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

Update: March 2015

Surrey Heath
Clinical Commissioning Group

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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

The Determinants of Health (1992) Dahlgren and Whitehead

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.

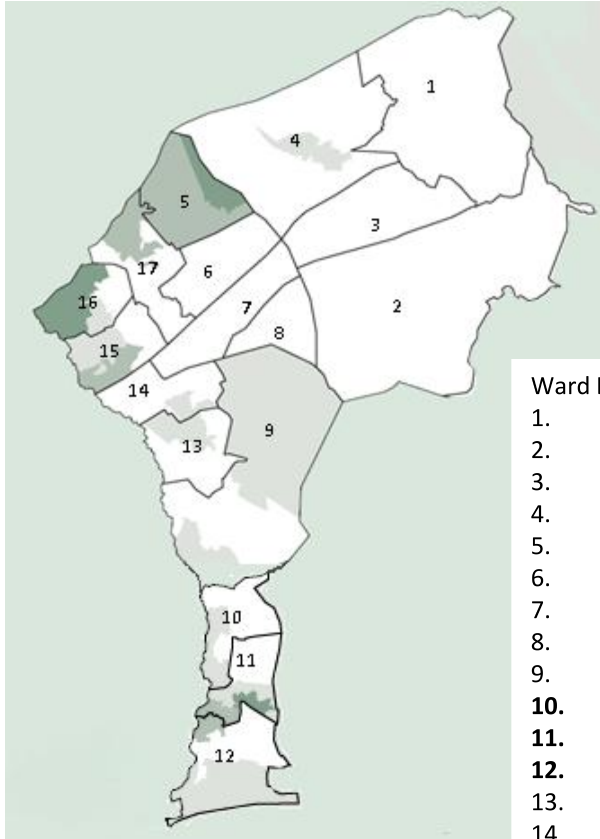
The priorities within the plan have been chosen based on assessment of the health and wellbeing needs of the Surrey Heath population. Further information on these needs is given in the appendices of this document (list of resources to be provided).

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.

Surrey Heath: Geography

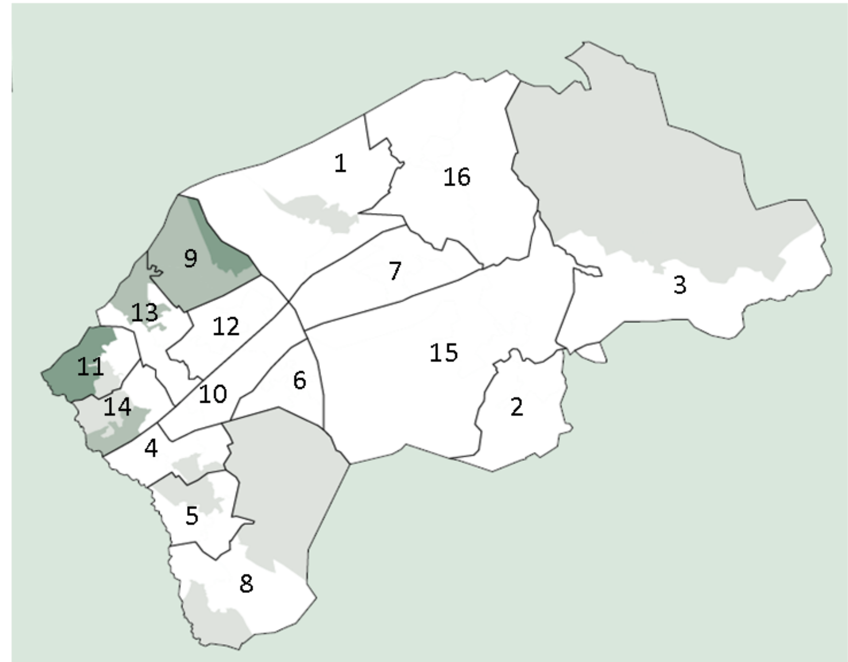
There are boundary differences between Surrey Heath CCG and Surrey Borough Council. The maps below indicate these differences (ward names in bold indicate differences)

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. Mythcett 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



Ward legend: 1. Bagshot 2. Bisley 3. **Chobham** 4. Frimley 5. Frimley Green 6. Heatherside 7. Lightwater 8. Mytchett and Deepcut 9. Old Dean 10. Parkside 11. St Michael's 12. St Paul's 13. Town 14. Watchetts 15. West End 16. Windlesham

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

Healthy Work places

The Workplace Wellbeing Charter 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.

