Hidden disadvantages in Surrey

Taking action on poor wellbeing

Public Health
Annual Report
2012-2013

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Foreword

Welcome to my Director of Public Health Annual Report for Surrey.

The aim of this report is to stimulate discussion and effective action to address avoidable differences in health outcomes and wellbeing (the so called health inequalities) in Surrey. As the title suggests, health inequalities in Surrey are often hidden and will require collective action and determination to reverse the widening gap between those that have good health and those that do not in our relatively prosperous County.

This report focuses on life expectancy as a key indicator of health inequalities in Surrey. The average life expectancy in Surrey is 82 years. This is good compared to other parts of England. However, by calculating, reviewing and analysing life expectancy at the electoral ward level we can see a less desirable picture compared to the county average.

In one ward in Reigate and Banstead, life expectancy is as low as 77.3 years whereas in one ward in Tandridge it is 92.1. This gap of nearly 15 years shows that at the extreme, people in Surrey experience health and wellbeing very differently. Further analysis reveals a strong relationship between life expectancy and deprivation. If you live in one of the most deprived areas of Surrey, as a man you are likely to have a shorter life expectancy of about 6 years and 4 years as a woman compared to your neighbours in the more affluent parts of the county.

Tackling the difference in health and life outcomes related to deprivation and disadvantage requires action on the root causes of these inequalities, the "Cause of the Causes" which are income, education, housing/living conditions and lifestyles. The real life stories in the Case Studies section towards the end of this report make the issues real and goad us to act now.

With the new statutory powers and the transfer of public health functions into local authorities, we should be ideally placed to facilitate an organised effort of Surrey citizens, local authority colleagues across the county, NHS partners, voluntary organisations and industry to deliver good outcomes for all sections of Surrey society.

All the data presented in this report is available in the Joint Strategic Needs Assessment (JSNA) which is available from the www.surreyi.gov.uk website. Surrey-i is a one-stop treasure trove of data, information, specialist reports, summary analysis and headline statistics, covering Surrey's demographics (details about our population), our health, our economy and public services. Evidence and information have always been important in planning, developing, improving and delivering effective local services and governance, and never has this been more the case than it is now if we are to truly understand and help the population that we serve.

The real question is "how do we use the relative affluence, capabilities and social networks in Surrey to get what Surrey wants – everyone's health and wellbeing, life chances and prosperity?" While I describe the picture of disadvantage in Surrey in this report, my main goal is to highlight where action is needed and encourage a movement towards better wellbeing for all of Surrey.

This asset based approach goes beyond a dependency on public service spend and focuses on using what we've got to get what we want more effectively. Thank you for taking time to read the report. I would welcome your comments and suggestions at public.health@surreycc.gov.uk

Dr Akeem Ali, Director of Public Health

Acknowledgements

I would like to thank the following people for contributing to this report:

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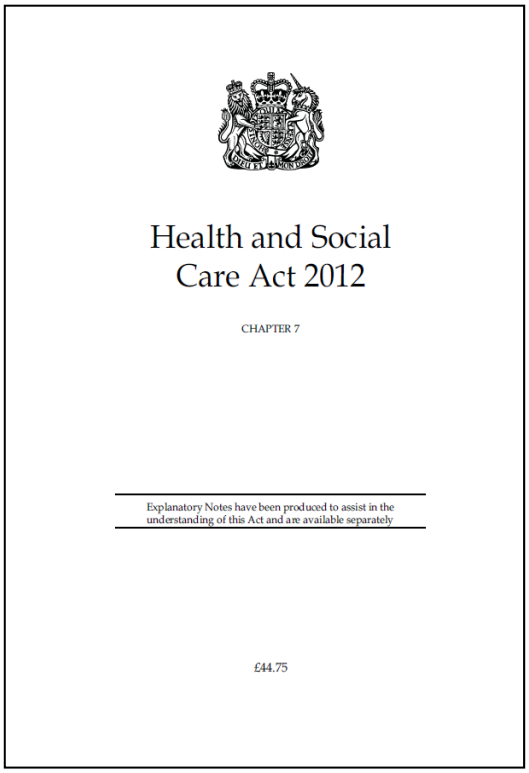
1. Introduction

This report is split into 10 chapters, which provide an overview of health and wellbeing in Surrey and then explores in-depth the health inequalities that exist with the difference in life expectancy and with specific communities. It looks at how a focus on assets could help address some of these inequalities and provides some case studies of some promising work with local communities. It concludes with a look at how we can measure changes in health with the introduction of the public health outcome framework together with recommendations about how we can address the widening differences in health across Surrey. First though we examine the exciting development of the public health function moving into the local authority and what benefits this change will bring.

The Public Health Function Moving to Surrey County Council

The Health & Social Care Act (2012) made provisions for the transfer of local public health functions from the NHS (in Primary Care Trusts) to Local Authorities (at County Level in two tier Local Authorities, such as Surrey). From April 2013, local authorities will take on a range of new responsibilities for protecting and promoting the public's health, funded by a ring-fenced grant. These new responsibilities will be supported by the transfer of specialist public health staff from the NHS to local authorities to provide professional leadership for public health.

Local authorities have a long history of providing a home to public health (which moved into the NHS in 1974). Since then, Councils have continued to work with public health colleagues - all tiers of local government deliver services relevant to population health. For example, access to good quality housing, community development, education, transport and the environment are all associated with the health of populations.



Health and Social Care Act 2012

CHAPTER 7

Explanatory Notes have been produced to assist in the understanding of this Act and are available separately

£44.75

Public Health from April 2013

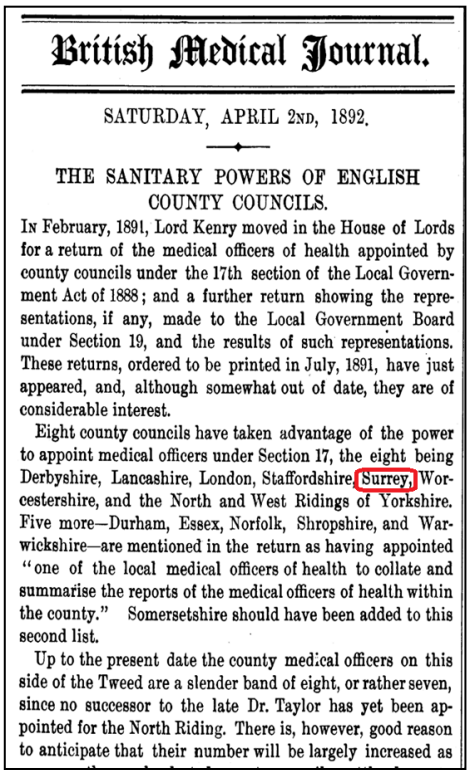
Local authorities will deliver and commission a range of public health services, including those in 6 key mandatory areas: Commissioning appropriate access to sexual health services; Commissioning the NHS Health Check programme; Commissioning the Healthy Child Programme 5-19 years; Commissioning the National Child Measurement Programme; Ensuring, through a duty of the Director of Public Health, that plans are in place to protect the population's health; Ensuring NHS commissioners receive the public health advice they need.

As Director of Public Health I will be the lead officer for health in the local authority and a statutory chief officer[1]. In this role I will have specific responsibilities for health protection and emergency health planning and for publishing an annual report on population health.

The Public Health Outcomes Framework (PHOF) published in January 2012 describes the Government's vision for measuring the success of its new public health strategy at a local and national level[2]. 66 indicators will underpin 2 key outcomes:

- Healthy life expectancy (the number of years, on average, that people can expect to live in good health)
- Reduced differences, or inequalities, in life expectancy (the number of years, on average, that people can expect to live), and healthy life expectancy between communities.

Transition in Surrey



British Medical Journal.

SATURDAY, APRIL 2ND, 1892.

THE SANITARY POWERS OF ENGLISH COUNTY COUNCILS.

In February, 1891, Lord Kenry moved in the House of Lords for a return of the medical officers of health appointed by county councils under the 17th section of the Local Government Act of 1888; and a further return showing the representations, if any, made to the Local Government Board under Section 19, and the results of such representations. These returns, ordered to be printed in July, 1891, have just appeared, and, although somewhat out of date, they are of considerable interest.

Eight county councils have taken advantage of the power to appoint medical officers under Section 17, the eight being Derbyshire, Lancashire, London, Staffordshire, Surrey, Worcestershire, and the North and West Ridings of Yorkshire. Five more—Durham, Essex, Norfolk, Shropshire, and Warwickshire—are mentioned in the return as having appointed "one of the local medical officers of health to collate and summarise the reports of the medical officers of health within the county." Somersetshire should have been added to this second list.

Up to the present date the county medical officers on this side of the Tweed are a slender band of eight, or rather seven, since no successor to the late Dr. Taylor has yet been appointed for the North Riding. There is, however, good reason to anticipate that their number will be largely increased as

April 2012 saw the successful relocation of members of the public health team from NHS Surrey bases to Surrey County Council premises in preparation for the transfer of functions the following year. During this 'shadow' year, the team continue to be formally employed by NHS Surrey. Over this time, the team has been making preparations for transition, whilst delivering existing NHS

programmes. A draft vision and operational strategy have been developed, and plans for the commissioning of public health services are in place to ensure that the County Council is ready to take on its new role to lead the promotion and protection of population health in Surrey.

2. Background to Surrey

Surrey people generally enjoy good health and wellbeing and expect to live a long and healthy life. Although Surrey is relatively affluent, there are pockets of deprivation, and this is the theme that this report will explore.

Surrey's population is projected to rise over the coming decade, with notable increases in the number of older people. This will have a major impact on service planning, as older people are more likely to experience disability and long-term-conditions resulting in increased social care costs (residential care homes, carer costs, palliative care, etc), increased use of primary and acute care (GP services, hospital admissions, patient transport, etc), implications for housing (as there will be potentially more older people experiencing fuel poverty resulting in increased winter deaths) and implications for planning (as there may be increased need for disabled access, public transport and other services upon which older people rely). Apart from the higher financial costs associated with an increasing older population (estimated at £885m Surrey), there is also a cost to society – family members are often carers for elderly relatives and, as can be seen in the Carers section of this report, the role of caring can have a negative impact on the physical and mental health of the carer.

Part of the challenge will be to ensure the right preventative and support services are in place so older people can remain independent for as long as possible.

During these challenging economic times it has never been so important for the NHS, Local Authorities and society at large to work together to find our more cost effective ways to provide health and social care.

