Appendix 3

Version: 1 (Last updated: 28/02/2014)

Surrey Prevention Action Plan

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1. Background

Surrey Prevention Action Plan (DRAFT)

Why prevention is important?

Ill-health prevention must form the foundation of any strategy to improve health and wellbeing

The evidence base for this is substantial, and includes:

The Global Burden of Disease Survey 2010
The US County Health Rankings Model
The Marmot Review

The Global Burden of Disease Survey 2010

The Global Burden of Disease 2010 study is the largest study ever undertaken, and shows that in the

UK, the contribution of unhealthy behaviours to the overall burden of disease is enormous.

This represents a key opportunity to improve health and wellbeing through targeting these behaviours through a prevention strategy

Leading Risk Factors

According to the Global Burden of Disease Survey 2010 the top 5 risk factors are tobacco smoking, hypertension, high BMI, physical inactivity, and alcohol, all of which are entirely, or in large part amenable to prevention (significant weight loss through calorie restriction or bariatric surgery leads to a cure rate for hypertension and diabetes of over 70% - not an argument for bariatric surgery necessarily, but for the impact of weight loss on hypertension)

All dietary and exercise components together account for 14.3% of the burden of disease

Tobacco smoking alone accounts for 9% of the burden of disease, the single greatest cause of ill health in the UK

It should also be noted that tobacco smoking, as the single greatest cause of preventable deaths in England, kills over 80,000 people per year, greater than the COMBINED total of preventable deaths from obesity, alcohol, road traffic accidents, illegal drugs, and HIV (source: NICE)

US County Health Rankings

The US County Health Rankings systematic review of determinants of health outcomes estimates the following contributions:

- Socio-economic factors: 40%
- Unhealthy behaviours: 30%
- Clinical care: 20%
- Environmental factors:10%

Marmot Review

The Marmot Review shows us with staggering clarity that health inequalities arise from social inequalities, and action on inequalities require a focus on prevention

Prevention here incorporates both the narrow definition of tackling unhealthy behaviours, and the wider definition of action on socio-economic determinants to prevent the onset of ill-health in the future

Surrey Health and Wellbeing Strategy

Surrey Prevention Action Plan links with the Surrey Health and Wellbeing Board Priorities

(Priority 2):

The Surrey Health and Wellbeing priorities are as follows:

1. Improving children's health and wellbeing
2. Developing preventive approach
3. Promoting emotional wellbeing and mental health
4. Improving older adults' health and wellbeing
5. Safeguarding population

Other Strategies

This prevention plan will not be implemented in isolation - there are interdependencies with numerous other regional and local strategies and programmes.

Public Health Outcomes Framework

The outcomes reflect a focus not only on how long people live, but on how well they live at all stages of life

Overarching indicators:

1. increased healthy life expectancy

2. Reduced differences in life expectancy and healthy life expectancy between communities.

2. Alcohol

Needs Assessment

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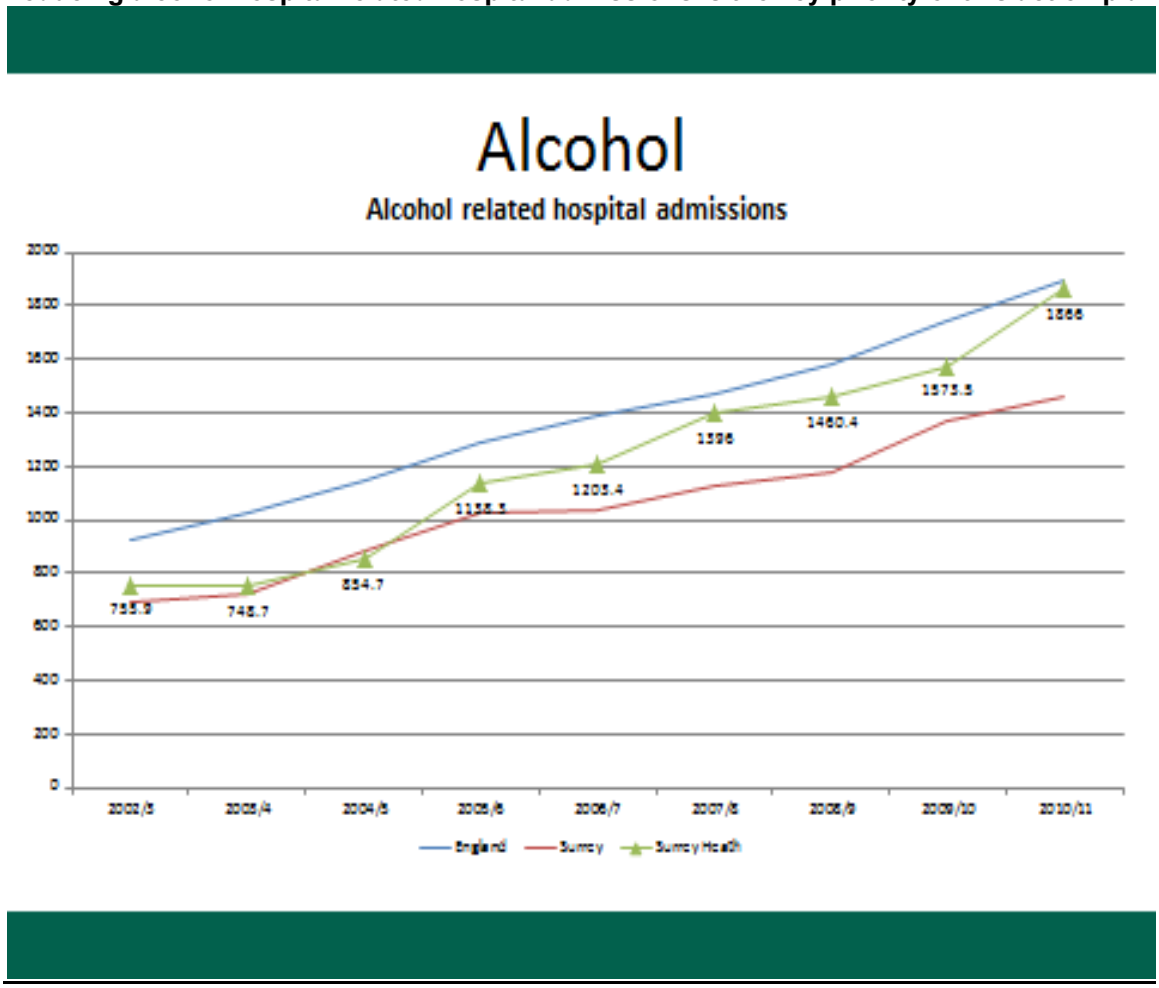
- Surrey has:
  - One of the highest rates of increasing risk drinking (formerly hazardous drinking) in the country
  - A lower rate of higher risk drinking and binge drinking than the national/regional average

		Higher risk drinking rates - drinking population aged 16+ - Rate (%)	**Increasing risk drinking rates - drinking population aged 16+ - Rate (%)**	**Binge drinking rates - full population aged 16+ - Rate (%)**	**Abstainers - population aged 16+ - Rate (%)**
	Population 16+ census 2011	***Mid 2009 Synthetic estimate of the percentage of the population aged 16 years and over who report engaging in harmful drinking***	***Mid 2009 Synthetic estimate of the percentage of the population aged 16 years and over who report engaging in increasing risk drinking***	***Synthetic estimate of the percentage of the population aged 16 years and over who report engaging in binge drinking (2007-2008)***	***Mid 2009 synthetic estimate of the percentage within the total population aged 16 years and over who report in abstaining from drinking***
England	42,946,840	6.75	20	20.1	16.53
South East	6,992,100	6.75	20.54	18.1	14.73
Surrey	914,880	6.44	21.02	17.99	14.26

Hospital admissions for alcohol related conditions is increasing at a faster rate than the national average, doubling between 2002/3 and 2009/10

Reducing alcohol hospital related hospital admissions is the key priority of this action plan.



1. Strategy

The alcohol strategy will only be delivered through partnership working across statutory and voluntary organisations with delivery of actions by:

- Education providers (schools and colleges)
- Borough Council
- Public Heath (Surrey County Council)
- Health Commissioners (Surrey Clinical Commissioning Groups)
- Health Providers (Acute, Surrey and Borders Partnership, Community Trusts, GPs)
- Police
- Local business community
- Housing
- Community groups
- Voluntary agencies

2. Focus of action plan (see appendix A)

The focus of the action plan is around three main areas for improvement:

Focus Area	Measure
Education and prevention	Survey: % of sample population who were aware of appropriate levels of alcohol consumption (improvement

	expected by March 2014)
Reduction in hospital alcohol related activity	Quarterly reports of alcohol related admissions & attendances
Community awareness of services & enhanced collaborative working	Clear pathways produced & feedback from agencies re improved understanding of services available (Survey)

