burden of Disease Study physical activity is the fourth leading cause of death worldwide. There is strong evidence that regular maintained physical activity can alleviate the risk of over twenty chronic conditions including, including coronary heart disease, type 2 diabetes, stroke, mental health problems, musculoskeletal conditions and some cancers (NICE, 2013). It is important to note that increasing physical activity levels can elicit these health benefits irrespective of whether weight loss is present or not.

Recommended levels

Guidance from the Chief Medical Office (CMO) is that adults should undertake 150 minutes of moderate intensity physical activity a week which can be built up in short 10 minute bouts throughout the day. A full breakdown of the guidelines can be found here.

Physical Inactivity in Surrey Heath

![Percentage of people who are physically inactive](chart.png)

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>25%</td>
</tr>
<tr>
<td>Surrey</td>
<td>20%</td>
</tr>
<tr>
<td>Surrey Heath</td>
<td>15%</td>
</tr>
</tbody>
</table>

Source: Active People Survey 2012

Evidence of effective prevention

Evidence suggests that the most significant health benefits will be elicited by an inactive individual doing no physical activity starting to some physical activity, highlighting the importance of working with the least active individuals. There are currently six NICE guidance papers for increasing physical activity, focusing on a range of different settings, these can be found here.

Physical Activity Services in Surrey Heath

6 GP practices are currently signed up to the Exercise Referral Scheme. GPs and Health Professionals refer appropriate patients to a qualified exercise specialist. The specialist devises and delivers a 12 week tailored exercise programme for the patient, at a reduced price.

The Mychett Centre runs a Stroke Clinic and a Cardiac Rehabilitation group.

There are a wide range of exercise and cultural activities available through the Borough Community Centres (list available on request) plus many opportunities for sport and physical activity through the leisure centres and other organisations operating within the Borough.

Building physical activity into everyday lives

The way that our transport systems and buildings are designed can influence the amount of physical activity people have in their daily routine. For example, cycle lanes, green spaces, signage for walking times, stairs etc. Local planning departments can work in partnership with public health professionals to ensure that plans discourage unhealthy behaviours and encourage healthy behaviours.
Why is healthy eating important for public health?

Good nutrition is important to maintain health and in the prevention and management of diet-related conditions such as cardiovascular disease, cancer, diabetes, obesity and malnutrition. Being overweight (BMI >25) or obese (BMI>30) is linked to the diseases outlined above and, in addition, is associated with poorer psychological and emotional health. Whilst diet is of course crucial in prevention and management of obesity, as with physical activity good nutrition is related to is important for the prevention of other conditions such as malnutrition and vitamin D deficiency.

Recommended levels

National dietary recommendations have remained consistent for some years and the Eatwell Plate provides a pictorial representation of the recommended balanced diet for people over 2 years of age.

Healthy eating in Surrey Heath

Evidence of effective ways of improving diet nutrition

There are currently four NICE guidance papers for increasing improving diet and nutrition intake and managing overweight and obesity across the lifespan, focusing on a range of different settings, these can be found here.

Health eating initiatives in Surrey Heath

Specific population groups have been identified as being at greater risk of poor diet and require targeted interventions based on their needs. Partnership working is crucial for developing an environment that enables people to make positive behaviour changes in respect of their food choices. The following community nutrition initiatives involve a range of partners from many sectors and most are targeted at people at greater risk of poor diet.

The HENRY (Health Exercise and Nutrition for the Really Young) programme is available for children under five and their families from groups at high risk of obesity. Families can self-refer or be referred by health and care professionals to HENRY groups or one-to-one sessions run by 0–19 teams and children’s centres. Please visit the Surrey Nurturing Links website for more information.