Surrey's young people mostly experience good health, are safe, well-educated and have good leisure and employment opportunities. Young people generally get better qualifications than the national average, with 64% achieving five or more A* – C grades at GCSE compared to the England average of 58%. Most Surrey families benefit from higher than average household incomes and live in relatively safe and affluent areas.

Surrey has a low number of young people who are "Not in Education, Employment or Training" (NEET) compared with the average for South East England. Teenagers who are pregnant or are parents and people with some form of learning disability or difficulty are more likely to be NEET.

Although, on the whole, health and wellbeing in Surrey is good, behind these headlines there are a number of major issues facing our communities and this report aims to highlight these challenges.

3. Health Inequalities

As highlighted already, Surrey is a healthy place to live. It is an affluent county and includes some of England's finest parks and woodlands. However, despite the general affluence there are geographical pockets of relative deprivation: The table below shows 11 of the 204 wards in Surrey which are among the most deprived wards in England:

LA Name	WARD
Spelthorne	Stanwell North
Woking	Maybury and Sheerwater
Guildford	Stoke
Reigate and Banstead	Preston
Epsom and Ewell	Court
Spelthorne	Ashford North and Stanwell South
Surrey Heath	Old Dean
Guildford	Westborough
Mole Valley	Charlwood
Spelthorne	Sunbury Common
Runnymede	Chertsey St Ann`s

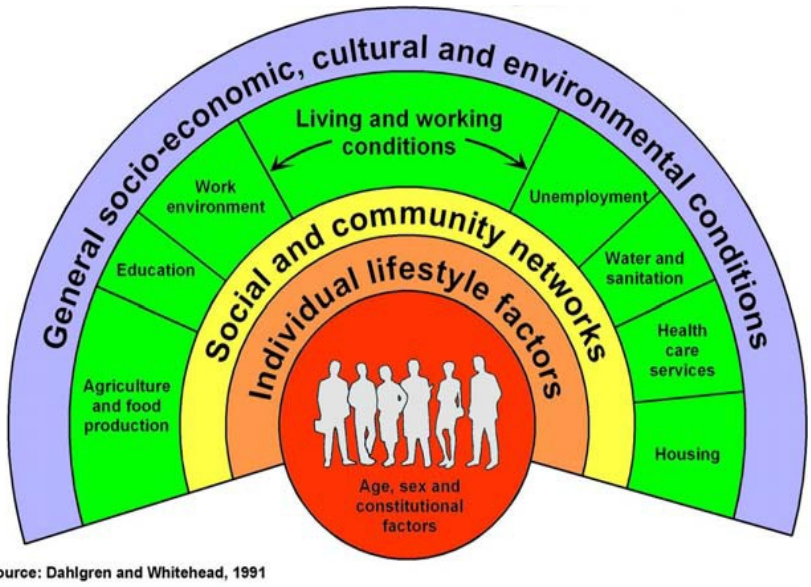
Inequalities also exist within the same geographical areas across different population groups. People who live in the more deprived areas of Surrey or who represent certain population groups have worse health outcomes and have a lower life expectancy than the people who live in the least deprived areas of Surrey. Vulnerable populations include Black and Minority Ethnic populations such as South Asians living in Woking, Gypsy Roma Traveller populations, veterans and military families.

Understanding & Tackling Inequalities - The Marmot Review

The Marmot Review - 'Fair Society, Healthy Lives'[3] undertook a strategic review of health inequalities in England and reported in 2010. The report indicates that people are dying prematurely in England every year because of health inequalities. These health inequalities are the product of social inequalities: people are more likely to suffer poor health if they have a lower social position.

"Reducing health inequalities is a matter of fairness and social justice"

We therefore need to take action across all the social determinants of health in order to reduce the health inequalities that exist within Surrey. The diagram below shows how a person's health is determined by many factors, which go far beyond the individual lifestyle factors.



Source: Dahlgren and Whitehead, 1991

The Marmot Review suggests adopting a "Life Course" approach. As disadvantage often starts before birth and accumulates throughout life, it therefore follows that action to reduce these health inequalities must commence before birth and continue throughout the child's life. A call to action is required on the following six policy objectives:

1. *Give every child the best start in life*
2. *Enable all children, young people and adults to maximise their capabilities and have control over their lives*
3. *Create fair employment and good work for all*
4. *Ensure healthy standard of living for all*
5. *Create and develop healthy and sustainable places and communities*
6. *Strengthen the role and impact of ill health prevention*

Surrey County Council's current strategic focus areas are:

Residents

Individuals, families and communities will have more influence, control and responsibility.

Value

We will create public value by improving outcomes for residents.

Partnerships

We will work with our partners in the interests of Surrey.

Quality

We will ensure the highest quality and encourage innovation.

People

We will develop and equip our officers and Members to provide excellent service.

Stewardship

We will look after Surrey's resources responsibly.

With the evidence behind the Marmot report together with the introduction of Public Health to the statutory responsibilities to the council, the time may be right to review the council's strategic focus to ensure that health and wellbeing are at the core of what the council wants to achieve.

The challenge with having a generally affluent population, as is the case in Surrey, is that the infrastructure is geared towards the more affluent members of society (for example Surrey has the highest per capita vehicle ownership in Britain) whilst those living in relative poverty are excluded from the norms that surround them. For example, Surrey County Council Transport Statistics (2011) shows that 26% of the Westborough households do not own a car; this is much lower than the Surrey average of 14% and the South East regional average of 19%.

This hidden deprivation has been highlighted in a report entitled "Hidden Surrey: why local giving is needed to strengthen our communities"[4] which claims that within the hidden pockets of deprivation, there are high levels of child poverty, low income and poor mental health. These deprived areas are often next door to an affluent area which has the effect of camouflaging the extent of need, and diverting much needed public funds to other areas of the country where the need is more visible.

Additionally, research has shown that where there are large differences between the most deprived and the least deprived (as can be seen in Surrey), there are worse health and social problems[5]. Although the UK is one of the richest of the developed countries, it is also one of the most unequal. Data taken from the United Nations Development Program human development indicators (2003-6) measure of income inequality reveal a very strong correlation between developed countries with high income inequality and increased health and social problems. It is likely therefore that the gap between the most deprived and the least deprived in Surrey is a contributory factor in the poor health outcomes for some of the Surrey population.

Together with the challenges of the current financial climate, there is also the possibility that some of Surrey's residents will be adversely affected by the welfare reform. A report by ESRO (2012)[6], commissioned by Surrey County Council, looked into the likely impacts of welfare reform on the lives of Surrey residents. The qualitative research focused on low income families and people living with a disability. It concluded that low income families would be financially worse-off after the reforms, and that although they would use coping strategies, over time this would pose significant risks to housing security, physical and mental health and outcomes for children. Although the report did not consider it likely that people living with a disability would be affected financially by the reforms, the process of being reassessed for eligibility to work was shown to be causing confusion, anxiety and stress.

4. A Focus on Assets: What Makes Surrey Healthy?

Surrey benefits from a well educated and economically active population; for instance, of the working age population, three quarters are in employment. Mobilising skills from within its communities is key to Surrey meeting the Government's vision of a big society. The County has around 100,000 volunteers which represent a tremendous amount of skill and knowledge which commissioners and services could potentially tap into in order to improve the health, wellbeing and social functioning of Surrey residents.

Asset based approaches are gradually becoming an important element of community empowerment and community-led work. In particular, asset based approaches respect that sustained positive health and social outcomes will only occur when people and communities have the opportunities and facility to control and manage their own future[7].

In itself, asset based community development (ABCD) can be described as a way to identify and use the strengths within communities to improve sustainable development and local resilience, and thus contribute to people's health.

However, asset based approaches differentiate themselves from philanthropy in a sense that it is not so much the giving that makes a difference locally, it is the innovation and the community impact behind it.

Examples of how ABCD has been put into practice are numerous:

- Elmbridge Community Link: This was originally an initiative by a former mayor of Elmbridge who observed that there was no community support within the borough for disabled adults. Although originally envisaged as an advocacy service and drop-in centre, it now provides regular scheduled activities for its members on weekday evenings and at weekends[8].

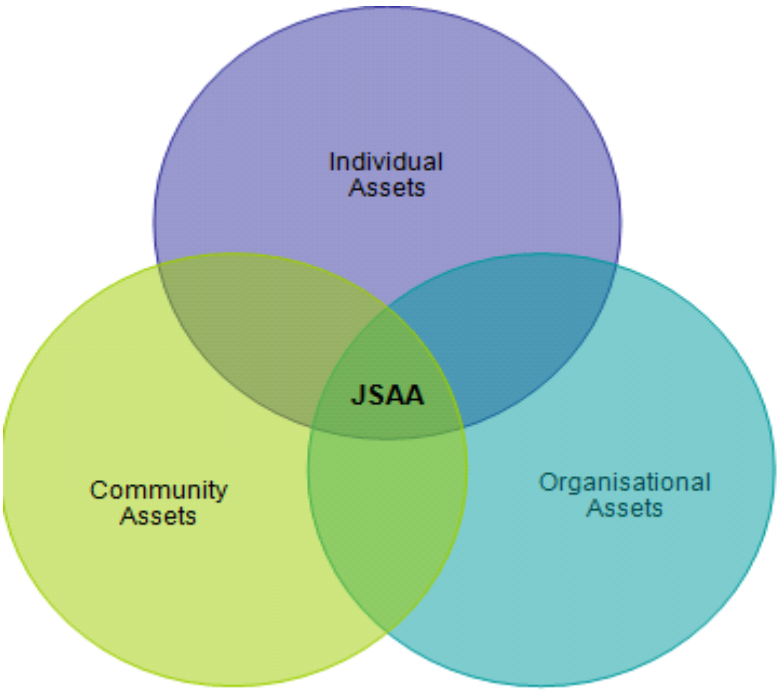
- Health Trainers: Developed and funded by Surrey Public Health following a Department of Health initiative, health trainers aim to provide practical support to members of deprived communities in order to achieve a marked reduction in health inequalities. The scheme works along the line of a peer-led model in a sense that support is ultimately provided by trained members of the same communities.

- Surrey also hosted a number of events as part of the London Olympics 2012 which not only put Surrey on the map internationally, but also inspired many individuals to build on the legacy of the games.