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Focus Area	KEY OUTCOME	KEY ACTIONS	MEASURE	HEALTH OUTCOMES	PHOF measures	TARGET GROUP	LEAD AGENCY	TIMESCALE
Education & prevention	Deliver alcohol harm reduction messages to Surrey population, in particular those drinking at increasing risk levels and in the home	Reproduce annual article with alcohol information into centre fold spread into Health magazine Include alcohol info webpage on Surrey Health and Wellbeing website Support delivery of messages during Alcohol Awareness Week and Surrey-wide C4L alcohol campaign (Feb 2014) Explore opportunities to deliver alcohol messages in workplaces. Liaise with Surrey Business Group and Surrey Chambers of Commerce Continue & expand with alcohol awareness and screening activities in Acutes	Deliver 37,000+ alcohol articles via Healthscene to SH homes and businesses One main alcohol campaign delivered in 2013-14 in line with SCC alcohol campaign; XX number of opportunities identified to deliver alcohol messages in workplaces % of population who are aware of C4L alcohol campaign	Reduce alcohol related hospital admissions	2.18- Alcohol-related hospital admissions 4.05ii - Under 75 mortality rate from cancer considered preventable (provisional) 4.06ii - Under 75 mortality rate from liver disease considered preventable (provisional)	High risk/minority individuals and hard to reach groups via Surrey's Family Support Programme and appropriate provision by way of access to specialist treatment services	Public Health	Mar-14
Education & prevention	Ensure consistent quality messages on alcohol and associated harm are delivered within schools via PSHE	Ensure Surrey Drug and Alcohol Toolkit and supplementary training is made available to all secondary schools Audit and evaluate current use of Surrey Drug and Alcohol Toolkit and seek support from B4S /SH Confederation of Schools to improve uptake Develop system to ensure a co-ordinated approach is taken to commissioning of external contractors which includes quality assurance measures Explore opportunity to deliver alcohol education in schools via PSHE as part of a holistic prevention programme aimed at addressing substance misuse and all risk taking behaviour (ie tobacco, drugs, sexual health)	All schools provided with Surrey Drug and Alcohol Toolkit and offered supplementary training for PSHE teachers and staff	Reduce alcohol related hospital admissions	2.18- Alcohol-related hospital admissions 4.05ii - Under 75 mortality rate from cancer considered preventable (provisional) 4.06ii - Under 75 mortality rate from liver disease considered preventable (provisional)	High risk/minority individuals and hard to reach groups via Surrey's Family Support Programme and appropriate provision by way of access to specialist treatment services	Public Health & SCC Education (working with Babcock 4S/Sarah Sewell)	Mar-14
Reducing acute hospital alcohol related activity	Ensure **EARLY IDENTIFICATION** of alcohol misuse among the general population: i) via GP Surgeries by improving quality and quantity of alcohol IBA delivered via alcohol DES ii) via Surrey Health Checks Programme iii) via training wider public and third sector workforce in delivery of alcohol IBA in	Ensure alcohol identification and brief advice (IBA) is delivered in primary care by promoting uptake of alcohol DES among GP surgeries Interrogate 2012-13 DES data in order to interpret current activity and make better use of intelligence Explore opportunities to commission delivery alcohol IBA within GP surgeries via use of a LES	At least 50% of GP surgeries signed up to Alcohol DES XX number of new patients screened for alcohol misuse and receiving brief advice	Reduce alcohol related hospital admissions	2.18- Alcohol-related hospital admissions 4.05ii - Under 75 mortality rate from cancer considered preventable (provisional) 4.06ii - Under 75 mortality rate from liver disease considered preventable (provisional)	High risk/minority individuals and hard to reach groups via Surrey's Family Support Programme and appropriate provision by way of access to specialist treatment services	Public Health / Surrey CCGs	Mar-14

	non-health settings	Ensure alcohol screening is fully integrated and delivered via Surrey Health Checks Programme						
Reducing acute hospital alcohol related activity	Ensure **TARGETED IDENTIFICATION** of alcohol misuse among high risk/minority individuals and **hard to reach groups via Surrey's Family Support Programme** (FSP) and appropriate provision of / access to specialist treatment services	Ensure alcohol IBA is delivered within Surrey's FSP and that screening is in line with NICE Guidance (ie using AUDIT screening tool)Ensure alcohol services are appropriate, accessible to the needs of vulnerable/minority groups	Alcohol screening is fully integrated into FSP - establish baseline measure for % of families/individuals screened for alcohol misuse	Reduce alcohol related hospital admissions	2.18- Alcohol-related hospital admissions 4.05ii - Under 75 mortality rate from cancer considered preventable (provisional)4.06ii - Under 75 mortality rate from liver disease considered preventable (provisional)	high risk/minority individuals and hard to reach groups via Surrey's Family Support Programme and appropriate provision by way of access to specialist treatment services	Public Heath / SCC	
Reducing acute hospital alcohol related activity	Explore effective interventions to reduce repeat alcohol-related A&E attendances and in-patient admissions	Obtain data on alcohol-related admissions and A&E attendances Review evidence base on 'frequent flier' (FF) interventions Undertake audit of alcohol-related FFs at acutes Explore and develop a care pathway to tackle FF patients at acute based on East Surrey CCG Pathfinder work Implement new care pathway for FFs	Care pathway for management of alcohol-related FFs at acute identified and implemented Reducing number of A&E attenders and admissions due to alcohol related disorders	Reduce alcohol related hospital admissions	2.18- Alcohol-related hospital admissions 4.05ii - Under 75 mortality rate from cancer considered preventable (provisional) 4.06ii - Under 75 mortality rate from liver disease considered preventable (provisional)	high risk/minority individuals and hard to reach groups via Surrey's Family Support Programme and appropriate provision by way of access to specialist treatment services	Surrey CCGs (working with acute and public health)	Mar-14
Reducing acute hospital alcohol related activity	Ensure there is effective management of dependent alcohol users within acutes	Explore opportunities to commission an Alcohol Liaison Nurse / Team within acutes Map current care pathway for alcohol patients requiring detox and identify opportunities for improvement	Care pathway identified and improvements implemented Business case to health commissioners available for 14/15 planning	Reduce alcohol related hospital admissions	2.18- Alcohol-related hospital admissions 4.05ii - Under 75 mortality rate from cancer considered preventable (provisional) 4.06ii - Under 75 mortality rate from liver disease considered preventable (provisional)	high risk/minority individuals and hard to reach groups via Surrey's Family Support Programme and appropriate provision by way of access to specialist treatment services	Acutes	Sep-13
Reducing acute hospital alcohol related activity	Ensure A&E assault data is shared with Community Safety Partnerships (CSPs) and used as intelligence in police licensing reviews, representations and targeted community safety activity	Manage monthly provision of A&E assault data from acute hospitals to CSPs in accordance with Public Health Core Offer and CEM guidance (2009) Co-ordinate and chair quarterly acute Violence Prevention Steering Groups Monitor A&E assault attendances from premises under review	Monthly dataset provided to CSPs 90% of acute assault data: 1) Integrated into Surrey Police Enforcement Licensing Systems 2) Cross-referenced with Surrey Police intelligence and used when appropriate in licensing	Reduce alcohol related hospital admissions	2.18- Alcohol-related hospital admissions 4.05ii - Under 75 mortality rate from cancer considered preventable (provisional) 4.06ii - Under 75 mortality rate from liver disease considered preventable (provisional)	high risk/minority individuals and hard to reach groups via Surrey's Family Support Programme and appropriate provision by way of access to specialist treatment services	Public Health	Ongoing

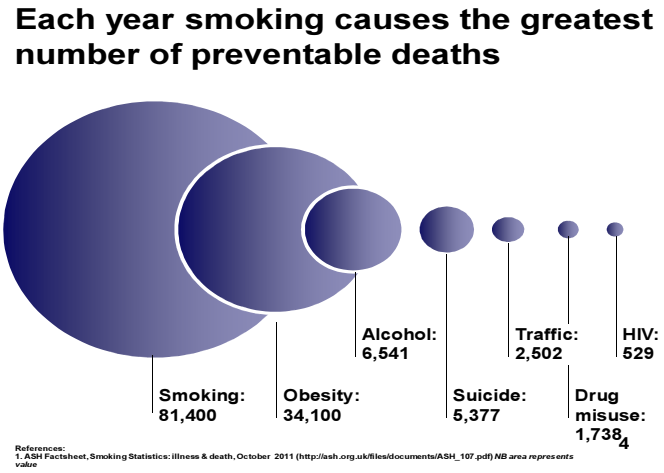
			reviews Reduction in A&E assault attendances from licensed premises which have undergone a review					
Community awareness of services & enhanced collaborative working	Improved communication between partners to enhance collaborative working to ensure local alliances and networks are able to raise awareness of alcohol services and provide appropriate sign posting	Ensure a list of all local stakeholders involved in delivery agencies and partners plus contact details and share Ensure DAAT Service Directory is kept up to date and made available to all partners	Alcohol stakeholder group list kept updated and circulated as appropriate DAAT Alcohol Service directory kept updated and made widely available	Reduce alcohol related hospital admissions	2.18- Alcohol-related hospital admissions 4.05ii - Under 75 mortality rate from cancer considered preventable (provisional) 4.06ii - Under 75 mortality rate from liver disease considered preventable (provisional)	high risk/minority individuals and hard to reach groups via Surrey's Family Support Programme and appropriate provision by way of access to specialist treatment services	Public Health & D&Bs	Ongoing (List issued and kept up to date)
Community awareness of services & enhanced collaborative working	Improve signposting to alcohol services by relevant agencies within SH in line with **MAKING EVERY CONTACT COUNT**	Review Street Angels cards to include relevant agencies (above) e.g. Catch 22Improve signposting. Ensure schools have access to information about Catch 22 Identify professionals (ie school nurses, youth workers, Supporting Families Link Workers) for alcoho IBA training	New card produced and distributed to Street Angels Signposting to alcohol services improvedXX number of professionals trained in alcohol IBA	Reduce alcohol related hospital admissions	2.18- Alcohol-related hospital admissions 4.05ii - Under 75 mortality rate from cancer considered preventable (provisional)4.06ii - Under 75 mortality rate from liver disease considered preventable (provisional)	High risk/minority individuals and hard to reach groups via Surrey's Family Support Programme and appropriate provision by way of access to specialist treatment services	Public Health	Mar-14
Community awareness of services & enhanced collaborative working	Improve liaison between acutes and local GPs	Improve communication between Acute Hospital and GPs concerning patients identified with an alcohol issue – explore use of discharge summary	Mechanisms in place to share information on referral and discharge	Reduce alcohol related hospital admissions		high risk/minority individuals and hard to reach groups via Surrey's Family Support Programme and appropriate provision by way of access to specialist treatment services	Acutes	Dec-13
Community awareness of services & enhanced collaborative working	Learn from best practice elsewhere and evidence-base - as identified by Surrey Public Health Department	As good practice is identified elsewhere, review to ensure it is incorporated as part of local delivery plans. In particular: 1) East Surrey CCG - Integrated Alcohol Care Pathway Project 2) Guildford BC / Business Improvement District - Workplace Wellbeing Charter Pilot	Implementation of best practice and learning from pilots elsewhere nationally and locally	Reduce alcohol related hospital admissions		High risk/minority individuals and hard to reach groups via Surrey's Family Support Programme and appropriate provision by way of access to specialist treatment services	All	Mar-14
Community awareness of services & enhanced collaborative working	Contribute to delivery of Surrey's Domestic Abuse Strategy	Identify what DA policies / procedures exist within FPH and gaps in relation to new NICE Guidelines on domestic violence and abuse - identification and prevention (due Feb 2014) Ensure patients identified as DA are routinely screened for alcohol misuse	Trust-wide DA policy in place at Acutes Mechanisms in place to ensure DA patients screened for alcohol misuse	Reduce alcohol related hospital admissions		High risk/minority individuals and hard to reach groups via Surrey's Family Support Programme and appropriate provision by way of access to specialist treatment services	Public Health	Mar-14
Community awareness of services & enhanced collaborative working	Ensure appropriate links are made between the alcohol strategy and Community Covenant work	Review both action plans and identify areas of mutual interest and mechanisms to work jointly/prevent duplication		Reduce alcohol related hospital admissions		High risk/minority individuals and hard to reach groups via Surrey's Family Support Programme and	D&Bs	Mar-14