To eat a healthy diet it is important to be able to cook. Cookery leader training is available (through Surrey Joint Training) for staff and volunteers working with families and other adults in the borough. The trained ‘cookery leaders’ offer cook and eat activities for the people in the groups they work with who need to increase their knowledge and skills.
## Healthy Weight: Action Plan

Health and Wellbeing Outcome: An increased proportion of people in Surrey Heath who are of a healthy weight

<table>
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<th>Objective (what do we want to happen)</th>
<th>Action(s) (what will we do to make it happen)</th>
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<th>When will we do this by (Milestones / Timescale)</th>
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</tr>
</thead>
</table>
| Increase physical activity levels amongst patients identified as inactive or with a condition that would benefit from exercise. | • Explore current referral levels to the EWMRS, Stroke and Cardiac Rehab sessions with the aim of increasing referrals  
• Work with GP practices to improve identification of inactive patients using GPPAQ (a screening tool integrated within the EMIS system)  
• Increase the number of GP practices registered with the Surrey Exercise and Weight Management Referral Scheme (EWMRS). | Public Health / SH CCG / Primary Care/ SHBC Leisure lead | Mar 2015: data exploration  
2015/16: Referral increase and GPPAQ project | New physical activity lead within Public Health Team in post Nov 2014. This post will then take forward work around exercise referral and physical activity in general. |
| Transport and planning processes within Surrey Heath take into account opportunities to increase physical activity | Public Health to identify a key link to provide planning teams with evidence, best practice and support to incorporate prevention into plans | SHBC / Public Health | 2015/16: Public Health advice becomes a core element of planning consideration | PH lead identified SH Transport plans commented on by PH |
| Reduce the number of children entering Reception year of school who are obese or at risk of obesity | Increase referrals to HENRY programme: Signposting information made available in:  
• GP newsletter  
• Children’s Centres  
• Libraries  
• Health visiting services  
• Early Years settings | Public Health / SHCCG and SHBC comms leads | On going activity | Comms plan to be developed |
Section 2: Protection from Harm
Excess Winter Mortality and Morbidity

Why is winter an important public health problem?
Seasonal variations in temperature can seriously affect health and cause death in high risk groups such as the very old, the very young, those with a disability and those living in fuel poverty. Excess winter deaths (an increase in number of deaths over what is normally expected) occur between December and March. The main causes of seasonal illness or death are respiratory and cardiovascular diseases such as influenza, asthma, pneumonia and heart attacks. Indirect effects of cold include mental health illnesses such as depression, and risk of carbon monoxide poisoning if boilers, cooking, and heating appliances are poorly maintained or poorly ventilated. In the recent past, the rate of excess winter deaths in England was twice the rate observed in some northern European countries, such as Finland.

Excess winter deaths in Surrey Heath
Each year, there are on average 28 extra deaths in Surrey Heath during the winter period. The Excess Winter Mortality Index for Surrey Heath is 12.9 which is better than the figure for England as a whole (16.5). The EWM index enables comparisons to be made different areas, and is calculated as the number of excess winter deaths divided by the average non-winter deaths.

Data for 2012 shows that over 2,000 households (6%) in Surrey Heath were in fuel poverty (i.e. they are unable to heat their home at a reasonable cost, given their income). This is lower than the figure for Surrey (7%) and the South East region (8%). However, there are areas of Surrey Heath with Fuel Poverty levels above 10%.

Effective prevention of excess winter mortality
The Public Health England Cold Weather plan recommends a series of steps to reduce the risks to health from cold weather for:
- NHS, local authorities, social Care, and other public agencies
- Professionals working with people at risk
- Individuals, local communities and voluntary groups.

There is a list of National Top Interventions listed in the Surrey JSNA Chapter for Excess Winter Deaths - What works

Current services available in Surrey Heath that help to reduce risk of winter death
- Action Surrey: helping homes and business reduce energy consumption;
- Affordable Warmth: schemes for free energy efficient boiler, loft insulation etc
- One Stop Surrey: an onward signposting and referral process for use by anyone in proximity to the vulnerable individual operated by Age UK Surrey.