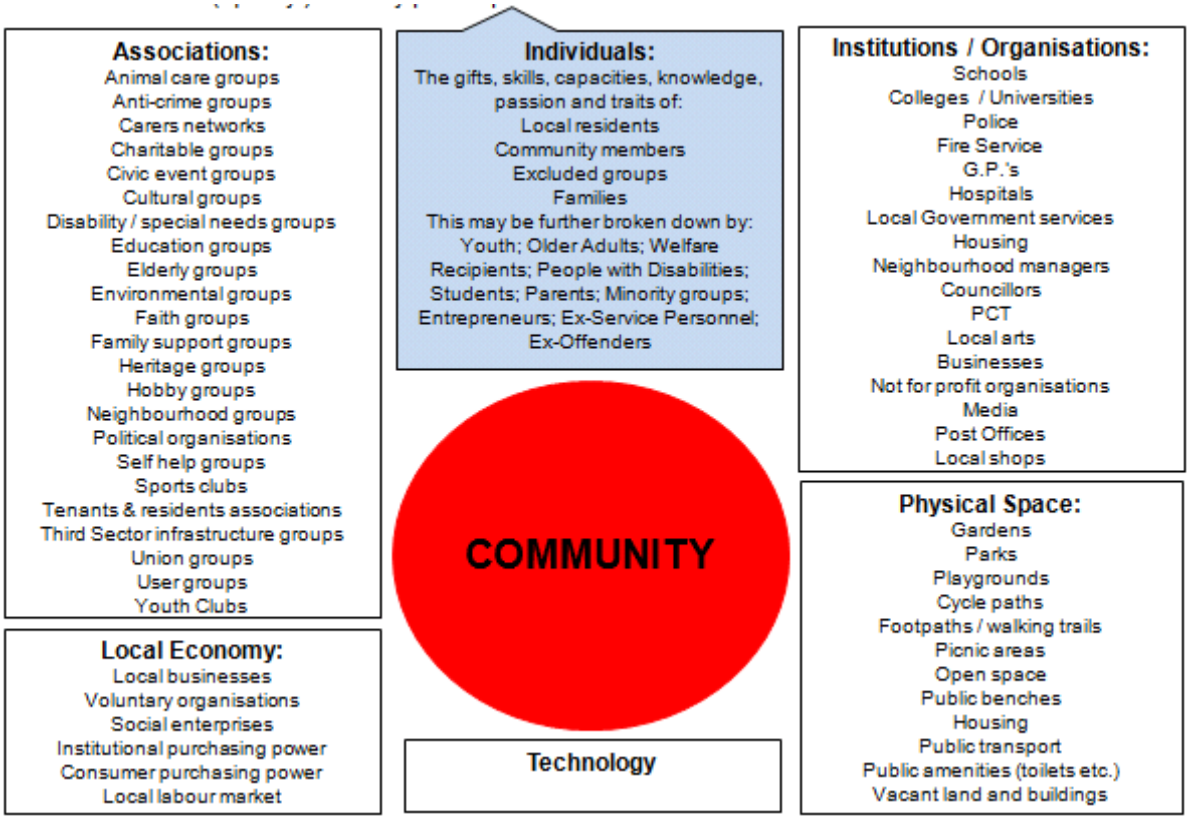
A crucial element of asset-based approaches is developing a sense of a common purpose among communities and community members, whilst identifying what skills and knowledge can be drawn from individuals, communities and organisations to help achieve that purpose.

The graphic below[9] illustrates asset mapping through the interdependencies between individuals, communities and organisations as part of a joint strategic asset assessment (JSAA) which ideally should be built into the JSNA process.

Asset Mapping – Joint Strategic Asset Assessment



The mapping process can be further explained by zooming into each of the 3 circles, and within each of them identifying who the assets really are[9].



However none of the above would be relevant without involving communities and individuals into the process of commissioning services. Even though local authorities and health services do have statutory targets which are set centrally – an asset based approach will not change that. Community involvement has to become more prominent in assisting local government officials and commissioners in identifying needs, planning services and delivering them. There are good examples of this taking place locally which we need to build upon, such as the partnership between Action for Carers, the NHS and Surrey County Council on the adult carers' health survey.

It is not only the mutual ownership of local problems but also the mutual ownership of local solutions to address them which will bring individuals, communities and public services closer together.

As Professor Edgar Cahn suggests, the service managers or the providers need their clients or customers as much as the clients or customers need the providers of services. There is a definite intricate dependency between both set of actors. That dynamic is often referred to as "co-production". In the words of Professor Cahn "Family, neighbourhood, community are the Core Economy. The Core Economy produces: love and caring, coming to each other's rescue, democracy and social justice. It is time now to invest in rebuilding the Core Economy"[10].

The assets perspective offers practical and innovative ways to impact on the positive factors that nurture health and wellbeing. Asset based activities are united by how they go about their business and what they are trying to achieve, how they deliver their services and how they engage with their clients or participants, and the relationships they build.

Features of asset based activities include[7]:

- Making individual issues community ones, building around needs and aspirations, building supportive groups and networks, developing opportunities for meaningful engagement;
- Identifying, building on and mobilising personal, local assets and resources – people, time, skills, experience – mapping the capacities and assets of individuals, associations and local institutions;
- Building and using local knowledge and experience to influence change, engaging people in decision making and local governance, building a community vision and plan, and defining local priorities;
- Empowering the workforce, changing the relationships between users and providers and across providers to share and liberate resources;
- Focusing on facilitating, enabling and empowering rather than delivering;
- Leveraging activities, investments and resources from outside the community, mobilising and linking assets for economic development.

5. Measuring Inequalities - Life Expectancy

Life expectancy at birth for an area in a given time period is an estimate of the average number of years a new-born baby would survive if he or she experienced a particular area's age-specific mortality rates for that time period throughout his or her life[11]. This is known as period life expectancy.

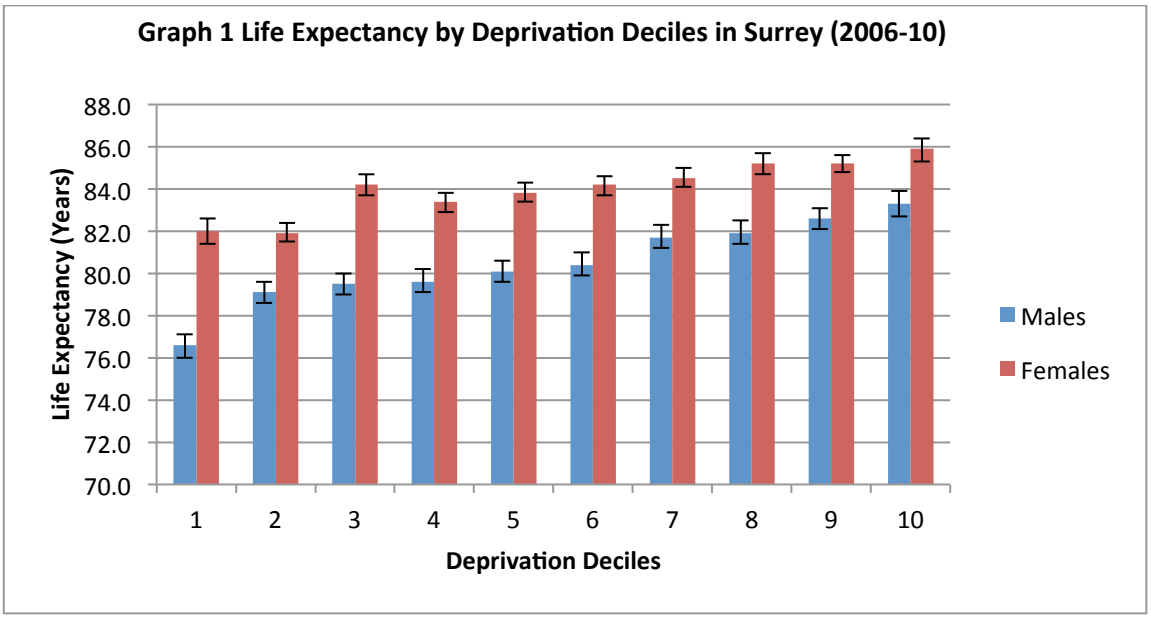
One of the overarching indicators in the Public Health Outcomes Framework (PHOF) looks at differences in life expectancy between communities. It is the only indicator in the PHOF which is explicitly an inequalities indicator[12]. This is measured using the slope index of inequality (SII) in life expectancy.

The SII is a single score which represents the gap in years of life expectancy between the best-off and worst-off within the local authority, based on a statistical analysis of the relationship between life expectancy and deprivation scores across the whole authority.

Life expectancy and deprivation are strongly correlated. This means areas with a wider range of deprivation will tend to have greater ranges of life expectancy and therefore a large SII. The local authority's population is divided into ten deprivation deciles by grouping Lower Super Output Areas (LSOAs) according to their IMD 2010 score[13].

With the population of Surrey grouped into 10 equal cohorts (deciles) based on deprivation, graph 1 shows the life expectancies for the different deciles of deprivation within the county. Each bar has the range of possible measures (confidence intervals) of life expectancy for each decile. The SII shows the gap to be bridged between the least and most disadvantaged population deciles.

Men in the most deprived decile of Lower Super Output Areas (LSOAs) in Surrey have a life expectancy of 76.6 years compared to 83.3 years for the least deprived. This gives the slope index of inequality (SII) for life expectancy at birth for men in Surrey as 6.3 years between the most and least deprived deciles. The SII for females is 4.1 years and represents the gap between a life expectancy of 82 years in the most deprived decile and 85.9 in the least deprived.



Note: Decile 1 is the most deprived decile. Population refers to the average of the mid-year population estimates for 2006-10. Sources: ONS death registration data and mid-year population estimates & Department of Communities and Local Government, Indices of Deprivation 2010. Analysis carried out by LHO and EMPHO.

Not all Places are Equal - Life Expectancy in District and Borough Councils

The next section shows the life expectancy in each local authority in Surrey and whether it is statistically significantly better, worse or not significantly different compared with England[14].

The life expectancy highlighted in green demonstrates that this is significantly higher than the Surrey average and those highlighted in red is significantly lower.