Surrey Public Health and Surrey Heath Borough Council are represented on the Surrey Workplace Wellbeing Charter implementation group.

NHS Healthchecks

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.

The NHS Healthcheck is currently available in three pharmacies and three GP practices within Surrey Heath (including Touchwood 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).

Primary Care

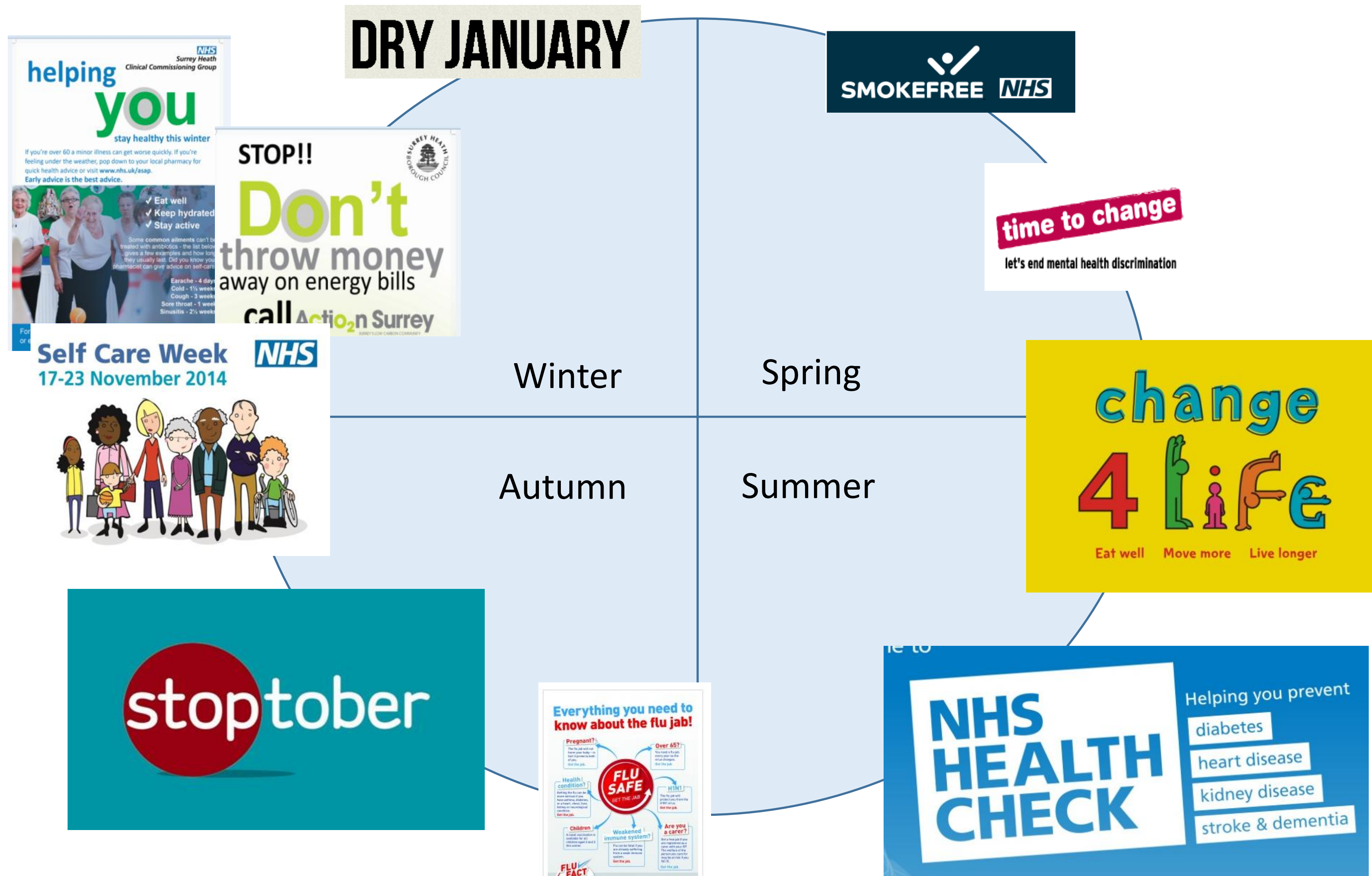
Primary care health professionals, including GPs, practice nurses, and pharmacists have many opportunities to offer brief interventions to support behaviour change, such as smoking cessation or reducing alcohol consumption. They encounter patients at times when they may be open to change – before an 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:

- Delivering NHS Health Checks
- Delivering and referring to Smoking Cessation
- Alcohol misuse Early Identification and brief advice
- Identifying physical inactivity and obesity
- Delivering immunisations
- Identification of domestic abuse
- Early identification of mental health issues including suicide risk and self-harm
- Falls prevention
- Self-care and Carer’s health

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.

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 . Some of the minor campaigns supported within Surrey Heath are also shown below.



Cross cutting services: Action Plan 1

Cross-cutting area	Action(s)	Who will do this (Lead / Organisation)	When will we do this by (Milestones / Timescale)	Current progress (Nov 2014)
PSHE / School Nursing	Ensure that teachers and school nurses have access to health improvement training including the Drug and Alcohol toolkit, Smoking toolkit and healthy weight information.	Public Health / Education Area Officer / Providers (Babcock4S & Virgin Care)	Ongoing activity	Currently all secondary schools in Surrey Heath (except Portesbury) have received the Drug and Alcohol and Smoking toolkits. All schools will participate in the Health Related Behaviour Questionnaire in 2015.
Workplace Health	Support businesses within Collectively Camberley Business Improvement District to achieve the Workplace Health Charter. Combine with pilot project for delivering NHS Healthchecks in workplaces.	Public Health / SHBC / CC BID	Achieve Charter: 2015/16 Develop NHS Healthcheck pilot: 2015/16	The Workplace Health Charter team are preparing for presentation of the programme to Collectively Camberley. A controlled roll-out of Healthchecks would need to stay in line with HC delivery capacity
Increase the number of NHS Healthchecks offered and delivered	Support GP practices and pharmacies with training, documentation, POC testing equipment and guidance. Deliver workplace and targeted community healthchecks. Deliver communications campaign	Public Health / Primary Care / SHBC	HC delivery: Ongoing activity Campaign: summer 2015	*See metrics section*
Health Improvement Campaigns	Use guidance available from Surrey Health and Wellbeing Communications Group toolkit and meetings to support campaigns including Healthchecks, Stoptober and Change4Life.	SHBC and SH CCG Communications leads	Ongoing activity	The Stoptober and Self-Care week campaigns have been supported locally.
Primary Care	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.	SHCCG and Public Health	Meeting dates to be confirmed	Proposal: Public Health lead to present Prevention Plan at May Governing Body. A n engagement programme with practice nurses, managers and GPs to be planned after this.