						appropriate provision by way of access to specialist treatment services		

3: Tobacco Control

1. Joint Strategic Needs Assessment Summary

Smoking remains the major preventable cause of premature death and disability and as a result reducing tobacco use is the single most effective means of improving public health. According to most recent estimates there are currently around 80,000 premature deaths from smoking each year in England, more that for all other major preventable cause of premature death. Above is a bar chart showing prevalence in Surrey– 15 per cent. However deprived communities in Surrey have higher prevalence.



Source : SCC PH

Surrey data on risk factors and specific conditions is that commissioners should have regard to improving morbidity, mortality, and unplanned admissions through:

Early identification and management of risk factors such as smoking, through supported behaviour change programmes and appropriate follow-up.

In this area both well-established and locally innovative approaches should be combined to tackle the stubbornly fixed levels of tobacco. Attention should be given to 'making every contact count', which includes opportunistic work in primary care, structured programmes in secondary care, e.g. in A&E and the use of in-hospital behaviour change programmes, and further innovative approaches.

In Surrey there is a case for discussing a Health Prevention strategy concentrating on smoker patients already on risk registers with long term conditions such as COPD to reduce their emergency admissions which cost an average of £2,000 each spell.

2. Strategy

The prevention strategy will only be delivered through partnership working across statutory and voluntary organisations with delivery of actions by:

- Education providers (schools and colleges)
- Borough Council (SCC Trading Standards)
- Public Heath (Surrey County Council)

- Health Commissioners (Clinical Commissioning Group)
- Health Providers (Acute Trusts, Community Services, GPs)
- Police
- Local business community
- Housing (Housing trusts, Social housing accommodation)
- Community groups
- Voluntary agen

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Focus Area	KEY OUTCOME	KEY ACTIONS	MEASURE	HEALTH OUTCOMES	PHOF measures	TARGET GROUP	LEAD AGENCY	TIMESCALE
COPD patients with smoking status	Reduce number of COPD admissions	Review smoking status Invite to treatment for nicotine addiction and behavioural support.	Increase number of these patients in treatment	Prevent deterioration of COPD	2.14 - Smoking prevalence - adults (over 18s) 4.07ii - Under 75 mortality rate from respiratory disease considered preventable (provisional)	Patients diagnosed with COPD	GP's from Surrey CCGs with support from Surrey Stop Smoking Service	1 year
Asthma patients aged 40 and upwards with smoking status	Ameliorate risk of increased number of COPD	Review smoking status Invite to treatment for nicotine addiction and behavioural support.	Measure increase in number of smoker patients on COPD register in Surrey GP practices	Reduction in the number of asthmatic patients who smoke developing COPD	2.14 - Smoking prevalence - adults (over 18s) 4.07ii - Under 75 mortality rate from respiratory disease considered preventable (provisional)	Smokers aged 40+ with asthma not yet identified as having COPD	GP's from Surrey CCGs with support from Surrey Stop Smoking Service	1 year
COPD A&E Admissions to acute trusts	Reduce number of these types of admissions	Work with acute trusts on brief intervention and referral pathways to Stop Smoking support.	Measure number of referrals received from Acute Trusts to Surrey Stop Smoking Service	Reduce COPD admissions in the over 18's	2.14 - Smoking prevalence - adults (over 18s) 4.07ii - Under 75 mortality rate from respiratory disease considered preventable (provisional)	Patients who identiy as smokers in primary care and those under secondary care respiritory teams	CCG commissioning and Surrey Stop Smoking Service	1 Year
Other Public Health Preventative Strategies :								
Education & Prevention	Delivery of Smoking Toolkit and training for staff Promote local Stop Smoking Services Give brief advice	Distribution of Toolkit Other local projects Family Support Programme Promotion of Healthy Surrey Website	Number of Schools using toolkit Number of referrals received by Surrey Stop Smoking Service	Reduce the uptake of smoking in under 18's Reduce the number of smoking related illnesses	2.14 - Smoking prevalence - adults (over 18s)	Those aged between 12 and 16 in full time education Family members who smoke engaging in the Family Support Programme	Public Health Babcock 4S	1 year
Children Centres	Promote local Stop Smoking Services Give brief advice	Offer to train staff on brief intervention Support centre with Stop Smoking Promotional materials	Number of referrals received by Surrey Stop Smoking Service from the centre	Reduce number of smoking related illnesses in parents/carers and their families	2.14 - Smoking prevalence - adults (over 18s)	Parents/carers aged 18 upwards	Surrey Stop Smoking Service	1 Year

Pregnant Smokers	Reduce the numbers of smokers at delivery	Review of Referral pathways Include stop smoking telephone support help on Wellbeing website Promote on CCG and GP Practice health websites (Include actions plan from FSP document)	Maintain current smoking at delivery rate 7 – 8 percent Number of pregnant referrals received year on year Where received from There is currently no national targets for pregnant smokers and young people in PHOF	Reduce the number of pregnant smokers to improve health of mother and baby	2.14 - Smoking prevalence - adults (over 18s) 2.03 - Smoking status at time of delivery	Pregnant smokers aged over 18	SCC Public Health	01/03/2013 01/04/2014
Workplaces	More local employers involved in stop smoking support, raising awareness, and referrals, in particular those in manual and routine sector and in priority areas	Liaison with workplaces Calendar of raising awareness events Referrals In House Clinics	Number of workplaces taking part Number of raising awareness events Number of clinics Number setting a quit date and numbers quitting	Reduce the number of smokers and smokers taking time off sick	2.14 - Smoking prevalence - adults (over 18s)	Smokers aged over 18	SCC Public Health	March 2013 April 2014
Health Checks	Increase number of Stop Smoking support offers to smokers	Include routine referral to smokers taking part in Health Checks	Count in number of referrals received from Surrey practices as a result of Health Checks	Reduce the numbers of smokers and prevent people from developing smoking related illnesses such as COPD	2.14 - Smoking prevalence - adults (over 18s) 2.22i - Take up of NHS Health Check Programme by those eligible - health check offered 2.22ii - Take up of NHS Health Check programme by those eligible - health check take up	Those aged 40 to 74 who identify as smokers	GP's from Surrey CCGs with support from Surrey Stop Smoking Service SCC Public Health	1 year
Surrey 4 week quit target	Achieve target	Increase referrals through various sources including street based referral generation, NHS health checks programme, workplaces, other settings including primary/secondary care and youth services, and through effective referral conversion via our telephone support service. Promotion of Healthy Surrey Website	Annual quit target - 3541	Reduce the number of smokers across the county to improve general health and wellbeing	2.14 - Smoking prevalence - adults (over 18s)	Smokers aged over 18	Surrey Stop Smoking Service	1 year

4. Health Checks

1. Joint Strategic Needs Assessment Summary – there is no JSNA for health checks

Cardiovascular Disease (CVD) is a major cause of mortality and long-term morbidity. Early detection can not only reduce the impact on individuals but also healthcare costs. NHS (vascular) Health Checks are an evidence based vehicle for increasing early detection.

Evidence published by the DH suggests that NHS Health Checks prevent strokes and heart attacks. They also prevent the development of diabetes and detect diabetes or kidney disease earlier, allowing individuals to be better managed and improve their quality of life.

Health checks enable the identification of clients with modifiable lifestyle factors such as smoking or inactivity. Once identified clients can be referred to appropriate early intervention and prevention initiatives such as the Stop Smoking Service, Healthy Walk and Exercise on Referral.