Flu Immunisation: increasing uptake of flu and pneumococcal vaccinations among priority groups is important for reducing winter illness. Please see Immunisation section for further details.
### Excess Winter Mortality: Action Plan
Health and Wellbeing Outcome: Reduce the number of excess winter deaths amongst Surrey Heath residents

<table>
<thead>
<tr>
<th>Objective (what do we want to happen)</th>
<th>Action(s) (what will we do to make it happen)</th>
<th>Who will do this (Lead / Organisation)</th>
<th>When will we do this by (Milestones / Timescale)</th>
<th>Current progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve the thermal efficiency of dwellings occupied by vulnerable people</td>
<td>Ensure all social housing meets the decent homes standard, especially in respect to insulation. Investigate how standards of private housing may be improved.</td>
<td>SHBC Housing</td>
<td>To be confirmed</td>
<td>All social housing currently meets decent homes criteria</td>
</tr>
<tr>
<td>Reduce the number of households in fuel poverty</td>
<td>Increase awareness of benefits and entitlements that can increase income and reduce fuel bills (through energy efficient boilers, loft insulation etc).</td>
<td>SHBC</td>
<td>Ongoing activity</td>
<td>The Living and Aging well programme has developed a referral form for One Stop Surrey.</td>
</tr>
<tr>
<td>Targeted reduction of the negatives effects of cold stress (both in and outdoors)</td>
<td>Deliver winter warmer packs to households identified as being occupied by people vulnerable to effects of the cold Develop and deliver wheelie bin hangars giving advice on staying warm and well this winter</td>
<td>SHBC / SHCCG</td>
<td>Winter 2014/15</td>
<td>Bin hangars: Action completed</td>
</tr>
</tbody>
</table>
Immunisation

Why is Immunisation a public health problem?

Immunisation against infectious diseases is one of the most effective ways to protect the population’s health. Maintaining high vaccine coverage is essential to prevent the spread of disease which may lead to more serious complications and death amongst more vulnerable individuals.

Immunisations are given during our childhood years and also throughout life to protect us from seasonal influenza, lifestyle, travel and occupational related infections. Therefore it is essential that the population has access to all required vaccinations to protect themselves and their families.

Recommended levels

A given percentage of the population (95%) needs to have been immunised against a specific disease in order to prevent its spread and outbreaks, this is known as herd immunity.

In Surrey as a whole there is an urgent need to work to improve the overall immunisation coverage and specifically low levels of uptake amongst certain groups such as the Gypsy and Traveller community and in places such as practices and schools where uptake is also known to be lower. Further details of groups where low levels of uptake is more likely is available in the immunisations chapter of the Surrey Joint Strategic Needs Assessment. NICE guidance also provides recommendations on how to reduce the variation in uptake in immunisation programmes.

Immunisation uptake in Surrey Heath

The percentage of children immunised in Surrey as a whole in accordance to the national vaccination and immunisation schedule are lower than regional and national rates. Recent 2014 practice data for Surrey Heath indicates that, for example, the average MMR uptake (first and second dose) was at 82% at age five. While this is an improvement on previous years it is still below the national average of 88% and the target of 95%. Significant variation between practices also suggests efforts should be focused in certain areas and practices.

Another focus alongside the child immunisation programme is the influenza vaccination programme which includes vulnerable groups of all ages. While Surrey Heath perform reasonably well when compared to other local areas, further work is needed to reach the 75% immunisation target particularly in those under 65 who are at risk (see figure 1).

Current Immunisation services available in Surrey Heath

GP practices provide a range of vaccination programmes. Each practice decides how they will operate their immunisation service, for example having immunisation clinics on set days and at set times. Local school nurses and immunisation teams also immunise eligible young people against the national childhood immunisation programme via school based programmes.

The seasonal influenza programme is an annual programme for people aged 65 and over and those in the identified clinical at risk groups. Those who wish to have this vaccine must attend each year to take into account evolving strains of the influenza virus. GP practices organise and plan their own seasonal flu programme for example ordering vaccine in the April of every year. Call and recall of patients is carried out by the practice and is done by sending individual letters or via telephone call.
### Immunisation: Action Plan