Elmbridge

Ward	Local Value	Surrey life expectancy	Surrey Worst	Surrey Range	Surrey Best
Claygate	84.2	82.6	76.9		92.1
Cobham and Downside	81.9	82.6	76.9		92.1
Cobham Fairmile	90.6	82.6	76.9		92.1
Esher	82.5	82.6	76.9		92.1
Hersham North	83.0	82.6	76.9		92.1
Hersham South	81.0	82.6	76.9		92.1
Hinchley Wood	85.3	82.6	76.9		92.1
Long Ditton	83.5	82.6	76.9		92.1
Molesey East	83.0	82.6	76.9		92.1
Molesey North	82.5	82.6	76.9		92.1
Molesey South	83.7	82.6	76.9		92.1
Oatlands Park	86.9	82.6	76.9		92.1
Oxshott and Stoke D'Abernon	84.4	82.6	76.9		92.1
St George's Hill	82.2	82.6	76.9		92.1
Thames Ditton	81.9	82.6	76.9		92.1
Walton Ambleside	80.9	82.6	76.9		92.1
Walton Central	85.1	82.6	76.9		92.1
Walton North	80.7	82.6	76.9		92.1
Walton South	82.6	82.6	76.9		92.1
Weston Green	85.9	82.6	76.9		92.1
Weybridge North	78.7	82.6	76.9		92.1
Weybridge South	83.2	82.6	76.9		92.1

Overall life expectancy in Surrey for someone born between 2007 and 2011 has risen by 2.2 years as compared to the period 1999-2003.

In Elmbridge life expectancy at birth (for period 2007-2011) has risen in 20 of the 22 wards, whilst in 2 of the wards life expectancy has fallen (however these figures are not significantly lower than the Surrey average). Life expectancy at birth for someone born between 2007 and 2011 is significantly higher than the Surrey average in 5 of the 22 wards. However in two of the wards, life expectancy for someone born within the same time period is significantly lower than the Surrey average.

Epsom and Ewell

Ward	Local Value	Surrey life expectancy	Surrey Worst	Surrey Range	Surrey Best
Auriol	84.9	82.6	76.9		92.1
College	85.3	82.6	76.9		92.1
Court	77.5	82.6	76.9		92.1
Cuddington	84.7	82.6	76.9		92.1
Ewell	82.1	82.6	76.9		92.1
Ewell Court	83.9	82.6	76.9		92.1
Nonsuch	84.4	82.6	76.9		92.1
Ruxley	84.0	82.6	76.9		92.1
Stamford	85.9	82.6	76.9		92.1
Stoneleigh	85.4	82.6	76.9		92.1
Town	82.4	82.6	76.9		92.1
West Ewell	86.1	82.6	76.9		92.1
Woodcote	84.6	82.6	76.9		92.1

In Epsom and Ewell life expectancy has increased in all 13 wards (for period 2007-2011 as compared to 1999-2003) with six of the wards having a significantly higher life expectancy (for period 2007-2011) than the Surrey average. However in one of the wards life expectancy is significantly lower than the Surrey average.

Guildford

Ward	Local Value	Surrey life expectancy	Surrey Worst	Surrey Range	Surrey Best
Ash South and Tongham	83.1	82.6	76.9		92.1
Ash Vale	83.4	82.6	76.9		92.1
Ash Wharf	81.3	82.6	76.9		92.1
Burpham	87.9	82.6	76.9		92.1
Christchurch	84.2	82.6	76.9		92.1
Clandon and Horsley	84.0	82.6	76.9		92.1
Effingham	84.5	82.6	76.9		92.1
Friary and St Nicolas	81.8	82.6	76.9		92.1
Holy Trinity	84.7	82.6	76.9		92.1
Lovelace	83.1	82.6	76.9		92.1
Merrow	85.0	82.6	76.9		92.1
Normandy	85.2	82.6	76.9		92.1
Onslow	85.1	82.6	76.9		92.1
Pilgrims	81.9	82.6	76.9		92.1
Pirbright	85.2	82.6	76.9		92.1
Send	83.7	82.6	76.9		92.1
Shalford	81.1	82.6	76.9		92.1
Stoke	81.1	82.6	76.9		92.1
Stoughton	82.1	82.6	76.9		92.1
Tillingbourne	85.7	82.6	76.9		92.1
Westborough	82.3	82.6	76.9		92.1
Worplesdon	84.1	82.6	76.9		92.1

In Guildford life expectancy has risen in all but 4 of the 22 wards (for period 2007-2011 compared to period 1999-2003). In 3 wards it has fallen and in one ward has remained the same.

7 of Guildford's wards have a significantly higher life expectancy than the Surrey average (for period 2007-2011) however one ward is significantly lower than the Surrey average.

Mole Valley

Ward	Local Value	Surrey life expectancy	Surrey Worst	Surrey Range	Surrey Best
Ashtead Common	85.1	82.6	76.9		92.1
Ashtead Park	82.3	82.6	76.9		92.1
Ashtead Village	82.4	82.6	76.9		92.1
Beare Green	81.3	82.6	76.9		92.1
Bookham North	83.4	82.6	76.9		92.1
Bookham South	84.9	82.6	76.9		92.1
Box Hill and Headley	82.3	82.6	76.9		92.1
Brockham, Betchworth and Buckland	81.7	82.6	76.9		92.1
Capel, Leigh and Newdigate	86.8	82.6	76.9		92.1
Charlwood	79.7	82.6	76.9		92.1
Dorking North	86.2	82.6	76.9		92.1
Dorking South	82.0	82.6	76.9		92.1
Fetcham East	84.8	82.6	76.9		92.1
Fetcham West	87.3	82.6	76.9		92.1
Holmwoods	80.9	82.6	76.9		92.1
Leatherhead North	81.3	82.6	76.9		92.1
Leatherhead South	84.4	82.6	76.9		92.1
Leith Hill	82.7	82.6	76.9		92.1
Mickleham, Westhumble and Pixham	78.3	82.6	76.9		92.1
Okewood	81.8	82.6	76.9		92.1
Westcott	80.6	82.6	76.9		92.1

In Mole Valley life expectancy has risen in 18 of the 21 wards (for period 2007-2011 as compared to period 1999-2003). In two wards it has fallen and in one ward life expectancy has remained the same. In one of the wards where life expectancy has fallen, it is now significantly lower than the Surrey average. Two other wards are also lower than the Surrey average. However 5 of the wards in Mole Valley have a significantly higher life expectancy than the Surrey average.

Reigate and Banstead

Ward	Local Value	Surrey life expectancy	Surrey Worst	Surrey Range	Surrey Best
Banstead Village	82.4	82.6	76.9		92.1
Chipstead, Hooley and Woodmansterne	81.9	82.6	76.9		92.1
Earlswood and Whitebushes	82.6	82.6	76.9		92.1
Horley Central	79.3	82.6	76.9		92.1
Horley East	88.3	82.6	76.9		92.1
Horley West	84.1	82.6	76.9		92.1
Kingswood with Burgh Heath	80.6	82.6	76.9		92.1
Meadvale and St John's	85.1	82.6	76.9		92.1
Merstham	77.3	82.6	76.9		92.1
Nork	83.3	82.6	76.9		92.1
Preston	81.1	82.6	76.9		92.1
Redhill East	82.4	82.6	76.9		92.1
Redhill West	81.8	82.6	76.9		92.1
Reigate Central	81.3	82.6	76.9		92.1
Reigate Hill	82.5	82.6	76.9		92.1
Salfords and Sidlow	83.4	82.6	76.9		92.1
South Park and Woodhatch	81.1	82.6	76.9		92.1
Tadworth and Walton	82.3	82.6	76.9		92.1
Tattenhams	83.7	82.6	76.9		92.1

In Reigate and Banstead, as in Epsom and Ewell, life expectancy (for period 2007-2011 as compared to 1999-2003) has risen in all 19 wards with two wards having a significantly higher life expectancy than the Surrey average. However, in 4 wards life expectancy is still significantly lower than the Surrey average.

Runnymede

Ward	Local Value	Surrey life expectancy	Surrey Worst	Surrey Range	Surrey Best
Addlestone Bourneside	82.4	82.6	76.9		92.1
Addlestone North	82.5	82.6	76.9		92.1
Chertsey Meads	83.8	82.6	76.9		92.1
Chertsey St Ann's	81.1	82.6	76.9		92.1
Chertsey South and Row Town	80.5	82.6	76.9		92.1
Egham Hythe	82.2	82.6	76.9		92.1
Egham Town	84.2	82.6	76.9		92.1
Foxhills	84.0	82.6	76.9		92.1
New Haw	80.6	82.6	76.9		92.1
Thorpe	84.4	82.6	76.9		92.1
Virginia Water	83.9	82.6	76.9		92.1
Woodham	82.7	82.6	76.9		92.1

In Runnymede life expectancy has risen in 10 of the 14 wards for the period 2007-2011. In one ward it has remained the same (as for period 1999-2003) and in one ward it has fallen (although not below the Surrey average). Data is still outstanding for two of the wards for period 2007-2011.

Three of the 14 wards have a significantly lower life expectancy than the Surrey average.

Spelthorne

Ward	Local Value	Surrey life expectancy	Surrey Worst	Surrey Range	Surrey Best
Ashford Common	83.0	82.6	76.9		92.1
Ashford East	82.8	82.6	76.9		92.1
Ashford North and Stanwell South	79.6	82.6	76.9		92.1
Ashford Town	84.5	82.6	76.9		92.1
Halliford and Sunbury West	80.1	82.6	76.9		92.1
Laleham and Shepperton Green	82.4	82.6	76.9		92.1
Riverside and Laleham	85.4	82.6	76.9		92.1
Shepperton Town	83.1	82.6	76.9		92.1
Staines	80.5	82.6	76.9		92.1
Staines South	82.5	82.6	76.9		92.1
Stanwell North	82.0	82.6	76.9		92.1
Sunbury Common	77.4	82.6	76.9		92.1
Sunbury East	84.3	82.6	76.9		92.1

Life expectancy in Spelthorne has risen in all 13 wards for the period 2007-2011 (as compared to 1999-2003) with two wards having a significantly higher life expectancy than the Surrey average. However four of the 13 wards in Spelthorne have a significantly lower life expectancy than the Surrey average.