Project Aim: To increase the number of NHS Health Checks offered and delivered in Surrey via primary care, pharmacy and workplaces. There will also be a focus on groups most at risk of CVD (including carers, BME groups, smokers, and people in areas of socioeconomic deprivation)

1. Strategy

The prevention strategy will only be delivered through partnership working across statutory and voluntary organisations with delivery of actions by:

- Education providers (schools and colleges)
- Borough Council
- Public Heath (Surrey County Council)
- Health Commissioners (Clinical Commissioning Group)
- Health Providers (Acute Trusts, Community Services, GPs)
- Police
- Local business community
- Housing
- Community groups
- Voluntary agencies

Focus Area	KEY OUTCOME	KEY ACTIONS	MEASURE	HEALTH OUTCOMES	PHOF	TARGET GROUP	LEAD AGENCY	TIMESCALE
Primary care delivery	Begin health checks delivery and meet allocated target	T and C's signed off and training done for GP's asap	No of health checks offered No of health checks delivered	Prevent heart attacks and save life Prevent people from developing diabetes Detect diabetes and kidney disease earlier	2.22i - Take up of NHS Health Check Programme by those eligible - health check offered 2.22ii - Take up of NHS Health Check programme by those eligible - health check take up	Those aged between 40 and 74 that have not had a stroke or been diagnosed with heart disease, kidney disease or diabetes	Surrey GP's	By March 2014
Pharmacy delivery	Begin health checks delivery and meet allocated target	Training to commence in Oct for pharmacy	No of health checks offered No of health checks delivered	Prevent heart attacks and save life Prevent people from developing diabetes Detect diabetes and kidney disease earlier	2.22i - Take up of NHS Health Check Programme by those eligible - health check offered 2.22ii - Take up of NHS Health Check programme by those eligible - health check take up	Those aged between 40 and 74 that have not had a stroke or been diagnosed with heart disease, kidney disease or diabetes	Surrey Pharmacy's	By March 2014
Workplace	Begin health checks delivery and meet allocated target	Maintain delivery momentum and increase capacity	No of health checks offered No of health checks delivered	Prevent heart attacks and save life Prevent people from developing diabetes Detect diabetes and kidney disease earlier	2.22i - Take up of NHS Health Check Programme by those eligible - health check offered 2.22ii - Take up of NHS Health Check programme by those eligible - health check take up	Those aged between 40 and 74 that have not had a stroke or been diagnosed with heart disease, kidney disease or diabetes	SCC Public health	By March 2014
Community	Begin health checks delivery and meet allocated target	Maintain delivery momentum and increase capacity	No of health checks offered No of health checks delivered	Prevent heart attacks and save life Prevent people from developing diabetes Detect diabetes and kidney disease earlier	2.22i - Take up of NHS Health Check Programme by those eligible - health check offered 2.22ii - Take up of NHS Health Check programme by those eligible - health check take up	Those aged between 40 and 74 that have not had a stroke or been diagnosed with heart disease, kidney disease or diabetes	SCC Public health	By March 2014

5.Physical activity

Why physical activity?

According to the Lancet report (2012) "The pandemic of physical inactivity: global action for public health", physical inactivity is the fourth leading cause of death worldwide. The high prevalence of physical inactivity, its harmful health and environmental consequences, and the evidence of effective physical activity promotion strategies, make this problem a global public health priority. Available data suggest that 31% of the world's population is not meeting the minimum recommendations for physical activity.

In July 2011, The Chief Medical Officer's (CMO's) of England, Scotland, Wales and Northern Ireland published guidelines for physical activity. The report emphasises the importance of physical activity for people of all ages and also highlights the risks of sedentary behaviour.

Meeting the government guidelines for physical activity can prevent and help to manage over 20 conditions and diseases including coronary heart disease, type 2 diabetes, stroke, mental health problems, musculoskeletal conditions and some cancers (NICE, 2013).

Public Health Outcomes Framework

There are three indicators directly related to physical activity.

PHOF indicator	Surrey	England
1.16 - Utilisation of Green Space for exercise/Health (Mar 2009 - Feb 2012)	**8.9%**	14.0%
2.13i - Proportion of physically active adults (active) (2012)	**60.1%**	56.0%
2.13ii - Proportion of physically active adults (inactive) (2012)	**23.1%**	28.5%

How active is Surrey?

Children

The activity levels of children in Surrey are unknown as no data collection mechanism is in place.

Adults

In Surrey 60.1% of adults are active, doing at least 150 minutes of moderate equivalent physical activity per week, while 23.1% are inactive, doing less than 30 minutes of moderate equivalent physical activity per week.

Table 1. Active People Survey results from January 2012 – January 2013 (APS6 Quarter2 to APS7 Quarter 1) by bands of activity highlighting which data are used for PHOF indicators

	<30 mins	30-89 mins	90-149 mins	150+ mins	Sample size
PHOF indicator	**2.13ii**			**2.13i**	
England	28.5%	8.1%	7.3%	56.0%	151912
Surrey	23.1%	8.4%	8.4%	60.1%	5204
Elmbridge	25.9%	8.0%	8.5%	57.7%	461
Epsom and Ewell	23.0%	8.4%	8.6%	59.9%	473
Guildford	23.2%	7.7%	9.7%	59.4%	471
Mole Valley	23.2%	9.2%	8.0%	59.6%	467
Reigate and Banstead	23.9%	8.7%	9.5%	57.9%	478
Runnymede	22.8%	9.5%	9.0%	58.7%	500
Spelthorne	28.0%	9.1%	5.2%	57.6%	469
Surrey Heath	21.4%	9.6%	9.3%	59.8%	460
Tandridge	18.7%	8.7%	7.7%	64.9%	484
Waverley	19.5%	6.4%	8.9%	65.1%	469
Woking	23.3%	8.1%	6.8%	61.8%	472

Source: Active People Survey 6 Quarter 2 to Active People Survey 7 Quarter 1 (January 2012-January 2013)[1]

The Active People Survey small area estimates tool[2] (Active People Survey 3/4 , 2008-2010) provides data at middle super output area (MSOA) level for adults achieving 3 x 30 minutes of sport and active recreation (formerly NI8). This is currently being updated in line with the new CMO physical activity guidelines, however, data from 2008-2010 showed a clear link between areas of deprivation and lower levels of physical activity.

Utilisation of open space for exercise/health reasons

This data is not available at borough level, however, 35% of adults in Surrey accessed the natural environment for exercise or health reasons in 2011 – 2012. This is similar to the England figure of

[1] Sport England (2013) Active People Survey 6 Quarter 2 to Active People Survey 7 Quarter 1 January 2012-January 2013

[2] Sport England (2010) Small area estimates tool, based on Active People Survey ¾ 2008 – 2010).

35% and is a 10% increase from 2009 – 2010 when 25% of adults in Surrey accessed for exercise or health reasons.

In Surrey (2011 – 2012) fewer females (27%) than males (48%) accessed for exercise or health reasons compared to England (39% and 36% respectively). Young people aged 16 – 24 years were least likely to access for this reason (7%) compared to England (25%). Socio-economic groups C1 (24%) and C2 (28%) were least likely to utilise open space for exercise or health reasons and no unemployed or those categorised as not white stated exercise or health as their reason for visiting.

Screening for physical activity in Primary Care

The Quality and Outcomes Framework (QOF)[5] is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not about performance management but resourcing and then rewarding good practice.

From April 2013, two indicators were included in QOF regarding physical activity screening and intervention for hypertensive patients within primary care. These indicators can be seen in table 3.

Table 3. QOF indicators

Indicator description	Points	%
HYP004. The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 in whom there is an annual assessment of physical activity, using GPPAQ[85], in the preceding 12 months NICE 2011 menu ID: NM36	5	40-80%
HYP005. The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 who score 'less than active' on GPPAQ[85] in the preceding 12 months, who also have a record of a brief intervention in the preceding 12 months NICE 2011 menu ID: NM37	6	40-80%

READ CODES:

a. 138b active
b. 138a mod active
c. 138Y mod inactive
d. 138X inactive

Table 4 shows the number of patients in Surrey with hypertension and the estimated number of inactive hypertensives and thus eligible for a brief intervention in physical activity (HYP005).

Table 4. Hypertension prevalence and estimated number of hypertensive patients eligible for HYP004 and HYP005 by Borough and District Council in Surrey (based on 2011/12 QOF data)

	Number with established hypertension[3]	Hypertensive prevalence (%)[5]	Proportion that are less than active (<30 mins, 30-90 mins, 90-149 mins)[2]	Estimated less than active hypertensives (Number of hypertensives/proportion of the population that are less than active)
England	7567965	13.6%	44%	3329905
Surrey	147871	12.8%	39.9%	**58,995**
NHS East Surrey CCG	20606	12.1%	N/A	N/A
NHS Guildford and Waverley CCG	26723	12.5%	N/A	N/A
NHS North West Surrey CCG	44453	12.7%	N/A	N/A
NHS Surrey Downs CCG	40030	13.8%	N/A	N/A
NHS Surrey Heath CCG	11788	13.0%	N/A	N/A
Elmbridge	16706	12.00%	42.3%	**7067**
Epsom and Ewell	10443	14.00%	40.1%	**4188**
Guildford	16519	11.60%	40.6%	**6707**
Mole Valley	12996	14.50%	40.4%	**5250**
Reigate and Banstead	17304	13.10%	42.1%	**7285**
Runnymede	9584	13.00%	41.3%	**3958**
Spelthorne	14047	14.20%	42.4%	**5956**
Surrey Heath	11294	12.70%	40.2%	**4540**
Tandridge	9652	12.10%	35.1%	**3388**

[3] QOF disease prevalence 2011/12

Waverley	16839	13.30%	34.9%	**5877**
Woking	12486	11.80%	38.2%	**4770**

Sources: QOF (Quality Outcomes Framework) disease prevalence (2011/12)[5]

Source: Active People Survey 6 Quarter 2 to Active People Survey 7 Quarter 1 (January 2012-January 2013)[1]

Summary of need

The needs for physical activity in Surrey, including groups to target, are:

- Reduce the number of inactive people (those participating in <30 mins activity)
- Increase the number of active people (those participating in 150mins+ activity)
- Up-to-date data is required that provides children and young people's activity levels
- Adults living in deprived wards
- Females
- Older adults (aged 65+)
- People with a limiting illness or disability
- People from BME groups
- People on lower incomes
- Increase the number of people who travel actively
- Increase the number of people who use outdoor space for exercise/health reasons

Summary of Recommendations/Actions

- Collect children's activity data in line with the government guidelines for physical activity in children.
- Commission physical activity services that aim to address the needs identified in this chapter, in particular those that reduce the number of people achieving less than 30 minutes of physical activity each week and increase the number of people achieving 150 minutes or more of physical activity each week.
- Commission physical activity services that target the least active groups such as females, older adults, BME groups, people with limiting illness or disability, people living in areas of deprivation; and ensure the effectiveness is evaluated.
- Commission and signpost to services that encourage people to use outdoor space for exercise/health reasons.
- Particular attention to commission physical activity services for people from BME groups such as 'fit as a fiddle' faith and community strand project[4] and for people with limiting illness or disability such as 'steps to fitness' health and wellbeing pilot project.[5]