**Health and Wellbeing Outcome:** To increase the uptake of immunisations by Surrey Heath Patients

<table>
<thead>
<tr>
<th>Objective (what do we want to happen)</th>
<th>Action(s) (what will we do to make it happen)</th>
<th>Who will do this (Lead / Organisation)</th>
<th>When will we do this by (Milestones / Timescale)</th>
<th>Current progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve data reporting</td>
<td>Encourage practices to report immunisation information to appropriate bodies and identify areas for improvement</td>
<td>NHS Area Team</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Increase provision of immunisation</td>
<td>Work with the area team to support practices falling below the target thresholds to establish plans for improvement</td>
<td>SH CCGArea team</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Increase uptake amongst vulnerable groups</td>
<td>Support awareness of immunisation programmes through the use of local services that already reach vulnerable groups 1) Refuse bin fliers</td>
<td>SHBC / SH CCG</td>
<td>2014/15</td>
<td>Flu imms bin hangars planned for January</td>
</tr>
<tr>
<td>Increase uptake amongst pregnant women</td>
<td>Work with maternity services to ensure that midwives are encouraging pregnant women to receive the seasonal flu vaccine while also raising awareness of the child immunisation programme</td>
<td>Public Health / SH CCG / FPH</td>
<td>2014/15</td>
<td></td>
</tr>
<tr>
<td>Increase uptake amongst frontline health and social care professionals</td>
<td>Review and encourage the consistent vaccination of front line staff in key local organisations</td>
<td>SHBC social care teams / SH CCG / Primary Care</td>
<td>2014/15</td>
<td></td>
</tr>
</tbody>
</table>

**Current progress**
- Blue: Not started (planned)
- Red: Poor progress/failed
- Amber: Progress as planned
- Green: Successfully completed
Unintentional Injuries (falls)

Why are unintentional injuries a public health problem?

Unintentional injuries are defined as predictable and preventable injuries and associated events. It is estimated that unintentional injuries account for approximately 13% of emergency admissions and 4.5% of all Surrey hospital admissions. Most unintentional injury hospital admissions are for falls, followed by injuries on the roads. Smoke, fire and flames, drowning and poisoning injuries also result in admissions to hospital but are less common.

Over half of all hospital admissions for unintentional injuries are adults over 65 years of age, and out of those aged under 65, children aged four years and under are the most likely age group to be admitted to hospital. Children whose parents are long-term unemployed are 13 times more likely to die from an unintentional injury compared to children whose parents are in higher managerial or professional occupations. This social gradient is particularly steep in relation to deaths caused by household fires, cycling and walking.

Evidence of effective prevention

It costs £349 per person to put a person through a falls prevention programme, yet the average cost of hospital treatment per fall is £3,320 (A Health and Wellbeing Framework for England – PHE). The National Institute for Health and Care Excellence has published guidance on assessment and prevention of falls in older people which identified recommended programmes.

Prevalence of Unintentional Injuries in Surrey Heath

Surrey Heath has lower rates of unintentional injuries in children and young people when compared to other areas but the gradient in rates of unintentional injuries between socio-economic groups must be considered i.e the rate is likely to be higher in areas of deprivation.

In contrast, the number of falls in over 65s is particularly high in Surrey Heath which had the highest rate of emergency hospital admissions due to falls injuries in Surrey in 2012/13 at 2573 per 100,000 population. Data from this same year suggests the numbers of falls in those over 80 are also particularly high when compared to other local areas.

Current services to prevent unintentional injuries available in Surrey Heath

Falls services in Surrey are provided in hospitals and in the community and there is a Surrey-wide falls group which aims to reduce falls in the county.

Surrey Drive SMART road safety and antisocial driving strategy is a joint strategy between Surrey County Council (including Surrey Fire and Rescue) and Surrey Police which aims to tackle anti-social driving and reduce unintentional road injuries.

Surrey Fire and Rescue Service offer a wide range of services to prevent unintentional injuries due to fire as well as the partnership work for road safety. These include: targeted educational work with children and young people; targeted work for adults most at risk from fire injury; and offering support to all residents by providing home assessments and adjustments as appropriate.