Section 1: Healthy Lifestyles

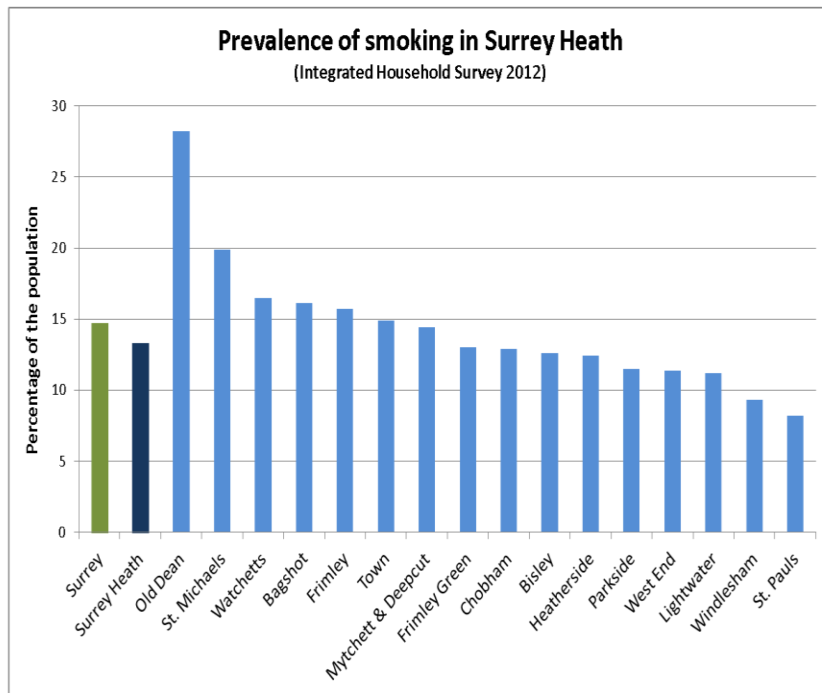
Smoking

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 yeas by 2025.

Smoking in Surrey Heath



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

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

Objective (what do we want to happen)	Action(s) (what will we do to make it happen)	Who will do this (Lead / Organisation)	When will we do this by (Milestones / Timescale)	Current progress (Nov 2014)
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 has been 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.
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?

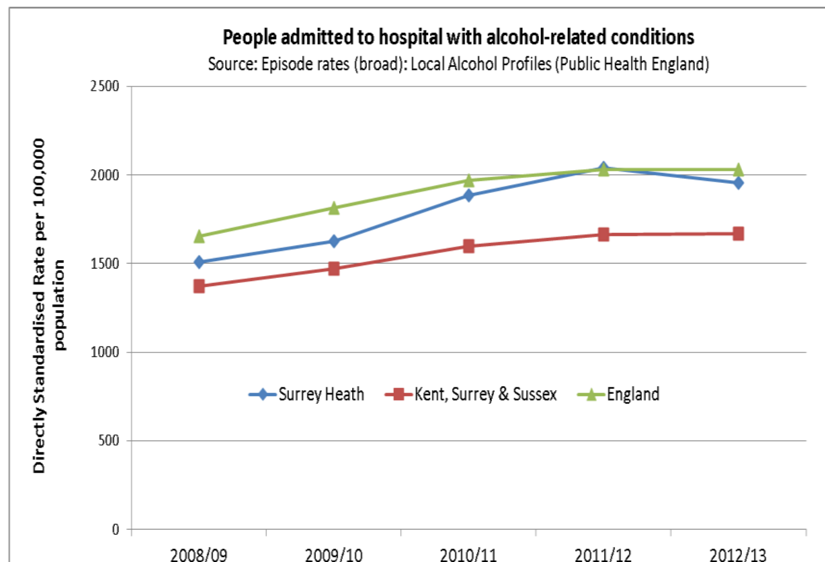
Liver problems, high blood pressure, increased risk of various cancers, heart attack and mental health problems are some of the numerous harmful effects of regularly drinking more than the recommended levels. There is also a social cost due to anti-social behaviour, drink driving and domestic violence.

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.