[4] Sporting Equals (2010) Fit as a fiddle: sporting equals older people faith and community strand project

- Build evaluation into existing services using the Standard Evaluation Framework for physical activity[6], ensuring that the single-item measure physical activity questionnaire is used.
- Review or de-commission services that don't evaluate the impact that service has on physical activity levels
- When developing new physical activity interventions use social marketing techniques, making use of existing insights as highlighted in this chapter and using tools such as Change4Life, promoting Activity Toolkit.
- Ensure a co-ordinated approach to activity, including all activities (not just sport) to be included on the Active Surrey Activity Finder
- Support the national Change4Life physical activity campaign locally, with all partners on board.
- Provide a forum for better partnership working between various sectors and organisations that impact upon physical activity levels, ensuring that increasing physical activity levels is everybody's business.
- When leisure centre contracts are re-tendered, ensure that the JSNA physical activity chapter guides the retendering.
- Provide educational support and training to staff that are involved in changing peoples physical activity behaviours.
- Develop local transport plans that incorporate walking and cycling
- Commission personalised travel planning programmes to support willing individuals to make daily changes.
- Ensure that all planning applications for new developments always prioritise the need for people to be physically active as a routine part of their daily life. Comprehensive networks for active modes of transport including those to public open spaces and parks.
- Ensure that workplace health initiatives support employees to become more physically active.
- Ensure that County and Borough and District strategies for physical activity and open space/parks incorporate the needs identified in this chapter, with particular focus on targeting inequalities and evaluating physical activity outcomes.
- Assist the Family Support Programme in Surrey to work with those families most at need to increase their physical activity levels by providing staff with training and up to date information on local physical activity opportunities.

http://www.sportingequals.org.uk/PICS/files/Fit%20as%20a%20fiddle%20Executive%20Summary.pdf

[5] Poynor L (2008) Steps to fitness: a health and wellbeing pilot project. Learning Disability Practice, 11 (3) **http://rcnpublishing.com/doi/full/10.7748/ldp2008.04.11.3.10.c6475**

[6] Public Health England (2013) Standard evaluation framework for physical activity interventions **http://www.noo.org.uk/core/frameworks/SEF_PA**

Primary Care

- Ensure that a brief intervention, such as Lets Get Moving, is undertaken and evaluated for effectiveness in primary care. Patients should be screened for physical activity levels in primary care using GPPAQ[7] and referred onto or recommended appropriate services for anyone identified as less than active.
- Ensure brief advice on physical activity is included in care pathways for mental health, particularly services for groups that are more likely to be inactive i.e. people aged 65 years and over, people with a disability and people from certain minority ethnic groups.
- Provide information and training for primary care practitioners that addresses how physical activity promotion can help prevent and manage a range of health conditions.
- Ensure systems such as Read Codes are being used to identify opportunities to assess people's physical activity levels and that information and resources about local opportunities to be active are up to date.

Diet

Poor nutrition results from eating an unbalanced diet in which certain nutrients are lacking, in excess or in the wrong proportions. An unbalanced diet can contribute to: diet-related conditions including cardiovascular disease, cancer, diabetes and obesity; mineral and vitamin deficiencies such as vitamin D deficiency; and under nutrition usually termed malnutrition.

There is scarce local data on the nutritional intake of the Surrey population as dietary surveys are both complex and expensive. Intake of fruit and vegetables is often used as a proxy measure for the nutritional quality of diet.

The only source of local healthy eating data shows that 32.5% of the Surrey population meet the recommended minimum intake for fruit and vegetables and therefore approximately two-thirds of the population are not eating enough fruit and vegetables. Spelthorne has the lowest intake of fruit and vegetables, 29.2%, and Elmbridge the highest intake at 34.7%.

National data shows that groups of people at particular risk of poor diet are:

People in lower socio-economic groups

[7] Department of Health (2013) General Practitioner Physical Activity Questionnaire (GPPAQ) **https://www.gov.uk/government/publications/general-practice-physical-activity-questionnaire-gppaq** [Accessed on 14/10/13]

Women of childbearing age – those planning pregnancy, during pregnancy and whilst breastfeeding as increased physiological demands for nutrition may put them at risk

- Infants and young children
- School aged children and young people aged 11 to 18 years
- Children in care/Looked After Children
- Young adults aged 19-24 years
- Adults aged 65 years and over
- People with dementia
- People with a mental illness
- People with a learning disability
- South Asian and African Caribbean communities
- Smokers
- Prisoners
- People being admitted to hospitals, care homes and mental health units

Public Health Outcomes Framework (PHOF)

2.11 Diet - is currently a placeholder indicator
2.02ii Breastfeeding prevalence 6 - 8 weeks after birth

Global Burden of Disease (WHO, 2010) - 13 of the top 20 leading risk factors for disease in the UK are an imbalance of dietary components e.g. low intake of fruit or diet-related e.g. high blood pressure

Healthy Weight

Adults

There is a lack of local prevalence data for adult obesity in Surrey. Figures for obesity prevalence in the local population are extrapolated from national data available from the HSE (Health Survey for England) which shows that

· the proportion of adults with a normal BMI decreased between 1993 and 2011 from 41 per cent to 34 per cent among men and from 50 per cent to 39 per cent among women.

· the proportion that were overweight including obese increased from 58 per cent to 65 per cent in men and from 49 per cent to 58 per cent in women between 1993 and 2011

· There was a marked increase in the proportion of adults that were obese from 13 per cent in 1993 to 24 per cent in 2011 for men and from 16 per cent to 26 per cent for women.

The latest data for Surrey showed that in 2008 obesity prevalence was estimated to be 20.3% which is significantly lower than the England average and is linked to the lower level of deprivation in Surrey.

In terms of absolute numbers of obese adults there are estimated to be over 180,000 adults in Surrey who are obese and by including those who are obese and overweight it is estimated this would represent over 500,000 (61.3%) of the adult population of Surrey.
National data shows that groups of people at particular risk of obesity and who would benefit from support to achieve a healthy weight include:

- People with long term conditions that would benefit from weight management including those with diabetes and pre-diabetes
- Men who are currently under represented in community weight management services as they may not be suitable for their needs.
- Women pre and post pregnancy
- BME communities who are at greater risk of identified long term conditions including type 2 diabetes and coronary heart disease and for whom current community weight management services may not be suitable
- People with physical and learning disabilities for whom current community weight management services may not be suitable
- People in lower socio-economic groups
- Adults aged 65 years and over living in residential or nursing care

Children

Over 20,000 children in Surrey were weighed and measured in 2011/12 and the results show that obesity prevalence In Surrey was 6.8% (9.5%) in year R and 14.4% (19.2%) in year 6.

(Figures in brackets for England)

There is a public health outcome framework (PHOF) indicator for excess weight in children and in 2011/12. Surrey had 18.4% (22.6%) obese and overweight children in year R and 28.2% (33.9%) in year 6. (Figures in brackets for England). This equates to 1 in 5 children in year R having an excess weight with this rising to over 1 in 4 in year 6. (And nearer to 1 in 3 in some boroughs) Surrey is one of the better performing local authorities in terms of obesity prevalence but this is little reason to be complacent as the health survey data shows that over 57,000 children in Surrey have an excess weight.

7

The main concerns are

· obesity prevalence doubles from year R to year 6
· obesity is strongly linked to deprivation

2. Strategy

The prevention strategy will only be delivered through partnership working across statutory and voluntary organisations with delivery of actions by:

- Education providers (schools and colleges)
- Borough Council
- Public Heath (Surrey County Council)
- Health Commissioners (Clinical Commissioning Group)
- Health Providers (Acute Trusts, Community Services, GPs)
- Police
- Local business community
- Housing
- Community groups
- Voluntary agencies

Focus Area	KEY OUTCOME	KEY ACTIONS	MEASURE	Health Outcomes	PHOF measures	Target Group	LEAD AGENCY	TIMESCALE
All groups	Increase knowledge and skills of the population of Surrey to enable them to make lifestyle changes leading to improved health outcomes as demonstrated through living longer as a result of "eating well, moving more" **(Making Every Contact Count)**	Support the local population of Surrey to access Change4 Life materials and join up Support all staff to sign up as local partners. Ensure Change4Llife resources are available at all NHS health premises in the Surrey CCGs with particular focus on targeting C2DE socioeconomic families with children aged 5 - 11 years	XX number of Change4Life resources accessed xx number of residents registered to the Change XX number of staff signed up to Change4Life website as local partners XX % increase in life expectancy	Eating well important to maintain health and prevent and manage diet-related conditions e.g. cardiovascular disease, cancer, diabetes and obesity	2.06i Excess weight in 4 - 5 year olds 2.06ii Excess weight in 10 - 11 year olds 2.11 Diet - is currently a placeholder indicator	C2 and DE socioeconomic families with children aged 5 - 11 years	Surrey CCGs SCC Public Health	*Baseline* April 2013 to March 2014
	Education and prevention Staff are aware of existing services to support patients to make lifestyle changes for themselves around physical activity, diet and healthy weight and are able to signpost them to appropriate services	Ensure all staff have the opportunity to access appropriate training on local services and resources that can help support their patients to follow a healthy lifestyle	XX number of courses provided XX number of staff trained XX numbers referred to local services	Eating well important to maintain health and prevent and manage diet-related conditions e.g. cardiovascular disease, cancer, diabetes and obesity. Also to prevent malnutrition and related deficiency diseases	2.11 Diet - is currently a placeholder indicator	Primary care staff and their patients	Surrey CCGs with support from SCC Public Health	Baseline April 2014 - March 2013
	Education and prevention Staff can access training on physical activity, diet and healthy weight to enable them to advise and support their patients/clients and to make lifestyle changes for themselves and their families	Promote need for and provide opportunity for staff to access training on: o Healthier eating and special diets ○ Cookery leader training o Physical activity o Healthy weight o Health improvement including behaviour change (All training to include health inequalities and working wtih vulnerable and hard to reach groups)	XX courses available XX staff trained	Eating well important to maintain health and prevent and manage diet-related conditions e.g. cardiovascular disease, cancer, diabetes and obesity. Also to prevent malnutrition and related deficiency diseases	2.11 Diet - is currently a placeholder indicator	Primary care staff and their patients	Surrey CCGs SCC Public Health	
	Surrey CCGs to support discussions regarding the improvement of infrastructure that promotes cycling in Surrey	Ensure that cycling is everyone's business and as a CCG feed into the Surrey Cycling Strategy with support from the Borough Council.	Feedback provided to the consultation on the Surrey Cycling Strategy by 1st November	Increased levels of physical activity and thus redcution in risk of over 20 diseases/conditions	1.16 Utilisation of outdoor space for physical activity 2.13i Proportion of active adults (150mins+) 2.13ii Proportion of inactive adults (<30mins activity)	All patients - particular focus on those likely to be less than active: - Females - Older adults - People living in Old Dean and St Michaels - People from minority ethnic groups - Families being supported by the Family Support Programme	Surrey CCGs with support from Surrey District & Borough Councils and SCC	09/09/2013 - 01/11/13