When a child under 5 years of age attends A&E, local health visitors are informed. They subsequently work with families to reduce the risk of injury by providing guidance, raising awareness of risk and promoting the use of safety equipment e.g. stair gates.
<table>
<thead>
<tr>
<th>Objective (what do we want to happen)</th>
<th>Action(s) (what will we do to make it happen)</th>
<th>Who will do this (Lead / Organisation)</th>
<th>When will we do this by (Milestones / Timescale)</th>
<th>Current progress (Nov 2014)</th>
</tr>
</thead>
</table>
| Prevent and reduce the impact of falls | Complete Unintentional Injury Needs assessment  
Mapping of current falls services and falls prevention | Surrey PH | March 2015 |  |
| | Further development of Thirst for Life  Train the Trainer programme for roll out to front-line staff working with frail elderly | Surrey PH | Development of programme: Mar 2015  
Roll-out: 2015/16 |  |
| | Increase referrals of older people to Exercise Referral Scheme.  
Leisure providers to support Older People Exercise Referral qualification  
Increase provision of Strength and Balance exercise programmes | Primary Care Surrey Heath Leisure providers SH CCG | 2015/16 |  |
| | Incorporate primary prevention into the Frimley Park Falls Pathway (i.e. Exercise, hydration and nutrition, alcohol awareness) | Surrey PH | 2015/16 |  |
Domestic Abuse

Why is Domestic Abuse a public health problem?

Domestic Abuse is associated with an increased risk of physical injury, increased substance misuse, mental health problems, self harm and sometimes death.

Prevalence of Domestic Abuse in Surrey Heath

There is limited data available on the prevalence of domestic abuse and there is a significant issue with under-reporting. The Crime Survey for England and Wales reports that 7.3% of women aged 16-59 years have experienced DA. Applying these rates to the relevant population of Surrey Heath indicates that there could be over 6,000 women in the area who have experienced DA. Data from Surrey Adult Social Care indicates that 22% of safeguarding referrals for over 65s were initiated because of alleged abuse committed by a partner or family member.

In July 2012 to June 2013 there were 968 DA incidents reported to police (Surrey Single Strategic Assessment: Priorities for 2014-17). In 2013/2014 there were 182 referrals from the Surrey Heath area to local domestic abuse outreach services. These figures show that of the DA incidents reported to police (which in themselves are likely to be under-reported), only a small proportion are referred to DA services.

Multi-Agency Risk Assessment Conferences (MARACs) are regular local meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. The MARAC for Surrey Heath and Woking reported that in 2013/14 they considered 133 cases, 51 of which were repeat cases. There were 137 children associated with these cases.

Evidence of effective prevention

There is published NICE Guidance (PH50) on how health services, social care and the organisations they work with can respond effectively to the needs of those suffering from domestic abuse.

Current Domestic Abuse services available in Surrey Heath

The Your Sanctuary Domestic Abuse Outreach service covers Woking, Runnymede and Surrey Heath

Your Sanctuary also run a Surrey wide 24 hour helpline 01483 776822
# Domestic Abuse: Action Plan

**Health and Wellbeing Outcome:** To reduce the incidence and impact of domestic abuse

<table>
<thead>
<tr>
<th>Objective (what do we want to happen)</th>
<th>Action(s) (what will we do to make it happen)</th>
<th>Who will do this (Lead / Organisation)</th>
<th>When will we do this by (Milestones / Timescale)</th>
<th>Current progress (Nov 2014)</th>
</tr>
</thead>
</table>
| Increase co-ordination between organisations who deal with domestic abuse | • All relevant service providers to be signed up to the Multi Agency Sharing Protocol  
• All prevention plan partners to be members of the Surrey Heath Partnership (community safety)  
• Ensure health representation on the Surrey Heath MARAC | SH CCG / SHBC / Public Health | March 2015 | Surrey Child Safeguarding lead for health subgroup is considering suitable health representation to the MARAC. |
| Increase referrals into DA outreach services by improving health professionals understanding of DA | Make DA awareness training available to frontline health and social care professionals | Surrey Domestic Abuse Development Group | 2015/16 | DA awareness training is available generally through Surrey Joint Training. DA group to consider incorporating training into GP education programme |
| Improve identification of DA within primary care | Commission the IRIS (Identification and Referral to Improve Safety) programme | SH CCG / Surrey Domestic Abuse service commissioners | To be confirmed | Action yet to be planned |
| Increase referrals into DA outreach services for members of the Gypsy, Roma and Traveller community | Commission Domestic Violence Advisor time to work with primary care and the GRT community | SH CCG / Surrey Domestic Abuse service commissioners | To be confirmed | Action yet to be planned |
**Why is self-care important?**

In the past, patients have had very little opportunity to safely self-manage their long-term but stable medical conditions at home. Consequently, the patient has had to be managed within the healthcare system, requiring travel to hospital or local provider creating further dependency on the system. However, new technologies, Telehealth and Telecare, are providing safe home-based services that allow the patient to monitor their condition themselves and have technologies that support them to keep well in their own home.