Surrey Heath

Ward	Local Value	Surrey life expectancy	Surrey Worst	Surrey Range	Surrey Best
Bagshot	83.9	82.6	76.9		92.1
Bisley	80.1	82.6	76.9		92.1
Chobham	86.6	82.6	76.9		92.1
Frimley	82.7	82.6	76.9		92.1
Frimley Green	80.9	82.6	76.9		92.1
Heatherside	84.8	82.6	76.9		92.1
Lightwater	81.8	82.6	76.9		92.1
Mytchett and Deepcut	84.5	82.6	76.9		92.1
Old Dean	77.6	82.6	76.9		92.1
Parkside	84.9	82.6	76.9		92.1
St Michaels	80.0	82.6	76.9		92.1
St Pauls	83.3	82.6	76.9		92.1
Town	83.3	82.6	76.9		92.1
Watchetts	80.2	82.6	76.9		92.1
West End	82.8	82.6	76.9		92.1
Windlesham	86.1	82.6	76.9		92.1

Surrey Heath has seen an increase in life expectancy (for period 2007-2011) in 14 of the 16 wards with three of the wards having a significantly higher life expectancy than the Surrey average. Five of the 16 wards however have a significantly lower life expectancy than the Surrey average.

Tandridge

Ward	Local Value	Surrey life expectancy	Surrey Worst	Surrey Range	Surrey Best
Chaldon	80.3	82.6	76.9		92.1
Dormansland and Felcourt	82.5	82.6	76.9		92.1
Felbridge	92.1	82.6	76.9		92.1
Godstone	80.2	82.6	76.9		92.1
Harestone	83.2	82.6	76.9		92.1
Limpsfield	85.7	82.6	76.9		92.1
Lingfield and Crowhurst	80.3	82.6	76.9		92.1
Oxted North and Tandridge	83.2	82.6	76.9		92.1
Oxted South	84.8	82.6	76.9		92.1
Portley	79.2	82.6	76.9		92.1
Queens Park	81.2	82.6	76.9		92.1
Tatsfield and Titsey	89.9	82.6	76.9		92.1
Valley	81.5	82.6	76.9		92.1
Warlingham East and Chelsham and Fa	79.7	82.6	76.9		92.1
Warlingham West	86.7	82.6	76.9		92.1
Westway	80.8	82.6	76.9		92.1
Whyteleafe	85.1	82.6	76.9		92.1
Woldingham	89.4	82.6	76.9		92.1
Bletchingley and Nutfield	83.4	82.6	76.9		92.1
Burstow, Horne and Outwood	82.6	82.6	76.9		92.1

Of the 20 wards in Tandridge, 18 have seen an increase in life expectancy (for period 2007-2011 as compared to 1999-2003) with 5 wards having a significantly higher life expectancy than the Surrey average. Four wards report a significantly lower life expectancy than the Surrey average (although all four have increased compared to previous period).

Waverley

Ward	Local Value	Surrey life expectancy	Surrey Worst	Surrey Range	Surrey Best
Alfold, Cranleigh Rural and Ellens Green	80.1	82.6	76.9		92.1
Blackheath and Wonersh	87.9	82.6	76.9		92.1
Bramley, Busbridge and Hascombe	82.3	82.6	76.9		92.1
Chiddingfold and Dunsfold	83.7	82.6	76.9		92.1
Cranleigh East	82.3	82.6	76.9		92.1
Cranleigh West	83.8	82.6	76.9		92.1
Elstead and Thursley	84.3	82.6	76.9		92.1
Ewhurst	82.5	82.6	76.9		92.1
Farnham Bourne	83.8	82.6	76.9		92.1
Farnham Castle	83.3	82.6	76.9		92.1
Farnham Firgrove	82.1	82.6	76.9		92.1
Farnham Hale and Heath End	82.1	82.6	76.9		92.1
Farnham Moor Park	83.4	82.6	76.9		92.1
Farnham Shortheath and Boundstone	87.4	82.6	76.9		92.1
Farnham Upper Hale	85.6	82.6	76.9		92.1
Farnham Weybourne and Badshot Lea	85.7	82.6	76.9		92.1
Farnham Wrecclesham and Rowledge	83.5	82.6	76.9		92.1
Frensham, Dockenfield and Tilford	81.9	82.6	76.9		92.1
Godalming Binscombe	83.5	82.6	76.9		92.1
Godalming Central and Ockford	80.2	82.6	76.9		92.1
Godalming Charterhouse	81.1	82.6	76.9		92.1
Godalming Farncombe and Catteshall	81.0	82.6	76.9		92.1
Godalming Holloway	84.8	82.6	76.9		92.1
Haslemere Critchmere and Shottermill	79.9	82.6	76.9		92.1
Haslemere East and Grayswood	82.6	82.6	76.9		92.1
Hindhead	82.0	82.6	76.9		92.1
Milford	85.3	82.6	76.9		92.1
Shamley Green and Cranleigh North	84.0	82.6	76.9		92.1
Witley and Hambledon	83.2	82.6	76.9		92.1

Of the 29 wards in Waverley, 26 have seen an increase in life expectancy (for the period 2007-2011 as compared to 1999-2003) with six wards having a significantly higher life expectancy than the Surrey average. Two wards have a significantly lower life expectancy than the Surrey average (although both record an increase as compared to the previous period).

Woking

Ward	Local Value	Surrey life expectancy	Surrey Worst	Surrey Range	Surrey Best
Brookwood	85.1	82.6	76.9		92.1
Byfleet	82.6	82.6	76.9		92.1
Goldsworth East	82.5	82.6	76.9		92.1
Goldsworth West	80.6	82.6	76.9		92.1
Hermitage and Knaphill South	83.6	82.6	76.9		92.1
Horsell East and Woodham	84.1	82.6	76.9		92.1
Horsell West	83.2	82.6	76.9		92.1
Kingfield and Westfield	80.4	82.6	76.9		92.1
Knaphill	83.1	82.6	76.9		92.1
Maybury and Sheerwater	76.9	82.6	76.9		92.1
Mayford and Sutton Green	80.9	82.6	76.9		92.1
Mount Hermon East	82.1	82.6	76.9		92.1
Mount Hermon West	81.7	82.6	76.9		92.1
Old Woking	82.8	82.6	76.9		92.1
Pyrford	81.3	82.6	76.9		92.1
St John's and Hook Heath	84.1	82.6	76.9		92.1
West Byfleet	83.5	82.6	76.9		92.1

Of Woking's 17 wards, 15 have seen an increase in life expectancy for the period 2007-2011 (compared to 1999-2003). None of the wards have a significantly higher life expectancy than the Surrey average whereas two wards report a significantly lower life expectancy than the Surrey average (although both these have increased compared to previous period).

6. Going beyond Place to People - Specific populations

This next section highlights specific communities and populations that often experience health inequalities. We explore each community and describe what the issues are and what has been done or could be done to address these needs.

Black and Minority Ethnic Communities

What is the health inequality with this community?

The JSNA shows that although Surrey has relatively few people from ethnic minorities overall, this varies between our boroughs & districts. Some local authorities show similar or higher levels of ethnic groups than England e.g. Woking, where 5.7 % of the population identify themselves as Pakistani. This provides a challenge to ensure that the health needs of these small communities and individuals are appropriately met. The JSNA identifies that it is essential to work across partner organisations to ensure a good understanding of the varying needs this diversity brings[15]. The main challenges facing people from minority ethnic backgrounds include: social isolation due to communication or cultural issues, access to services and services adequately meeting need.

What has been done/what could be done to address the needs

The JSNA indicates that it is important that Surrey County Council and partners consider the total population in developments, access to services and cultural/religious sensitivities. It is important to be aware that predisposition to, and hence prevalence and incidence of some diseases (heart disease, diabetes and stroke) vary by ethnic origin.

For example South Asians have a considerably higher morbidity from coronary heart disease than the white population. South Asians also tends to be diagnosed at more advanced stage of disease and have poorer survival rates. Individuals from different ethnic minorities have different religious backgrounds. Health and social care education providers must be aware of differing religious requirements regarding aspects of inpatient and outpatient treatment and personal care, particularly around beliefs concerning birth, death and dying.

Surrey Public Health has been working on a number of initiatives to directly address the health needs of minority ethnic groups:

- Health Checks (between the ages of 40 and 74) have been offered to BME communities living in geographical areas with high deprivation (known as priority places) through their GP practices.
- We have worked with practice managers/GPs on delivering Health Checks to their eligible patients and to help signpost their patients to locally available weight management/exercise referral schemes and stop smoking services.
- A health equity audit identified that women from BME communities were less likely to take up the offer of cervical screening. An action plan was put into practice to work with practices identified in audit to support them to increase their uptake rate.

- A specific dementia awareness campaign and interactive quiz was undertaken with BME communities to raise awareness.

- North West Surrey Clinical Commissioning Group has been supported on early detection of diabetes through signposting to local interventions and the provision of a local bilingual diabetes expert programme for BME patients.

Gypsy, Roma and Traveller (GRT) Communities

What is the health inequality with this community?

Gypsies and Travellers collectively comprise one of the county's largest minority ethnic groups. GRT ethnic groups include Gypsies, Travellers of Irish Heritage, and European Roma. The first two groups comprise the majority of Travellers in Surrey and include both mobile and housed families. Surrey has one of the highest numbers of resident Travellers in England. Non-ethnic Travellers include Fairground and Circus families, and New Travellers. According to the biannual Gypsy and Traveller Caravan Count, in July 2010 the total of public and private Gypsy and Traveller sites in Surrey sites was 675.

Outcomes measures across a range of health, education and social indicators show that Surrey's GRT children and young people have some of the poorest life chances when compared with Surrey's children and young people generally. Surrey's Families in Poverty Needs Assessment identifies GRT as a group who are most likely to be in poverty. First hand evidence from Gypsy Roma and Traveller representatives in Surrey tells us that cultural factors are sometimes compounded by institutional discrimination and a lack of meaningful engagement with the GRT community[15].

Findings from the GRT Strategy[15]:

- There is insufficient accommodation to meet local need with some sites being in poor condition.

- There is a high prevalence of mental health issues within the GRT community including anxiety and depression.

- Alcohol consumption and substance misuse are a concern as GRT young people assume adult roles and responsibilities earlier in life than there non GRT peers.

- Cultural beliefs around immunisations and vaccinations leave the GRT community vulnerable to illness.

- The incidence of heart disease, asthma, bronchitis, diabetes and long-term illness is significantly higher than for the general population.

- The GRT community is characterised by a sense of fatalism and low expectations in relation to health.

- Fear and a lack of knowledge about statutory services mean that they are often only accessed at a point of crisis.

- There are significant gaps in educational attainment for GRT CYP compared to their non GRT peers.

- Services can be 'hard to reach' for GRT families, for reasons including expectations around literacy; issues of trust and discrimination; and the isolated location of many GRT sites.

- GRT children and young people are often disadvantaged by a lack of play amenities, and their social isolation is often compounded by bullying, racist attacks and by their roles as young carers.