Starting well	Support all pregnant women to breastfeed as seen through an increase in breastfeeding initiation rates and 6-week rate	Provide 10 day breastfeeding rate data	XX number of babies being breastfed at 10 days	Benefits of breastfeeding include: decrease risk of: infection e.g. gastro-intestinal; developing allergic disease e.g. eczema; and becoming overweight/obese and developing related diseases e.g. diabetes	2.02ii Breastfeeding prevalence at 6 - 8 weeks after birth	Pregnant and breastfeeding women including Families being supported by Family Support Programme	Surreys CCG SCC Public Health	
	Ensure more health staff are aware of the need to advise all pregnant and breastfeeding women on taking a 10µg daily supplement of vitamin D **(Making Every Contact Count)**	Increase awareness of all those in contact with pregnant and breastfeeding women to take 10µg daily supplement of vitamin D	XX number of pregnant and breastfeeding women have been advised on vitaminD Awareness raising through training and communication to NHS staff	Reduction in conditions caused by Vitamin D deficiency such as rickets		Health staff such as GPs, midwives, HVs, etc. and their clients including families being support by Family Support Programme	CCGs SCC Public Health	Mar-14
	Increase in uptake of Healthy Start Vouchers combined with promotional campaign to increase children drinking cow's milk at age 1 with vitamin supplement **(Making Every Contact Count)**	Increase in the uptake of healthy start vouchers both for fruit and vegetables and vitamins (available for pregnant women and families with children under four on benefits - midwives, health visitors and children's centres to promote scheme)Promote the use of cow's milk as a drink with vitamin supplement from age 1. This will save money for parents. Promote drinking from cup rather than a bottle, which should have positive benefits for teeth (HVs, GPs and children's centres to promote in particular to families on low income and teenage parents)	Increased uptake in vitamin vouchers to above 3% consistently. Promotional campaign to ensure parent's are aware that they can provide their children with cow's milk and drops	Improvement in nutritional intake leading to decrease in short- and long term-diet-related health conditions such as rickets, diabetes, overweight/obesity, etc	2.11 Diet - is currently a placeholder indicator	Pregnant women and families with children under four on benefits including families being supported by Family Support Programme GPs, midwives, HVs and children's centres staff	Surrey CCGs SCC Public Health	Healthy Start returns April 2013-March 2014
	Ensure that those families who would benefit from attending the HENRY programme are signposted to their local Children's Centre in order to enable them to develop the knowledge and skills to follow a healthy lifestyle	Ensure that GP practices are aware of HENRY programmes available to their practice population. Identify and signpost families who would most benefit from attending HENRY programme Ensure that GP practices are aware of HENRY programmes available to their practice population. Identify and signpost families who would most benefit from attending HENRY programme	X number of parents/carers have been signposted to HENRY programme by their GP. XX number of parents/carers have been signposted to HENRY programme by their HV		2.06i Excess weight in 4 - 5 year olds		Surrey CCGs SCC Public Health	On-going evaluation of HENRY programme

Developing Well	All staff to be aware of NCMP programme and offer appropriate support to families	Ensure participation target is met Signpost parents/carers to support and advice as appropriate including C4L Signpost parents/carers to weight management programmes as appropriate Use findings alongside other data to identify target areas	PHOF for healthy weights in school year R and Year 6		2.06i Excess weight in 4 - 5 year olds 2.06ii Excess weight in 10 - 11 year olds		Surrey CCGs SCC Public Health	
Developing well **Living and working well**	**Screening for physical activity levels** Patients screened for physical activity levels using GPPAQ within primary care **(Early identification)**	Work with GP surgeries to screen patients for physical activity levels using GPPAQ. GPPAQ is integrated into EMIS. NB. 5 QOF attached to indicator HYP004 for hypertensive patients	Xxx number of patients screened using GPPAQ	Early identification of inactivity highlighting the risk to patient i.e. CVD, diabetes, stroke, high cholesterol, hypertension, depression, dementia	1.16 Utilisation of outdoor space for physical activity 2.13i Proportion of active adults (150mins+) 2.13ii Proportion of inactive adults (<30mins activity)	All patients - particular focus on those likely to be less than active: - Females - Older adults - People living in Old Dean and St Michaels - People from minority ethnic groups - Families being supported by the Family Support Programme	Surrey CCGs	Apr-14
	Brief intervention Patients are offered brief advice on physical activity and are signposted to appropriate services.**(Making Every Contact Count)**	Offer patients that score less than active on GPPAQ brief advice on physical activity within a primary care setting. Refer to appropriate services such as Surrey Exercise Referral and Weight Management Scheme or Let's Get Moving: a physical activity care pathway (providing funding for Let's Get Moving is secured) NB. 6 QOF points attached to indicator HYP005 for hypertensive patients.	Xxx number of GP surgeries offering patients a physical activity brief intervention xxx number of patients referred to Surrey Exercise and Weight Management Referral Scheme xxx number of patients recommended to other physical activity opportunities	Increased physical activity levels and thus redcution in risk of over 20 diseases/conditions	1.16 Utilisation of outdoor space for physical activity 2.13i Proportion of active adults (150mins+) 2.13ii Proportion of inactive adults (<30mins activity)	All patients that score less than active on GPPAQ	GP Surgeries	Apr-14
	Brief intervention Funding secured from Surrey County Council and NESTA to deliver Let's Get Moving in Surrey	Apply for funding to ensure Lets Get Moving: a physical activity care pathway can be delivered in Surrey. This will provide a one point of referral for patients screened on GPPAQ as less than active. Lets Get Moving will be the gateway to all physical activity opportunites in Surrey	Funding secured	Increased physical activity levels and thus redcution in risk of over 20 diseases/conditions	1.16 Utilisation of outdoor space for physical activity2.13i Proportion of active adults (150mins+)2.13ii Proportion of inactive adults (<30mins activity)	Those likely to be less than active:those likely to be less than active:- Females- Older adults- People living in Old Dean and St Michaels- People from minority ethnic groups- Families being supported by the Family Support Programme	Surrey CCGs, District & Borough Councils with support from SCC Public Health	Apr-14

	Brief intervention Brief advice on physical activity included in mental health care pathways	Ensure brief advice on physical activity is included in care pathways for mental health	Physical activity included in mental health care pathway xx number of people on the pathway recieving brief advice on physical activity	Increased physical activity levels in people with recorded mental health problem		Those likely to be less than active:those likely to be less than active: - Females - Older adults - People living in deprived communities - People from minority ethnic groups - Families being supported by the Family Support Programme	Surrey CCGs	Apr-14
	Staff promote the Surrey Eat Out Eat Well scheme to their patients who eat a nutritionally unbalanced diet and/or those with a diet-related condition such as hypertension, diabetes, overweight/obesity, etc	Raise awareness of Surrey Eat Out Eat Well (EOEW) award scheme with patients	XXX number of patients provided with EOEW promotional material all link to EOEW website	Eating well important to maintain health and prevent and manage diet-related conditions e.g. cardiovascular disease, cancer, diabetes and obesity	2.11 Diet - is currently a placeholder indicator	GPs, practice nurses, HVs, etc and their patients in particular those who eat a nutritionally unbalanced diet and/or those with a diet-related conditions such as hypertension, diabetes, overweight/obesity, etc.	SCC Trading Standards SCC Public Health Surrey CCGs	
Ageing well	More people aged 65 years and over will take a daily supplement containing 10 µg of vitamin D **(Making Every Contact Count)**	Promote the intake of 10µg daily supplement of vitamin D to all people aged 65 years and over (GPs, district nurses, other health staff and care staff to promote with their patients/clients in particular those housebound and/or cover their skin for cultural reasons)	XX number of staff resent CMOs letter on vitamin D????	Reduction in conditions caused by Vitamin D deficiency including bone problems such as bone pain and tenderness as a result of osteomalacia		People aged 65 years and over in particular those housebound and/or cover their skin for cultural reasons	Surrey CCGs SCC Public Health	Mar-14
	Education and prevention Staff working in care homes and day centres for older people are able to access evidence based training in nutrition and hydration	Promote need for and support development of staff training on: o Nutrition and hydration training for older people including need for vitamin D supplement	XX number of staff accessing training courses	Eating well important to maintain health and prevent and manage diet-related conditions e.g. cardiovascular disease, cancer, diabetes and obesity. Maintaining adequate hydration is important to prevent conditions e.g. urinary tract infection, constipation, etc		Staff working in care homes and day centres for older people and their clients	Surrey CCGs SCC Public Health	Mar-14

6. Sexual Health

Joint Strategic Needs Assessment Summary

Having good sexual and reproductive health is an important aspect of overall physical and emotional health and well-being and is central to the development of some of the most important relationships in our lives. Any person who is sexually active could be negatively affected by their sexual health decisions and may require the support from non-judgemental professionals to help put in place the necessary precautions in order to have a positive and healthy sexual life and to know what to do and where to go in a timely manner if things go wrong.