In many cases, the patient will have carer support, to aid a holistic approach to patient care in Surrey Heath, carer health and support is recognised as being essential to the wellbeing of the carer and patient.

**Available programmes to support self-care**

**Telehealth** – The patient puts their daily or weekly health information into a hand held device, this information is monitored by the provider’s clinical staff and clinical decisions are made to ensure the patient remains at optimal health. In the event of sub-optimal health, the patient is flagged to their GP for remedial action to ensure only appropriate admissions to hospital are made.

**Telecare** – The patient is provided with a number of self-care technologies from personal alarm, falls detectors, motion detectors, house temperature detector, medication reminder, hydration reminders etc. This allows a patient who wants to remain in their own home to have the technical support and response centre monitoring to ensure the patient is safe and to alert social care if the technology indicates a problem.

**Carer Support** – The carer is provided with an opportunity to register as a carer with their GP to ensure their health needs are managed appropriately, they can also apply for carers’ breaks via Action for Carers.

**Current services to support self-care available in Surrey Heath**

The Telehealth and Telecare projects are led by Surrey County Council. The Telehealth project provider is Medvivo. People with stable medical conditions (Currently COPD and HF) can be referred by their GP, Community Heart Failure or Respiratory Team to Telehealth so that they can remain in their own home with remote care monitoring. The Telehealth project allows for up to 200 patients between 2014 and 2016 to be referred into the remote care monitoring service.

The Telecare project is currently partly delivered via the borough council and is under review. The outcome of the review is likely to recommend a procuring the service as a Surrey wide contract to deliver technology based support e.g. medication reminder, falls or movement detection and alarms etc. on a means tested basis across Surrey. They also work with Accent Peerless to provide sheltered housing across the borough.

The Carers Support Service is provided via Action for Carers who manage and award the carers breaks requests. Carers register with their GPs.

Surrey County Councils Housing - Related Support Services also provide support to disabilities, Homeless and Socially excluded Groups.

The CCG will also promote NHS Self Care Week in November this year (17th to 23rd November) to encourage people to be healthy this winter.
## Self-care: Action Plan

**Health and Wellbeing Outcome:** To increase the number of people able to live independently in their own home

<table>
<thead>
<tr>
<th>Objective (what do we want to happen)</th>
<th>Action(s) (what will we do to make it happen)</th>
<th>Who will do this (Lead / Organisation)</th>
<th>When will we do this by (Milestones / Timescale)</th>
<th>Current progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the number of patients receiving telehealth</td>
<td>Identify new patients via GPs and community respiratory and heart failure teams suitable for assessment for Telehealth</td>
<td>SH CCG</td>
<td>2014/15</td>
<td>Currently 23 patients out of an identified 44 receiving telehealth</td>
</tr>
<tr>
<td>Ensure that Surrey Heath patients have access to Telecare</td>
<td>Work with SCC Telecare lead to deliver the review and procurement of Telecare for the Surrey Heath area</td>
<td>SH CCG / SHBC</td>
<td>Mar 2015: procurement plan From Apr 2015: implementation plan to be developed</td>
<td>Part of larger review of equipment and adaptations within the Surrey Joint Telecare Strategy</td>
</tr>
<tr>
<td>Increase support to Carers</td>
<td>Support the identification and registration of carers to meet the Surrey Heath target of ?%</td>
<td>SH CCG</td>
<td>To be confirmed</td>
<td>Part of Commissioning Incentive scheme</td>
</tr>
</tbody>
</table>
Information and advice

The Community Connector role is part of the Diocese of Guildford Communities Engagement Team. The role:

• Builds relationships with the voluntary, community and faith based groups as well as statutory health and social care providers and commissioners in Surrey Heath.