- Gypsy and Traveller young people are over-represented within Surrey's Youth Justice System.

What has been done/what could be done to address the needs

The Surrey Public Health team are represented at the Surrey Wide GRT Forum and have enabled the recommendations from the GRT strategy to begin to be acted upon.

Public Health are also engaged with the Gypsy Skills project that offers opportunities for GRT young people that are not in full time education.
Key focus is needed in the following areas:

- Acknowledgement of the wider determinants of health and social wellbeing, in particular addressing accommodation issues.

- Development of staff within Health and Social Care and primary care on cultural awareness issues.

- Joint working between statutory organisations, voluntary organisations and the GRT community to address issues affecting the community.

The Homeless in Surrey

What is the health inequality with this community?

Compared to the general population, homeless people experience poorer health outcomes. Physical health, harmful use of drugs and alcohol, poor mental health and wellbeing have been recognised as priority health issues among the homeless. Despite these needs, homeless people generally experience difficulties with accessing health services; this poor access also impacts on their health status. Single homeless people and rough sleepers generally have the worst outcomes among this group. Homeless people are much more likely to die young than people who are not homeless[15].In Surrey between 2010 and 11 there were 190 people recorded as "Statutory homelessness" although this figure is underrepresented as there are a number of people who are homeless, but sleeping on friends sofas etc who are then not recorded in the official figures.

What has been done/what could be done to address the needs

- Continue the Homelessness Enhanced Service in primary care and health visitor provision

- Explore ways to increase the supply of affordable housing across Surrey, mindful of the need for affordable family accommodation, accessible housing for disabled people and sufficient accommodation to meet the particular needs of rural areas

- Ensure homelessness prevention services remain fit for purpose against the backdrop of ever increasing financial challenges

- Ensure an adequate supply of supported housing for those at risk of social exclusion, including vulnerable young people and care leavers; people experiencing domestic abuse; those with an offending history; those with mental health issues; and those with a history of substance abuse

- Undertake a review of sheltered housing services with scheme managers delivering support to older people in the wider community.

Offenders

What is the health inequality with this community?

Adults and young people in contact with the criminal justice system are more likely to be socially excluded and experience high levels of health inequalities. They are more likely to suffer from mental health problems and learning disabilities, and to have problems with drugs or alcohol. The link between offending, reoffending and wider factors, including health, is widely recognised[15].

A Health Needs Assessment has been undertaken by Surrey Youth Justice which found that substance misuse services to this group were robust and effectively delivered but identified gaps in provision in respect of mental and emotional health, speech, language and communication needs, identification and response to ADHD and learning difficulties, and a range of unmet physical health needs. The YJS works with approximately 1000 children and young people each year and the levels of need identified by the HNA would suggest greater attention should be given by commissioners to targeted services for this cohort of young people.

What has been done/what could be done to address the needs

Eight main areas of recommendations were identified, with areas 3 and 4 having implications for commissioning. A multi-agency action plan has been developed and published separately. Many of these recommendations relate to improvements in the 'system' given the high level of health needs reported[15].

1. Improve assessment of health by the Youth Justice Service (YJS)

2. Increase Health Capacity in the YJS

3. Improve access to Child and Adolescent Mental Health Services

4. Develop services/ pathways to meet emotional health needs

5. Develop care pathways for young people with speech, language and communication problems and learning disabilities

6. Increase support for looked after children in the YJS

7. Improve accommodation options, and review use of bed and breakfast facilities

8. Increase engagement and empowerment opportunities.

People with a Learning Disability

Valuing People (2001) was the first White Paper on learning disability for thirty years and set out an ambitious and challenging programme of action for improving services. The paper defined a learning disability as including the presence of;

- Significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
- A reduced ability to cope independently (impaired social functioning);
- Disability that started before adulthood, with a lasting effect on development.

The movement of large numbers of people into long stay hospitals in the County during the last century artificially increased the proportion of people with a learning disability in the general population. In the long-term these numbers will gradually reduce returning the number of people in Surrey with a learning disability towards the national average for the indigenous population. However in the medium term these circumstances present a number of challenges in planning, commissioning and managing health, social and related services in the County[15].

What has been done/what could be done to address the needs

The Learning Disability Public Value Review has been completed, and can be found on Surrey's Learning Disability Partnership Board website:

http://www.surreypb.org.uk/index.php?page=/index.

Surrey has a robust Partnership Board represented by the Council, health, the voluntary sector, carers and users of services who will oversee the implementation of the public value review recommendations. These recommendations contained actions including: personalisation of services, improvements to housing, personal reviews, integrated services between health and social care, better access to transport, support for those transiting to adulthood, services for older people, improving quality of care, greater access to information and more partnership working.

Teenagers and Teenage (under 18) Pregnancy

What is the health inequality with this community?

While most teenagers in Surrey do well, some groups of young people have a higher risk of suffering poorer outcomes than their peers. Many of these groups are linked to one another and include those whose parents have poor mental health, those living in lone parent households, those affected by domestic abuse, those living in a family where there is a disability, young carers, those in or on the edge of poverty, Gypsy, Roma and Traveller (GRT) children and young people, children with special educational needs (SEN), looked after children and care leavers, unaccompanied asylum seeking children (UASC), and young people who offend.

Teenagers are more likely to become healthy and productive adults when their family life is stable. It is important that we therefore support parents and carers who are facing a range of problems or who are experiencing change, for example separating parents, lone parents, military families, young parents and kinship carers.

Teenage pregnancy

The JSNA tells us that approximately 200 babies are born to teenage mothers and around 280 teenagers have terminations in Surrey each year. 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 which showed that England had the highest teenage conception rate in Western Europe[16]. There are links between high teenage conception rates and areas of deprivation and poverty. Babies born to teenage mothers often have worse health outcomes than those of older mothers. They are at more risk of premature birth, death in their first year and accidental harm. Teenage mothers are also 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[15].

Reigate and Banstead, Spelthorne and Runnymede are the teenage pregnancy 'hotspots' for Surrey. Public Health practitioners and partners are working together to understand the needs of teenage parents and what works to reduce unintended teenage conceptions.

What has been done/what could be done to address the needs

There are a number of initiatives/interventions that address teenage pregnancy these include:

- Developing peer mentoring programmes
- Making contraception easier to obtain by reviewing the Community and Sexual Health services locations.
- Making Free Emergency Hormonal Contraception (EHC) available at Community Pharmacies
- Making 'Get It On'- Condom Distribution Scheme available for young people

- Training more GPs to be able to provide longer acting reversible methods of contraception and ensure that contraception advice is provided post termination of pregnancy (abortion).

Carers

What is the health inequality with this community?

It is estimated that there are approximately 106,000 carers in Surrey at the present time and approximately 14,000 are young carers (under the age of 18). This equates to 9.6% of the Surrey population.

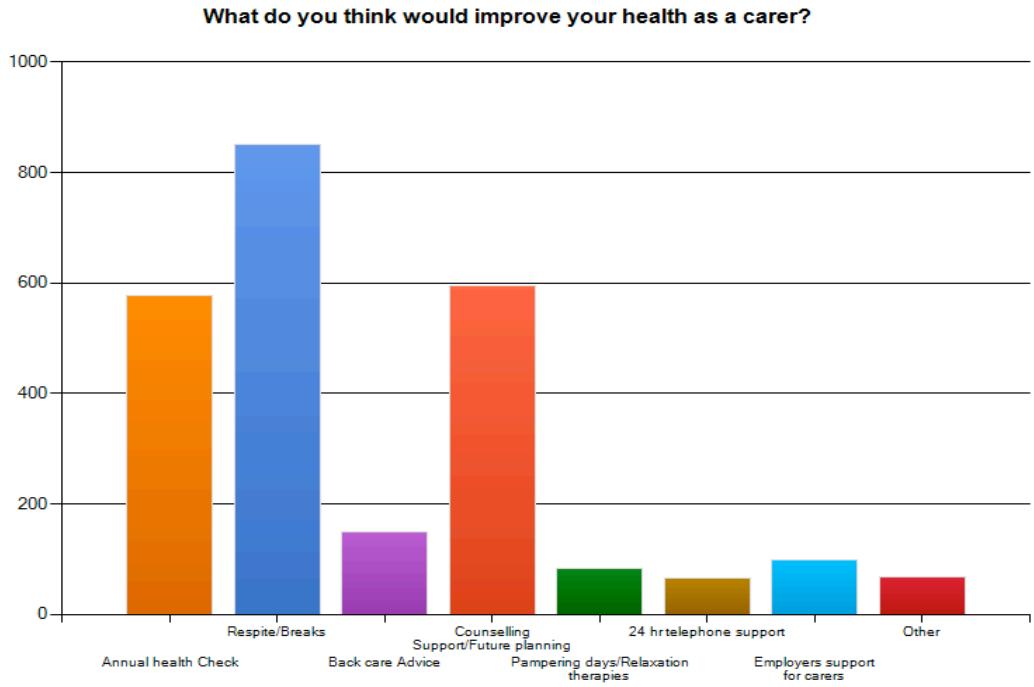
Carers fulfil a vital role in providing (unpaid) care for family members or friends who are ill, frail or who have a disability. Care is often provided by adults to their partners, parents to their disabled children or by children to their parents, siblings or other relatives. Analysis of the 2001 census data by Carers UK found that those caring for 50 hours a week or more were twice as likely to be suffering poor health; in Surrey this represents over 23,000 people in 2012. Health problems associated with caring include stress related illness and physical injury (such as back strain). Younger carers in the 18-25 year age group who provide 50 hours care or more per week are three times as likely to not be in good health as people in that age group who do not provide care[15].

Many carers have full time or part time employment in addition to their caring responsibilities. Projected figures based on 2001 census data suggest that about 60% of carers in Surrey are in some form of employment; 17% of carers are not working because of their caring responsibilities. In terms of financial support, of the carers providing 35 hours or more care per week in 2010, only 16% were in receipt of carers allowance in Surrey[15].