According to the Health Protection Agency (8), sexually transmitted infections (STIs) and human immunodeficiency virus (HIV), remain among the most important causes of illness due to infectious disease across all age groups, but particularly among younger people. If left untreated, STIs can lead to long-term fertility problems, cervical cancer, and long-term illness and HIV can reduce life span and cause premature death. Teenage parenthood can lead to many health and social disadvantages for mother and baby but an unplanned pregnancy can have a devastating effect both emotionally and economically for people of any age. Termination of pregnancy can have long term emotional consequences and sexual dysfunction can lead to low self esteem, relationship problems and possible marriage and family break-up. All of these aspects of poor sexual health can occur at any stage of life and can have an enduring and severe impact upon people's overall quality of life.

Levels of need around the issue of sexual and reproductive health remain diverse in Surrey. In the case of HIV, Black African people and men who have sex with men (MSM) are the two population groups in Surrey who are most affected by this infection given their relative proportions within the Surrey population. The numbers of new diagnoses decreased in 2009 but the number of people being diagnosed late for this infection means that opportunities have been missed to offer testing and access to effective treatments before they become very ill.

The overall number of new STI diagnoses has decreased in Surrey between 2009 and 2010 although young people under the age of 25 are disproportionately represented in these figures. Surrey did not achieve the 2010-11 target for screening 35% of sexually active young people under the age of 25 for Chlamydia infection though the numbers being screened is increasing year on year. However, the positivity rate is in line with the National average so we can be confident the young people being tested are those more likely to be having unprotected sex and at risk of catching Chlamydia.

The numbers of abortions and repeat abortions performed on women in Surrey has increased over the same period which implies that access to abortion services is good but women are not protecting themselves adequately from getting pregnant in the first place. Long Acting Reversible Contraception (LARC) is cited by the National Institute for Health and Clinical Excellence (NICE) as being the most reliable form of contraception and is recommended for preventing teenage pregnancy and reducing the demand upon abortion services by women of all ages. The numbers of women in Surrey opting for a LARC method of contraception remains low compared to other, less reliable methods. However, the uptake of a LARC method is increasing steadily and GPs are continuing to receive enhanced funding to offer these methods, whilst increasing the choices offered to women to help them find something suitable. The psychosexual health needs of Surrey's population are as yet unknown as it is notoriously difficult to assess the needs of people with problems that they often choose to keep private. At present, two specialist therapy services funded by the NHS are oversubscribed though private options remain available

Approximately 200 babies are born to teenage mothers and around 280 teenagers have terminations in Surrey each year.

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High levels of under 18 year old conception rates were highlighted as a major public health issue and social problem in 1999 with the publication of the Social Exclusion Report (1) which showed that England had the highest teenage conception rate in Western Europe. There are links between high teenage conception rates and areas of deprivation and poverty. Babies born to teenage mothers have worse health outcomes than those of older mothers. They are at risk of premature birth, death in their first year and accidental harm.

Teenage mothers are more at risk of poor mental health, more likely to smoke, less likely to breastfeed and more likely not to be in education, employment or training (NEET) and live in poverty. In response to this, the national strategy for teenage pregnancy and parenthood (2000) was published.

The importance of improving sexual health is acknowledged by the inclusion of three indicators in the Public Health Outcomes Framework (PHOF). These indicators have been prioritised, as each represents an important area of public health that needs sustained and focused effort in order to improve outcomes. The indicators are: • under-18 conceptions; • chlamydia diagnoses (15–24-year-olds); and • people presenting with HIV at a late stage of infection.

Strategy

The prevention strategy will only be delivered through partnership working across statutory and voluntary organisations with delivery of actions by:

Education providers (schools and colleges)

Borough Council

Public Heath (Surrey County Council)

Health Commissioners (Clinical Commissioning Group)

Health Providers (Acute Trusts, Community Services, GPs)

Police

Local business community

Housing

Community groups

Voluntary agencies

Focus of action plan (see Action Plan)

The focus of the action plan is around contributing to the sexual health strategy:

Focus Area	KEY OUTCOME	KEY ACTIONS	MEASURE	HEALTH OUTCOMES	PHOF measures	TARGET GROUP	LEAD AGENCY	TIMESCALE
Chlamydia and Gonhorrea screening	Increase screening uptake	Promotion of NCSP	Screening uptake increased		3.02ii - Chlamydia diagnoses (15-24 year olds) - CTAD	15-24 years old	SCC Public Health and Virgin Care	Sexual Health Strategy to be finalised by Jan 2014
Teenage conceptions	Reduction in teenage conceptions	Work with services for young people and education to ensure all children and young people receive good-quality sex and relationship education at home, at school and in the community.	Reduction in teenage conceptions		2.04 - Under 18 conceptions	13-19 year olds	SCC Public health via sexual health strategy	Sexual Health Strategy to be finalised by Jan 2014
HIV and STIs	Individuals and communities have information and support to access testing and earlier diagnosis and prevent the transmission of HIV and STIs	Appropriate signposting and access to CASH services by wider public health workforce including primary care, pharmacy	Appropriate signposting and access to CASH services by wider public health workforce including primary care, pharmacy		3.04 - People presenting with HIV at a late stage of infection	16 plus	SCC Public Health and wider PH workforce	Sexual Health Strategy to be finalised by Jan 2014
Access to CASH services	Ensure appropriate access to CASH services	Appropriate signposting and access to CASH services by wider public health workforce including primary care, pharmacy and services for young people.	Appropriate signposting and access to CASH services by wider public health workforce including primary care, pharmacy and services for young people.			16 plus	SCC Public health via sexual health strategy	Sexual Health Strategy to be finalised by Jan 2014

7. Mental Health

Risk and Protective Factors

There are evidence based protective and risk factors for mental health and a central element of Prevention and Mental Health Promotion is to reduce the risk factors and increase the protective factors. Mental health risk factors can be grouped into the following key categories:

Family factors: Parental mental health, Parenting

Wider determinants of health and Social economic factors

Individual factors:

Genetic factors

Poor health/long term health conditions

Caring role

Poor resilience (eg poor problem solving, communication skills, low self- esteem)

Adverse life experiences (eg neglect, abuse, bullying, job loss, relationship breakdown bereavement)

Incidence of Mental Health Problems

The table below shows the percentage of people with various mental health disorders (based on the Adult Psychiatric Morbidity Survey (2007) and the *estimated* numbers of adults in Surrey with these disorders (based on the Surrey population aged 16+ 2012 estimate (ONS))

	16+			Number in Surrey (16+)		
	Male %	Female %	Persons %	Male	Female	Persons
Prevalence of common mental disorder (CMD) in past week	12.5	19.7	16.2	55,807	93,586	149,286
Suicidal thoughts lifetime (self completion)	14	19.2	16.7	62,504	91,211	153,893
Suicide attempts lifetime (self completion)	4.3	6.9	5.6	19,198	32,779	51,605
Self harm lifetime (self completion)	4.4	5.4	4.9	19,644	25,653	45,154
Prevalence of psychotic disorder in past year	0.3	0.5	0.4	1,339	2,375	3,686
Antisocial personality disorder in past year	0.6	0.1	0.3	2,679	475	2,765
Borderline personality disorder in past year	0.3	0.6	0.4	1,339	2,850	3,686
Comorbidity: 1 condition	15.1	16.4	15.8	67,415	77,910	145,600
Comorbidity: 2+ conditions	6.9	7.5	7.2	30,806	35,629	66,349
Surrey 16+ 2012 population estimate (ONS)				446,459	475,058	921,517

Source: Psychiatric morbidity among adults living in private households 2007, The Stationery Office,

However these figures are underestimates as the Adult Psychiatric Morbidity Survey demonstrates there is considerably higher prevalence of mental health problems among the general population, than those receiving treatment as indicated by data from primary and secondary health services [2]: Often the stigma surrounding mental health can make people reluctant /make it harder for people to seek help from health services, hence the importance of self-help and anti-stigma interventions.

The table below shows the areas in Surrey with the highest level of common mental health needs (The indicator measures mood or anxiety disorders, based on prescribing, suicides, and health benefits data).

IMD 2010: Surrey Lower Super Output Areas with the highest levels of common mental illness (Highest Mental Health Indicator scores)

LSOA11CD	LSOA11NM	LA	Ward	Surrey CCG	ID 2010 Mood and anxiety disorders indicator
E01030914	Waverley 010A	Waverley	Godalming Central and Ockford	NHS Guildford and Waverley CCG	0.97
E01030985	Woking 004F	Woking	Maybury and Sheerwater	NHS North West Surrey CCG	0.94
E01030599	Reigate and Banstead 008A	Reigate and Banstead	Merstham	NHS East Surrey CCG	0.85
E01030793	Surrey Heath 008A	Surrey Heath	St Michaels	NHS Surrey Heath CCG	0.83
E01030893	Waverley 003D	Waverley	Farnham Moor Park	NHS North East Hampshire and Farnham CCG	0.81

Comparative Data

Incidence

Overall common mental health needs in Surrey – as measured by the Index of Multiple Deprivation (2010) Mental Health Indicator – are *relatively low compared to nationally,* with the worst score being .97 in Surrey compared to 3.32 nationally

Surrey has a statistically significantly lower percentage of adults aged 18+ with depression (11.32%), compared to national data (11.68%, where 20.29% is the highest in the country and 4.75% is the lowest) [3].