Alcohol: Action Plan

Health and Wellbeing Outcome: A reduction in alcohol-related hospital admissions for Surrey Heath

Objective (what do we want to happen)	Action(s) (what will we do to make it happen)	Who will do this (Lead / Organisation)	When will we do this by (Milestones / Timescale)	Current progress
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	See metrics section. Quarter 3 data requested from NHS England. Primary care IBA Pubilc Health Agreement is currently a pilot in East Surrey. Dry January campaign delivered by Surrey Heath CCG and Surrey Public Health.
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 and Surrey PH and NE Hants and Farnham and Surrey Heath CCGs have agreed to jointly fund a 6 month alcohol intervention pilot at FPH (due to start March 2015). The results will inform how to implement integrated identification, treatment are referral for alcohol misuse within the Frimley system.
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	Public Health producing an options appraisal on data and capacity needed to implement a licensing toolkit to support police licensing reviews. FPH A&E assault data group to become a broader groups looking at alcohol related violence and domestic abuse. SHBC to Chair this group.

Healthy weight: Physical Activity

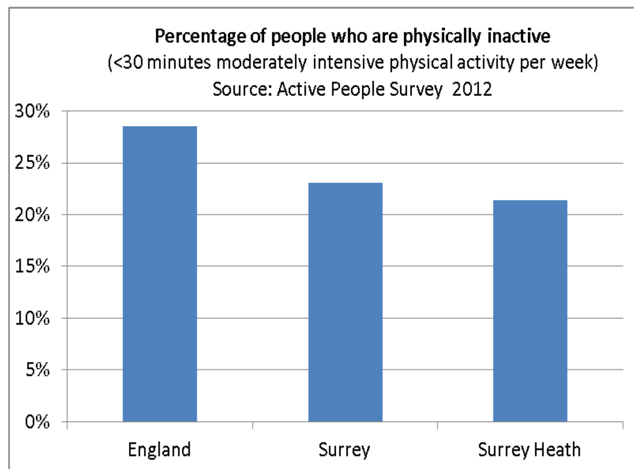
Why is Physical Inactivity a public health problem?

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.

The cost of physical inactivity in Surrey Heath is estimated to be £1.35 million per year.

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



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.

Healthy weight: Diet

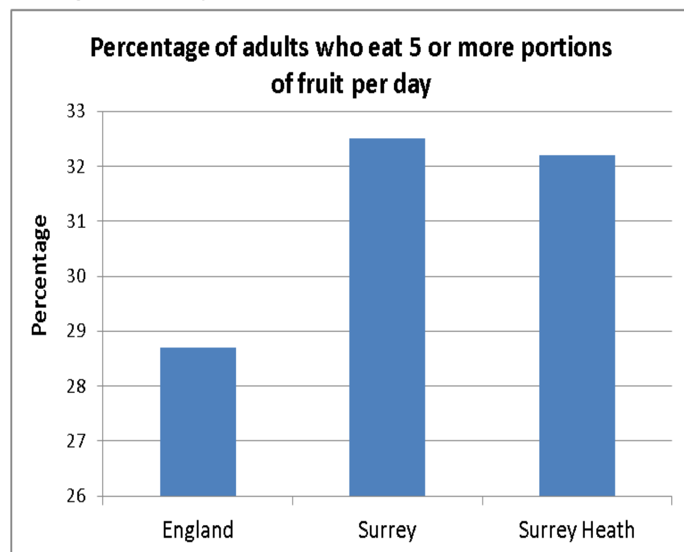
Why is healthy eating important for public health?

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 over weight (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

Objective (what do we want to happen)	**Action(s) (what will we do to make it happen)**	**Who will do this (Lead / Organisation)**	**When will we do this by (Milestones / Timescale)**	**Current progress**
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
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 •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	Public Health lead for physical activity is setting up a Surrey-wide network for PA/Sport leads within Borough Councils. SHBC lead linked in to this work. SH CCG, SHBC and Public Health to meet to discuss the Exercise on Referral scheme.
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	PH lead identified and linked SH Transport plans commented on by PH
Increase opportunity for physical activity	Develop plans for increasing physical activity including a cycling strategy, development of the Walking for Health Scheme, PPP projects and use of green spaces	Public Health/SHBC		Physical activity plans to be reviewed as part of Surrey network described in first objective. Public Health are working with Surrey Nature Partnership on the use of green spaces to promote health. Windle Valley Youth Project have developed the Doorstep Sports programme

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 through the implementation and installation of energy reducing works and advice via the various grants and offers available from the Government and energy companies.