Young carers (under 18 years) are often undertaking substantial caring tasks on a regular basis and assuming a level of responsibility that would normally be associated with an adult. The average age of a young carer in Surrey is 12 years. They are more likely to be living with a single parent, suffering social exclusion and have parent(s) who are unemployed or on low incomes. Risks to young carers, according to the Social Care Institute for Excellence[17] (SCIE) include possible difficulty in attending school or finding time for homework; possible mental health disorders (such as stress, anxiety, depression, sleeping problems, eating disorders and self harm); lack of time to socialise; lack of material wellbeing; risk of physical injury and poorer educational/employment outcomes. Some young carers are referred to Surrey Young Carers and Mid Surrey Young Carers, both charities commissioned by Surrey County Council to provide support to young carers in Surrey. However this only supports a small proportion (about 10%) of young carers as relatively low numbers are identified. Reasons for this include lack of awareness by professionals in contact with the family; poor information systems collating data; reluctance of young carers/families to be identified; children/young people not seeing themselves as carers. As a result, a new carers recognition project hosted by Action for Carers in Surrey is working with GPs to raise awareness of young carers and their needs.

In 2011 Surrey County Council, in partnership with NHS Surrey and Action for Carers undertook an adult carers' health survey. More than 80% of carers reported that their caring role had damaged their health, with almost 100% of carers suffering from a health condition and a third of these felt their condition had worsened as a result of their caring role[18].

The graph below highlights three key areas of importance to Surrey carers, namely carer respite breaks, counselling and annual health checks.



What has been done/what could be done to address the needs

The recommendations from the Surrey Carers Health Survey Report 2011 have been incorporated in the Surrey Carers Commissioning Strategy and Development Plan 2012-14. Priority areas include:

- Carers' breaks (£1 million has now been paid to carers under the GP carer break scheme implemented by NHS Surrey)

- Health checks specifically for carers

- Counselling services for carers

- Training in the disease/condition of the person being cared for

- Recognition as carer during hospital discharge

- Flexible GP appointments

- Support from employers

Health of Children in Care/Looked After Children

What is the health inequality with this community?

The health and wellbeing of looked after children and young people, including their physical health and emotional wellbeing, is influenced by nearly all aspects of their lives including the care they receive. Children who enter care often come from families that have problems associated with poverty and deprivation and have worse levels of health than their non-looked after peers. Children in care are significantly more likely to experience changes in general practitioner; have incomplete immunisations; receive inadequate dental care. They are at greater risk of mental health disorders and teenage pregnancy, and are more likely to have less healthy behaviours such as smoking, using illegal drugs and eating a poor diet. Many children who leave care go on to experience poor health and social outcomes[15].

In Surrey, the percentage of children looked after in care during the period 1 April 2011 - 31 March 2012 who had a health check was 73.3%, dental check 91.8% and 82.6% had dental and health checks; these levels are lower than for comparable areas. For the same period, 71% of looked after children had a Strengths and Difficulties Questionnaire (SDQ) completed about them (SDQ is a measure that detects child psychiatric disorders). Children with an abnormal score are referred to the CAMHS team (Child and Adolescent Mental Health Service (CAMHS) for Looked After Children). Other specialist teams that support the health needs of children in care include: Surrey Health Team; a peer education project run by young people in care aged 15-19; Targeted/Universal Partnership Plus service from the 0-19 Teams; and HOPE Service[15].

What has been done/what could be done to address the needs

Green Priorities

GREEN Priorities is a Surrey-wide project that offers support, guidance and direction to help children in care gain valuable life skills connected to food: growing fruit and vegetables; cooking; healthy eating; and linking to education and training opportunities. The project is based in 5 centres/homes: St Faiths Family Centre, Hope Guildford, Hope Epsom and two residential children's homes.

http://www.greenpriorities.org.uk/



Services should address health and wellbeing for looked after children and prepare them for leaving care. During care children should be supported to develop the knowledge and skills required to take responsibility for their own health and wellbeing including: life skills; how to access health services; and to manage personal health conditions.

Lesbian, Gay, Bisexual and Transgender (LGBT) Communities

What is the health inequality with this community?

The Surrey Joint Strategic Needs Assessment (JSNA) looks at health issues related to the LGBT population from a younger person's perspective and within the context of sexual health for adults.

The JSNA highlights that little is known about LGBT young people in Surrey. There is some evidence that young people need more places to meet and socialise with their peers, better support in school and more tailored health services. There are an estimated 5,700 young people aged 11-16 that are LGBT, although at some point during adolescence many more young people will be exploring their sexuality[15].

For the adult LGBT population men who have sex with men (MSM) are more at risk of contracting HIV and Sexually Transmitted Infections (STIs). It is perceived that MSM have more sexual partners than heterosexual people and the sex that they have with each other can include unprotected anal intercourse (UAI) which has the highest risk of passing on HIV. There is also potential for men to have sex with strangers when verbal communication is less likely to happen and this can impact on the ability to negotiate safer sex. This is especially true of sex performed in Public Sex Environments (PSEs). Health Protection Agency figures from 2000 to 2009 show a consistent increase in HIV infection among MSM, and in the South East Coast Strategic Health Authority area those using HIV services has risen from 839 in 2000 to 2267 in 2009 [15].

What has been done/what could be done to address the needs

The Surrey Harm Reduction Outreach Service (Virgin Care) employs a full time Health Promotion Development Worker who provides a range of services for gay men. These include: outreach work and condom distribution at Public Sex Environments (PSEs) in West Surrey, face to face work (safer sex messages and issues around sexuality), telephone support, safer sex messages and issues around sexuality and sign-posting, and group work with men who are married to women and attracted to other men. The service also provides particular work with men who have a learning disability who identify as being gay, and face to face work with male sex workers as their clients tend to be other men and not women. The work involves promoting safer sex and challenging men's risk taking behaviours. Most of the work is one off intervention, but some group work and work with men with disabilities is usually ongoing. The Service also looks at the broader picture of tackling prejudice and discrimination faced by this group. The service also provides:

LGBT awareness training for other statutory and voluntary organisations, including Surrey Police, Crown Prosecution Service, Citizens Advice, local and borough councils, social services and Surrey County Council, Your Sanctuary, and Leonard Cheshire Homes.

Significant amounts of partnership working happens with all of the above organisations and with Outline (Surrey LGBT Agency) offering telephone support two evenings a week and Gay Surrey who

provide a web based information and signposting service to all who access it. The Terrence Higgins Trust, based in Woking, has also been commissioned to conduct basic Outreach work in PSEs in the East of the county and their remit also involves a small degree of community development and engagement with the wider community. This service ensures that all PSEs in Surrey are covered by Outreach work and public relations maintained.

The JSNA recommends that a more detailed picture of LGBT young people in Surrey is built up, possibly through engaging the users of existing targeted services. There is a call that more places for LGBT young people to socialise are provided so that they can build up robust support social networks. The JSNA also recommends that all secondary schools adopt a clear anti-homophobic bullying policy, with teaching of LBGT issues and action on bullying that occurs.

A consultation with young people was carried out as part of the recent One in Ten needs assessment. The consultation identified the following needs for LGBT young people:

- A safe place to meet and socialise with peers
- Access to youth workers to have one-to-one conversations
- A safe, tolerant school environment where homophobic behaviour is actively discouraged
- Better access to appropriate health services, particularly for transgender young people

Older People

What is the health inequality with this community?

Nationally, for the first time in history the number of people over the age of 65 is outnumbering those aged under 16. In Surrey there is a vibrant mix of older people with differing needs and health priorities that presents bonuses and challenges. One challenge is the rising cost of providing health and social care. Some older people will have more complex needs than others due to ethnicity, lifestyle choices, level of mobility, lack of social networks and whether they live alone.

According to the Surrey Foundation report 'Hidden Surrey'[4], many older residents are asset rich but cash poor and live in relative hardship

The number of people with dementia is rising. Surrey is developing strategies to increase awareness and to make access to early diagnosis and treatment and support more accessible.

Due to the many factors that affect how individuals age, developing the right kind of support and making them easily accessible to older people is challenging.

What has been done/what could be done to address the needs

In response to this, Surrey has developed an Ageing Well Commitment which is a collaborative programme of work between health and social care, the voluntary sector and wider partners to help promote health and independence in older people.

The Ageing Well Commitment contains ten pledges based on priorities identified by older people in Surrey. These range from access to the right support and practical help, to encouraging people to live a healthy life and reduce being socially isolated or excluded.

Surrey's Joint Strategic Needs Assessment has given many recommendations to help improve the quality of life and support for this population group including increasing the awareness and use of services such as telecare and telehealth amongst health and social care professionals. Other recommendations include promoting dignity in care, developing preventative services to make independent living more likely and involving older people and their carers closely in the development of future health and social care services.

7. Health Protection

A clean, healthy and safe environment is a vital component to protect the public's health and well-being. This is particularly so for children who are more susceptible to environmental factors during their development stage and who have more exposure than adults due to their behaviour patterns[19].

As well as childhood conditions, some adult diseases, even those that emerge much later in life, e.g. hypertension, type 2 diabetes, ischemic heart disease, breast cancer and prostate cancer, have some of their origins in childhood. Childhood exposures to environmental health hazards may therefore constitute a source of inequity between generations[20].

Some children are also disadvantaged by poverty resulting in health inequalities. Socially and economically disadvantaged people often live in the worst environments e.g. the most deprived parts of England experience the worst air quality and have less access to green space and adequate housing. The Environment Agency Position Statement 'Addressing Environmental Inequalities' recognises that 'the quality of the environment can vary between different areas and communities. People who are socially and economically disadvantaged often live in the worst environment'[21]. While our environment is much healthier than in previous generations and continues to improve, environmental quality varies between different areas and communities and there is an emerging research base describing the scale and range of environmental inequality in the UK[22 23].

Whilst there has been less work carried out on environmental inequalities and ethnic minority communities, there is evidence that these communities are disproportionately exposed to the poorest housing and air quality[24 25]. Deprived areas in England contain four times as many people from ethnic minority groups as other areas. In addition there is some evidence of a disproportionate siting of major accident hazard sites in wards with higher ethnic minority populations[26]. However, the causes of these inequalities are complex. Some problems are due to the historical location of industry and communities; others are the result of the impacts of new developments such as traffic[21].

The public health team in the local authority works alongside the Health Protection Agency (HPA) to support the NHS in its role of assessing the potential public health impacts of those developments applying for authorisation under the Integrated Pollution Prevention Control system (IPPC). The IPPC is a regulatory process to ensure that industry adopts an integrated approach to pollution control to provide a high level of protection for the environment and human health. Operators of existing or proposed installations must apply for a permit to operate. This process ensures industrial activities

are regulated by the Environment Agency to ensure compliance with relevant environmental standards e.g. hazardous waste landfill sites and incinerators.