• Explores and notes the services and activities available for vulnerable people across the Surrey Heath building on existing information in order that there is a shared understanding across all organisations and groups of what support is available.

• Facilitates and promotes the exchange of information, between voluntary, community, faith and statutory sectors for the people of Surrey Heath.

• Engages statutory health and social care services to introduce them to the wider perspective of what is happening in communities and to promote the opportunities presented in the parishes and wards of Surrey Heath.

• Has a view to good practice and successful models in other locations within Surrey and across county borders.

The Social Care Development Co-ordinator for Surrey Heath, works alongside the Community Connector to provide support to front-line practitioners by taking responsibility for identifying, developing and organising services to support people in a particular locality or geographical area.

Surrey Heath CCG has recognised the value of social prescribing in their planning toward Integrated Care. The CCG is developing a proposal to offer a single point of access programme whereby patients and carers with physical, mental health or social care needs can be referred to community and voluntary groups who are well placed to address the wider relational and practical needs of the individual, carer or family. The programme will be co-ordinated by Community Voluntary Support liaison officers from Voluntary Support North Surrey (Surrey Heath team).

Surrey Heath CCG also commission several voluntary including Outline (support for the Gay, Lesbian, bi-sexual and trans-gender community), Headway (support for people following brain injury) and the Stroke Association (support for people following stroke).

Neighbourhood hubs: The Community Connector is engaged with local communities to provide neighbourhood contact points or ‘hubs’. To begin with, the Lightwater village community have assembled representatives of the majority of village social and activity groups, including representation from the parish council, the business association, the PPG and the church. Together they have determined to start a contact point in the village centre and the group would be called Lightwater Care Network. This initiative has found support and encouragement from Adult Social Care commissioners and project leaders and from the CCG.

Active and supportive communities

Befriending and Visiting: The Community Connector has been involved in the development of the Befriending for Dementia pilot in the Heatherside ward of Camberley. This is joint working between SHBC, SHCCG and Adult Social Care, with a major charity being considered for conducting the pilot. It is hoped that other groups will be able to replicate the work in other wards and parishes. This is a project also being followed by the community matrons and the parish nurses. Volunteers have been sourced by the CC from the local WI groups and a range of other local groups have shown interest, awaiting the start of the pilot in the last quarter of 2014.

The CC has facilitated relationships in Chobham village which will support befriending. Crossroads Care and local leaders now have a plan to start a social group for the cared-for, whilst providing respite for the carers. Discussions are continuing with the local church in order to provide the best venue and preparations for the group.
Section 3: Active and Supportive Communities

Community Asset Mapping: Community Connectors identify, map and share with other organisations information on services and activities to ensure appropriate support can be offered to people in a timely way. As part of the role in Surrey Heath, the CC has sourced activities, support and services that are offered to older and vulnerable people and has begun to identify potential “community champions” within communities.

Groups such as the Lightwater Care Network with their village contact point will themselves be engaged in mapping the local resources. It is clear that there is a high level of professional acumen and experience of caring within the community. The CC suggests that discussion around asset mapping can be useful, possible approaches weighed up, but it will be for the community themselves to decide what they are comfortable doing. In Lightwater a number of representatives of the active groups have knowledge of the village over 30 or 40+ years and between them have a wealth of information that guides any approach to mapping.

Dementia Friendly: A dementia friendly community has been describe as one that enables those with the condition to:

- Find their way about and be safe
- Access the local facilities that they are used to and where they are known, such as banks, shops, cafes, cinemas and post offices
- Maintain their social networks so they feel they continue to belong

SHBC to provide a brief summary of Dementia Friendly activity within Surrey Heath

Reducing stigma and discrimination for those with mental illness

Mental health problems are common - but nearly nine out of ten people who experience them say they face stigma and discrimination as a result. This can be even worse than the symptoms themselves. Fear of discrimination can lead to delay in seeking help, prolonged or increased severity of the condition and poor treatment adherence. The impact of mental health stigma and discrimination on important life areas e.g. people’s dignity, social status, employment opportunities or job security, marriage, family relationships and friendships can be devastating.