The Flexible Grant from Surrey Heath Borough Council is available to qualifying residents to help with installation costs of works such as new doors and windows.

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

Objective (what do we want to happen)	Action(s) (what will we do to make it happen)	Who will do this (Lead / Organisation)	When will we do this by (Milestones / Timescale)	Current progress
Improve the thermal efficiency of dwellings occupied by vulnerable people	Ensure all social housing meets the decent homes standard, especially in respect to insulation. Investigate how standards of private housing may be improved. All single walled properties adjacent to roads identified and contacted to offer financial help with wall insulation	SHBC Environmental Health	Completed Winder 2015	All social housing currently meets decent homes criteria
Reduce the number of households in fuel poverty	Increase awareness of benefits and entitlements that can increase income and reduce fuel bills (through energy efficient boilers, loft insulation etc).	SHBC	Ongoing activity	The Living and Aging well programme has developed a referral form for One Stop Surrey.
Targeted reduction of the negatives effects of cold stress (both in and outdoors)	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 Provide information to the public, GPs and Social Care Professionals on Cold Weather Advice	SHBC Environmental Health Surrey Public Health/ NHS England	January 2015	Completed January 2015

Immunisation

Why is Immunisation a public health problem?

Immunisation against infectious diseases is one of the most effective ways to protect the populations' health. Maintaining high vaccine coverage is essential to prevent the spread of disease which may lead to more serious compilations 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

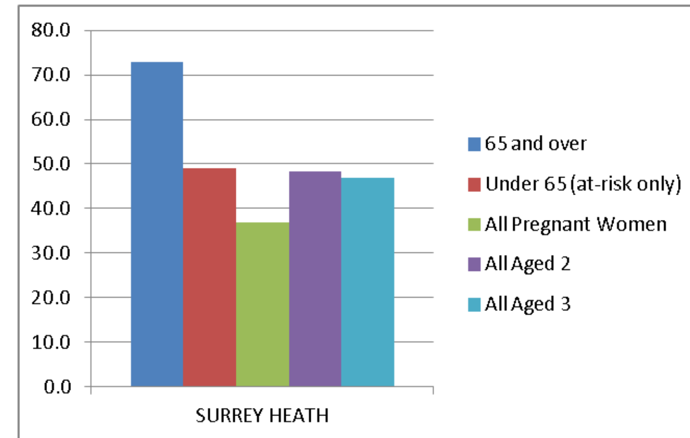
A given percentage of the population (95%) needs to have been immunised against a specific disease in order to prevent its spread and outbreaks, this is known as herd immunity.

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 Health 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

Objective (what do we want to happen)	Action(s) (what will we do to make it happen)	Who will do this (Lead / Organisation)	When will we do this by (Milestones / Timescale)	Current progress Blue: Not started (planned) Red: Poor progress/failed Amber: Progress as planned Green: Successfully completed
Improve data reporting	Encourage practices to report immunisation information to appropriate bodies and identify areas for improvement	NHS Area Team	Ongoing	The Local Area Team who commission this service believe that vaccination coverage is low due to recording issues. They are in the process of piloting a data extraction tool, which they believe will give a truer picture of immunisation uptake in Surrey.
Increase provision of immunisation	Work with the area team to support practices falling below the target thresholds to establish plans for improvement.	SH CCGArea team	Ongoing	Information and data on imms uptake included in CCG update for GP practices.
Increase uptake amongst vulnerable groups	Support awareness of immunisation programmes through the use of local services that already reach vulnerable groups 1) Refuse bin fliers	SHBC / SH CCG	2014/15	Completed Jan 2015
Increase uptake amongst pregnant women	Work with maternity services to increase uptake (flu for pregnant women and childhood imms)	Public Health / SH CCG / FPH	Ongoing	
Increase uptake amongst frontline health and social care professionals	Review and encourage the consistent vaccination of front line staff in key local organisations	SHBC social care teams / SH CCG / Primary Care	Ongoing	Healthcare staff uptake this year was very low across Surrey. Plans for increasing uptake next winter to be developed.