Surrey has statistically significantly lower prevalence of schizophrenia, bipolar disorder and other psychoses than England *(QOF 2011) and* The MINI2000 score for Surrey indicates an incidence of severe mental illness that is *40% lower in Surrey than England* [4]

Wider Determinants [3] – Surrey is statistically significantly better than England on:

Percentage of 16-18 year olds not in employment, education or training (2011)

Percentage of the relevant population living in the 20% most deprived areas in England (2010)

Working age adults who are unemployed (rate per 1 000 population 2011/11)

Hospital admissions for alcohol attributable conditions (rates per 1 000 population 2011/12)

Risk factors – Surrey is statistically significantly better than England on [3]:

Rate of statutory homeless households per 1 000 households (all ages) 2010/11 (0.42 vs 2.03)

Percentage of population with a limiting long term illness 2001 (12.5% vs 16.9)

Number of f first time entrants into the youth justice system (10-17 year olds) 2001-11

Suicide & undetermined injury: Indirectly standardised mortality rate 2010-11 in Surrey was slightly higher, than for England (109 vs 100 – although this difference was not statistically significant) [3]

Cost of Mental Ill Health

In 2009-10 the estimated total cost of mental ill health in England was £105.2 billion. £53.6 billion in human suffering and negative impact on peoples' quality of life; £30.3 billion in lost economic output and £21.3 billion in health and social care costs.

Nationally and in Surrey, Mental health disorders was the largest total expenditure of all health programme budgeting categories - accounting for 10.8% of the total health spend in Surrey [5].Surrey spend is £195 per head, just below the £198.3 per head national average, which puts Surrey in the second highest spend decile nationally [6]

Mental Health and Wider Determinants Public Health Outcome Indicators

The table below shows comparisons between England and Surrey on Mental Health Indicators and relevant wider determinants indicators. Where data is available, shaded boxes indicate that the differences between England and Surrey are statistically significant.

Mental Health Indicator (with published data)	England	Surrey	Surrey higher/lower than Eng
2.13i Percentage of physically active adults	56%	60.1%	Higher
2.13ii Percentage of physically inactive adults	28.5%	23.1%	Lower
2.23i Self-reported well-being: people with a low satisfaction score	24.3%	20.0%	Lower
2.23ii Self-reported well-being: people with a low worthwhile score	20.1%	16.7%	Lower
2.23iii Self-reported well-being: people with a low happiness score	29.0%	27.5%	Similar
2.23iv Self-reported well-being: people with a high anxiety score	40.1%	40.9%	Similar
2.08 Emotional wellbeing of looked after children (average difficulty score for all Looked After Children aged 4-16 who have been in care for at least 12 months)	13.8%	14.7%	confidence level data not available
Wider Determinants Indicator (with published data)			
1.04i First time entrants to the criminal justice system	537	151	Lower
1.06ii Adults in contact with secondary mental health services who live in stable accommodation	66.8%	72.3%	confidence level data not available
105 16-18 year olds not in education, employment or training	5.8%	4%	Lower
1.12ii Violent crime (including sexual violence) violent offences	13.6 per 1000 crude rate	10.7 per 1000 crude rate	Lower
1.13i Re-offending levels: % of offenders who re-offend	26.8%	22.9%	Lower
1.13ii Re-offending levels: average number re-offences per offender	0.77	0.71	Lower
1.15i Statutory homelessness: homelessness acceptances	2.3 per 1000 households	0.6 per 1000 households	Lower
1.15ii Statutory homelessness: households in temporary accommodation	2.3	0.8	Lower
1.8.i Social isolation: % of adult social care users who have as much social contact as they would like	42.3%	43.5%	Similar
Healthcare and Premature Mortality			
4.10 Suicide rate (provisional) 2009-11 Age standardised mortality rate from suicide and injury of undetermined intent	7.9 per 100 000	8.1 per 100 000	Similar

Hard to Reach Groups

The population based mental health promotion service for Surrey has within its specification, to work with high risk and hard to reach groups. Specifically:

Black Minority Ethnic groups (BME); older adults; men; unemployed people; people with long term health conditions; prisoners; carers; homeless people; victims of abuse; lesbian/ gay/bisexual/ transgender groups (LGBT).

The Supporting Families programme works with families that can be hard to reach.

References

The Mental Health Foundation, http://www.mentalhealth.org.uk/help-information/mental-health-statistics

Source: National Centre for Social Research (2009)

Community Mental Health Profiles 2013: North East Public Health Observatory http://www.nepho.org.uk/cmhp/index.php?pdf=E10000030

Glover G, Arts G, Wooff D (2004). A needs index for mental health care in England based on updatable data. Social Psychiatry and Psychiatric Epidemiology 39:730-738 and Quality and Outcomes Framework . NHS Information Centre 2011

PCT programme budgeting returns to the Department of Health for 2011-12

Department of Health (2013) National Survey of Investment in Adult Mental Health Services (2011-2012)

Strategy

The prevention strategy will only be delivered through partnership working across statutory and voluntary organisations with delivery of actions by:

Education providers (schools and colleges)

Borough Council

Public Heath (Surrey County Council)

Health Commissioners (Clinical Commissioning Group)

Health Providers (Mental Health Trusts Acute Trusts, Community Services, Mental Health Promotion Service, GPs)

Police

Local business community

Housing

Community groups

Voluntary agencies

Focus of action plan (see Action Plan)

The focus of the action plan is around 4 main areas for improvement:

Focus Area	KEY OUTCOME	KEY ACTIONS	MEASURE	HEALTH OUTCOMES	PHOF measures	TARGET GROUP	LEAD AGENCY	TIMESCALE
Mental Health Promotion & Prevention: Adults	Resilience	· Delivery of Mental Health Promotion Service: First Steps · Agencies directing people to it ·Ensure brief advice on physical activity is included in care pathways for mental health · Implement actions of the National Mental Health Strategy https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216870/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf Including: -CCGs & Local Authorities identifying a MH Lead -MH Awareness Training for front line staff: Primary Care, Acute & Community Trusts, Housing, Employment, Criminal Justice, Employer managers Prevention Actions in Joint MH Commissioning Strategy (tbc) ·Supporting Families Programme: ensure all staff understand the implications for mental health of the difficulties faced by these families. Offer staff MH Awareness training	Service delivered to the specification. -Service usage data -Signposting to the service by various agencies Physical activity is included in the MH care pathway. Measured by no. of people on path-way receiving brief advice Actions implemented (checklist to be developed) Strategy monitoring/evaluation Programme evaluation measures				Virgin Care CCGs, LA's, Health Providers, Housing, Employers, Voluntary sector -CCGs/GPs P18-19 -Primary Care P22-3 -MH Trusts P 19-20 - Acute/Comm.Trusts P21 -Local Authorities P24 -HW B Boards P25 -Social Care P26 -Public Health P27 -Education P31 -Employment Support P33, Employers P34 -Criminal Justice P36 -Housing Org.s P38 CCGs, Acute, MH, Social Care & Community Service Providers Local Authorities	Ongoing Jan 2014 onwards Ongoing
Mental Health Promotion & Prevention: Children and Young People		Healthy Schools – PSHE & Emotional Health & Wellbeing· Targeted Mental Health in Schools training to whole school staff in MH awareness and attachment theory. Identifying children who may need targeted support & ensuring good systems of delivering early interv-entions are in place, link to CAMHS· Supporting Families Programme	Established evaluation system Established evaluation system				CAMHS SCC & Babcock 4S SCC & Babcock 4S Local Authorities	Ongoing Ongoing Ongoing

Wider Determinants of Mental Health		· Implement actions from National Mental Health Strategy :-Appoint a member MH Champion-Assess impact of strategies/ commissioning decisions & services on MH & Wellbeing (eg via MWB Impact Assessment)-Involve people with MH problems &carers in service/pathway design-Consider whole place/community budgets for people with MH issues-Sign up to Surrey & national Time to Change campaign (belowActions from Health & Wellbeing Board workshop for Borough & District councils on Emotional Wellbeing & Mental Health 11 July. (Priorities: 5 ways to wellbeing campaign, MH Awareness Training for public facing staff, encouraging employment, volunteering & social capital, mapping & publicising social assets, use of Surrey Information Point , Digital Inclusion & Hubs, Co-location of services & encouraging voluntary & faith sector to do more around MH)	Actions implemented (checklist to be developed)Implementation table				District & Borough CouncilsThird Sector Agencies	TBC by Local Authorities. Monitoring quarterly
Stigma & Discrimination	More awareness of MH Reduced stigma & discrimination More confidence to address discrimination	Pilot & evaluate Time to Change-Surrey in Redhill/Merstham: MH awareness training Ambassador Scheme Arts approaches: councils & college Community Empowerment Local Authorities, Employers & Third Sector Agencies to sign the Surrey Time to Change Pledge www.surreycc.gov.uk/timetochangesurrey Roll out Time to Change to other high MH need areas in Surrey Anti-stigma work done by First Steps Service	Evaluation measures of pilot (based on national measures) Numbers of pledges on web page Contract Monitoring reports and meetings					Pilot Apr-Nov13 Sep-Nov 2013 & ongoing Roll out subject to evaluation Ongoing
Suicide Prevention	Reduction in suicide	Suicide Audit (Coroner data) gathered on a regular basis · Suicide Audit Working Gp. set up · Development of Surrey Suicide Prevention Strategy (based on audit & national strategy & Think Tank events with staff & users) · Implement strategy actions · Frontline staff to receive MH Awareness/MH First Aid /Suicide Prevention Training (as appropriate)	Audit data Group established Suicide Prevention Strategy completed Actions implemented Training provided and evaluated				Public Health Public Health Multi-agency & service users CCGs , staff in primary care, Acute, Community & MH Trusts, Ambulance), Police, Fire, Housing, Job Centre/Benefits	Nov 13 to collect 2012 data. Then bi-monthly 01/11/2013 Dec 2013 Jan 2014-2017

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