Time to change Surrey is a local programme of work supporting the aims of the national time to change campaign to reduce stigma and discrimination around mental health. Following a pilot project in East Surrey, it is now proposed to roll out the programme to the rest of the county. This will include training for front line professionals (including primary care), mental health ambassadors and drama events, all co-ordinated by appointed voluntary sector staff.

Action plan

Surrey County Council are looking to establish local partnership forums focusing on these community activities in each Borough and District, or to build on existing forums if appropriate. These forums will bring together ASC (front line staff and commissioners), Public Health, CSF, Borough Council, CCG, CVS and other local partners. Once such a forum is established for Surrey Heath, the group can develop an action plan around developing and improving the activities described in this section.

Update November 2014: The first Local Partnership Forum will meet on November 25th. Surrey Public Health, SH CCG and SHBC will be represented.
## Appendix 1: Metrics

<table>
<thead>
<tr>
<th>Public Health Topic</th>
<th>Indicator</th>
<th>Latest Reporting Period</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Number of people seen by health improvement worker (alcohol) in Frimley Park Hospital</td>
<td>805 patients screened (307 Surrey)</td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>Number of GP practices signed up to Alcohol DES</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>Number of patients screened</td>
<td>300 (Qtr1-2)</td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td>Number of practices signed up to deliver Stop Smoking Services</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td>Number of pharmacies signed up to deliver Stop Smoking Services</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td>Number of quit date set</td>
<td>15 (qtr 1)</td>
<td>Quarterly average for 2013/14: 46</td>
</tr>
<tr>
<td>Smoking</td>
<td>Number of quits</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td>Target:</td>
<td></td>
<td>5% of smoking population</td>
</tr>
<tr>
<td>Healthchecks</td>
<td>Number of practices signed up to deliver NHS Healthchecks</td>
<td>9 (3 delivering)</td>
<td></td>
</tr>
<tr>
<td>Healthchecks</td>
<td>Number of pharmacies signed up to deliver NHS Healthchecks</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Healthchecks</td>
<td>NHS Health Checks Offered</td>
<td>Not available</td>
<td></td>
</tr>
<tr>
<td>Healthchecks</td>
<td>NHS Health Checks Delivered</td>
<td>309 (GP only, Qtr1-2)</td>
<td>Improvement</td>
</tr>
<tr>
<td>Healthchecks</td>
<td>Target</td>
<td></td>
<td>20% of eligible population</td>
</tr>
<tr>
<td>Healthy Weight</td>
<td>Number of families referred to HENRY</td>
<td>Not available</td>
<td></td>
</tr>
<tr>
<td>Healthy Weight</td>
<td>Number of GP practices signed up to Exercise Referral Scheme</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Healthy Weight</td>
<td>Number of referrals to Exercise Referral Providers</td>
<td>Not available</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 2: The Health and Wellbeing Needs of Surrey Heath

The weblinks below lead to a range of datasets relating to the health-related needs of Surrey Heath. The list will be updated as new sources of data become available.

<table>
<thead>
<tr>
<th>Weblink Description</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>National General Practice Profiles</td>
<td><a href="http://fingertips.phe.org.uk/PROFILE/GENERAL-PRACTICE">http://fingertips.phe.org.uk/PROFILE/GENERAL-PRACTICE</a></td>
</tr>
<tr>
<td>Local Alcohol Profiles</td>
<td><a href="http://www.lape.org.uk">http://www.lape.org.uk</a></td>
</tr>
<tr>
<td>Local Tobacco Profiles</td>
<td><a href="http://www.tobaccoprofiles.info/">http://www.tobaccoprofiles.info/</a></td>
</tr>
</tbody>
</table>

### Appendix 3: Reporting process for Surrey Heath Prevention Plan

The Prevention Plan will be updated on a quarterly basis with the following timelines:

- **6 weeks prior to HWB:** Catherine Croucher to request update from those leading on each action (with two week deadline)
- **4 weeks prior to HWB:** CC to incorporate updates
- **1 week prior to HWB:** Updated Prevention Plan circulated to HWB membership with Quarterly Highlight Report.

Annual Review: All objectives within Prevention Plan reviewed alongside outcome data.

*Reporting responsibilities table to be added.*