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.

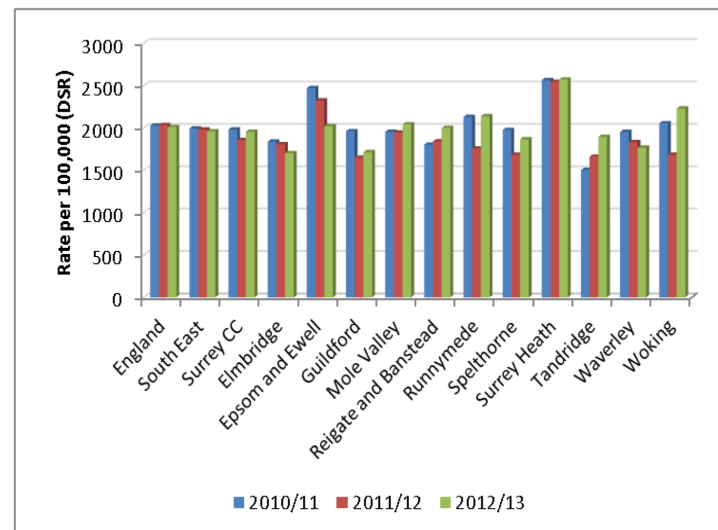
Evidence of effective prevention

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.

Unintentional Injuries (falls) : Action Plan

Health and Wellbeing Outcome: Reduce the number of Surrey Heath residents experiencing falls

Objective (what do we want to happen)	Action(s) (what will we do to make it happen)	Who will do this (Lead / Organisation)	When will we do this by (Milestones / Timescale)	Current progress (Nov 2014)
Prevent and reduce the impact of falls	Complete Unintentional Injury Needs assessment Mapping of current falls services and falls prevention	Surrey PH	March 2015	UI Needs Assessment Falls section complete (apart from falls service mapping section).
	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	This is dependent on the service mapping above as we don't wish to duplicate any existing hydration training being delivered.
	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	Investigate funding of training qualification S&B programmes depends on service mapping
	Incorporate primary prevention into the Frimley Park Falls Pathway (i.e. Exercise, hydration and nutrition, alcohol awareness)	Surrey PH	2015/16	Pathway received by PH. Meeting with NEH&F falls prevention lead booked to discuss primary prevention

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 for2014-17). 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

Objective (what do we want to happen)	Action(s) (what will we do to make it happen)	Who will do this (Lead / Organisation)	When will we do this by (Milestones / Timescale)	Current progress (Nov 2014)
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 front line 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

Self-care

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 allows for 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

Objective (what do we want to happen)	Action(s) (what will we do to make it happen)	Who will do this (Lead / Organisation)	When will we do this by (Milestones / Timescale)	Current progress Blue: Not started (planned) Red: Poor progress/failed Amber: Progress as planned Green: Successfully completed
Increase the number of patients receiving telehealth	Identify new patients via GPs and community respiratory and heart failure teams suitable for assessment for Telehealth	SH CCG	2014/15	Currently 23 patients out of an identified 44 receiving telehealth (March 2015 update has been requested)
Ensure that Surrey Heath patients have access to Telecare	Work with SCC Telecare lead to deliver the review and procurement of Telecare for the Surrey Heath area	SH CCG / SHBC	Mar 2015: procurement plan From Apr 2015: implementation plan to be developed	Part of larger review of equipment and adaptations within the Surrey Joint Telecare Strategy
Increase support to Carers	Support the identification and registration of carers to meet the Surrey Heath target of ?%	SH CCG	To be confirmed	This work is part of the Commissioning Incentive scheme. A meeting of Carer's organisations has been planned to look at how to increase effectiveness of support to Carers

Section 3: Active and Supportive Communities 1

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 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-ordinators** 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 are manning a contact point in the village centre and the group would be called Lightwater Information centre for Vulnerable and Elderly (LIVE). This initiative has found support and encouragement from Adult Social Care commissioners and project leaders, and from the CCG. 'LIVE' will access Surrey Information Point and signpost to appropriate agencies. They will also provide contact with very local neighbourhood helps. This approach of providing information through neighbourhood groups also lays a foundation for effective Timebanking arrangements.

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 AgeUK Surrey managing the pilot. It is hoped that other groups will be able to replicate the the work in other wards and parishes on a long-term sustainable basis. This is a project also being followed by the community matrons and the parish nurses.

The CC has facilitated relationships in Chobham village which will support befriending. Crossroads Care and local leaders have started a social group for the cared-for, whilst providing respite for the carers.

Section 3: Active and Supportive Communities 2

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 Lightwater 'LIVE' with their village contact point will themselves engage 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 described 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

Dementia Friendly activity within Surrey Heath includes the following:

- Dementia Friends Training available through the Borough Council
- Windle Valley Wellbeing Centre in Bagshot provides a variety of sessions, advice and activities for those living with dementia and their carers
- Saturday Club at Windle Valley Centre caters for those living with dementia and their carers
- Camberley Alzheimer Café opened in September 2014 and meets monthly

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 a 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.

Appendix 1: Metrics

Public Health Topic	Indicator	Latest Reporting Period	Progress
Alcohol	Alcohol Education and Brief Advice Initiative (AEBAI) in Frimley Park Hospital	2014/15 Q3: 2566 patients screened (1060 Surrey)	Activity in line with normal quarterly performance
	Number of GP practices signed up to Alcohol DES	8	
	Number of patients screened	300 (Qtr1-2)	
Smoking	Number of practices signed up to deliver Stop Smoking Services	9	
	Number of pharmacies signed up to deliver Stop Smoking Services	4	
	Number of quit date set	30(GP only qtr 1&2)	Quarterly average for 2013/14: 46
	Number of quits	19	
	Target:	5% of smoking population	
NHS Health Checks	Number of practices signed up to deliver NHS Healthchecks	7 (3 delivering)	
	Number of pharmacies signed up to deliver NHS Healthchecks	3	
	NHS Health Checks Offered	Not available	
	NHS Health Checks Delivered	402 (GP only. Qtr1-2)	Improvement
	Target	20% of eligible population	
Healthy Weight	Number of Surrey Heath organisations trained to deliver HENRY weight management programme	Data requested	
	Number of HENRY programmes delivered in Surrey Heath	Data requested	
	Number of GP practices signed up to Exercise Referral Scheme	6	
	Number of referrals to Exercise Referral Providers	Not available	
	Number of people starting Exercise on Referral Programmes	On average 6 per month	
	Exercise on Referral completion rates	Data requested	

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.

Surrey Joint Strategic Needs Assessment

http://www.surreyi.gov.uk

Resources for Surrey Heath CCG including the CCG Health Profile

http://www.surreyi.gov.uk/ViewPage1.aspx?C=resource&ResourceID=1361

Public Health England Health Profiles

http://www.apho.org.uk

National General Practice Profiles

http://fingertips.phe.org.uk/PROFILE/GENERAL-PRACTICE

Public Health Outcomes Framework

http://www.phoutcomes.info/

Local Alcohol Profiles

http://www.lape.org.uk

Local Tobacco Profiles

http://www.tobaccoprofiles.info/

National Obesity Observatory

http://www.noo.org.uk/data_sources

Mental Health Profiles

http://www.nepho.org.uk/cmhp/

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.