There is also an inequity in the incidence of infectious diseases such as tuberculosis (TB) in Surrey, as in England, due to environment and social deprivation factors such as poor housing, homelessness and migration from countries with a high incidence. These inequalities are further exacerbated as vulnerable groups often access services late when they become seriously ill. For infectious diseases like TB this is a greater problem as left untreated, one person with pulmonary TB may infect around 10-15 people per year[27]. These inequalities are often hidden in more affluent counties like Surrey where the general population incidence is lower.

The latest HPA's annual TB report shows an increase in the number of TB cases compared to 2010. However TB cases overall have been stabilising since 2005[28], 8,963 cases were reported in 2011, a rate of 14.4 cases per 100,000 population. The majority of cases are notified from urban areas, amongst young adults, those from countries with high TB rates, and those with social risk factors for TB. NICE[29] guidance emphasises the high rates of TB in a number of groups including problem hostel homeless (788/100,000); drug users (354/100,000); prisons (208/100,000); people with co-morbidities such as HIV also have higher rates of TB. The number of TB cases in Surrey is increasing, in part due to population changes in the vulnerable groups listed above. The public health team in the local authority works closely with the HPA to ensure all notified cases of TB, and their contacts, are followed up and managed effectively to reduce further spread.

There is an incontrovertible link between deprivation and ill health. The inter relationship between the physical and social environments and inequalities is less well understood and requires further work.

8. Case Studies

Stop Smoking Service

Smoking is the biggest single cause of the differences in quality of health and longevity between most and least deprived people and accounts for half the difference in death rates between them.

In Surrey, the percentage of the population who smoke is relatively low at around 15%, compared to the national average of 21%. However Surrey's overall low rate of smoking conceals hidden health and social disadvantages in certain areas of the population. For example in Spelthorne there is a significantly higher rate of 25%.

The distribution of smoker prevalence is due largely to socio-economic status. The lower your status the more likely you are to start smoking in early teens or younger and to have family and friends who smoke. These two factors combine to make quitting harder.

Data routinely collected on the numbers and socio-economic status of those who quit in Surrey in 2009 showed that only 13% of the total 3105 people who quit that year were unemployed or in routine and manual occupations. The challenge for the Stop Smoking Service in Surrey was developing a service that attracted smokers in areas of deprivation that effectively helped them quit.

In 2009 a telephone support service was introduced and has been the major driver for an increase in the number of smokers from these population groups achieving success in quitting. This service makes quit support attractive and accessible, and for many takes the perceived stigma of smoking and not quitting away. Other strategies included street recruitment of smokers with specialist providers trained in this style of engagement, inviting smokers to use the service. More than 3 in 10 people recruited this way made a quit attempt and over 55% of those quit. The service also targeted areas of deprivation in Surrey and worked with GP practices to establish special stop smoking clinics.

As a consequence of these approaches the percentage increase in numbers from these population groups quitting year on year has been dramatic. In the year 2010/11, 22 per cent of the total 3537 quitting were either unemployed or in routine and manual occupations and in 2011/12, 25 per cent of the total 3797 quits achieved were in these two groups.

For the first six months of the year 2012/13 numbers quitting in these two groups are still increasing with a potential doubling of the percentage quitting over the period 2009 to 2013.

One individual's experience

Jean, 65 years old says *"when you start smoking no one tells you it is bad for you, and when you are old enough to know you can't kick off the habit until you hear the unexpected news: quit smoking or your life is at risk".* Jean had been told by her doctor to give Surrey Stop Smoking Service a call to quit as soon as possible. Jean says "*when the doctor told me to give up smoking, I immediately became defensive but didn't want to sound rude so I joined the service for Telephone Support, but deep down I knew I was not determined to commit, especially when they asked me to give up my 'friend'*."

Jean quit in October 2011 and now says; *"The actual habit was all in my head and power was in my hands all along*."

Stoke and Westborough Needs assessment

Stoke and Westborough Health Needs Assessment 2012

Whilst Stoke and Westborough wards in Guildford are diverse, lively areas with a strong sense of community pride, they are also two of the most deprived wards in Surrey with significant health needs. One of the wards, Westborough had been previously designated a 'priority place' by the Surrey Strategic Partnership.

The Stoke and Westborough Action group (SWAG), a group made up of local residents, councillors and representatives of the public, voluntary and faith sectors, implements and monitors actions to improve the health and wellbeing of residents of these wards on behalf of the Guildford Local Strategic Partnership. In 2012, SWAG carried out a detailed health needs assessment of the wards with the aim of providing evidence to support future partnership work on health improvement. The health needs assessment included information on the social determinants of health in addition to data on health related behaviours, health conditions and clinical activity.

Results from the health needs assessment show significant improvements in the Indices of Multiple Deprivation (IMD) have taken place in Westborough ward but not in Stoke ward. The report suggests this may be, in part, due to the focused work in Westborough resulting from its designation as a priority place. Another key finding was that there are a wide range of services and organisations promoting the health of residents. However, feedback from the community showed that residents did not always know about these and would like more information on what is available.

Key findings from health data for Stoke:

- Life expectancy at birth is significantly lower than the national average
- Highest estimated rate of smoking in Guildford
- Higher rate of teenage conceptions than neighbouring wards
- Second highest percentage of adult obesity in Guildford

Key findings from health data for Westborough:

- Life expectancy at birth in Westborough is lower than for neighbouring wards but is higher than for Stoke
- Second highest estimated rate of smoking in Guildford
- Reception year children in the Spinney Children's Centre catchment area have the highest rate of obesity in Guildford

Feedback from residents, service providers, local organisations and groups and evidence from the health data has been used to produce 34 recommendations for future actions that build upon the existing programmes and utilises the physical environment (e.g. green spaces) that exist in the community. The actions have been included in the Stoke and Westborough action plans which are implemented and monitored by SWAG and the Guildford Local Strategic Partnership.

Pictures from the Community Garden, Fir Tree Avenue and Bellfield's green space project

9. Measuring Outcomes

As already highlighted, the Public Health Outcomes Framework has two high-level outcomes which underpin the overall vision for public health – these are (1) to increase healthy life expectancy and (2) to reduce differences in life expectancy and healthy life expectancy between communities (including differences between and within local authorities).

Alongside the two high level outcomes, the framework is comprised of 66 indicators. Currently, 39 indicators with data are published at national and upper-tier local authority levels, where possible indicators are disaggregated by equalities characteristics and socioeconomic categories.

The tool contains data for 39 public health indicators split over four domains:

• Improving the wider determinants of health

• Health improvement

• Health protection

• Healthcare public health and preventing premature mortality

Public Health Outcome Framework: Initial Data for Surrey

Improving the Wider Determinants of Health

Surrey compares favourably against England for many of these indicators.

Surrey has lower (and hence better) outcomes for the following indicators:

Child poverty, absence in school, crime and children who is not in education, employment or training, violent crime including sexual violence and re-offending levels, people affected with noise level, homelessness acceptance and households in temporary accommodation.

Surrey performs worse than England for the number of people killed in road accidents. Also, use of outdoor space for exercise for health reasons is lower in Surrey than the England average.

Health Improvement

Within this domain, Surrey performs worse than England for the following indicators:

Lower uptake of diabetic eye screening (although this has now been addressed and above national average); NHS health checks offered to those eligible is low (albeit take up to those offered is high in Surrey); Self reporting of wellbeing – i.e. satisfied with life, feeling worthwhile and 'happy yesterday' is low in Surrey and 'anxious yesterday' is high; Whilst injuries due to falls in people aged 65 and over is low it is higher for those aged 80+.

However, Surrey performs better than England for the remaining indicators in this domain:

fewer babies are born with low birth weight, breastfeeding initiation is higher, smoking status during time of delivery and under 18 conceptions are lower, the relative number of overweight children is lower as is smoking prevalence in adults within Surrey. Also, successful completion of drug treatment is higher in Surrey compared with the England average. Additionally, cervical cancer screening coverage is high compared to England. Also, emotional well-being of looked after children is good in Surrey.

Health Protection

The mortality attributable to particulate air pollution is slightly higher in Surrey compared to England. Immunisation coverage is low for all of the childhood vaccination programmes, as is Human papilloma virus (HPV) vaccination, Pneumococcal polysaccharide vaccine (PPV) and flu vaccination coverage.

Chlamydia diagnosis is low in Surrey compared to England (although this may be due to low update of testing).

Although Tuberculosis (TB) incidence in Surrey is low, treatment completion for TB in Surrey is also low.

Healthcare Public Health and Preventing Premature Mortality

Premature deaths from various causes of death such as cardiovascular disease, cancer, liver disease, respiratory disease and causes considered preventable is lower in Surrey compared to England. Emergency readmission within 30 days of discharge from hospital is low in Surrey.

In Surrey, preventable sight loss due to glaucoma is lower than the England average, whereas sight loss due to diabetic eye disease is similar to that within England overall.

Surrey performed worse on the following indicators:

- Suicide is slightly higher in Surrey than England.
- Hip fractures in over 65s is high in Surrey.

Conclusion: Areas to Focus on Within Surrey:

Road traffic accidents; use of outdoor space for physical activity; NHS Health checks; injuries due to falls in those aged 80+; air pollution; coverage of childhood immunisation, HPV and PPV vaccination, flu vaccination; Chlamydia diagnosis; treatment completion for TB; suicide and hip fractures**.**

10. Recommendations

Local public services must be of good quality, be effective and deliver within budget. It is, however, not enough to care for people when they become unwell. Every effort to prevent ill health must be taken and given adequate attention. It is also particularly important that avoidable differences in health outcomes and experiences of local services for different segments of the population are addressed.

Marmot poses an important question:

"Why do we keep treating people for illnesses only to send them back to the conditions that created illness in the first place?"[3]

In order to address the hidden health inequalities in Surrey, working through the newly formed Health and Wellbeing Board we need to:

1. Formally adopt Marmot's six policy objectives to improving the health of the population of Surrey. They are:

- *Give every child the best start in life*
- *Enable all children, young people and adults to maximise their capabilities and have control over their lives*
- *Create fair employment and good work for all*
- *Ensure a healthy standard of living for all*
- *Create and develop healthy and sustainable places and communities*
- *Strengthen the role and impact of ill health prevention*

2. Use the life expectancy data to target prevention services at those geographical communities most at risk of ill health, and monitor to ensure their experience of heath improves and the gap between the life expectancy of the most and least deprived falls.

3. Ensure prevention services work with the communities highlighted in this report to provide tailored, needs led interventions to reduce the inequalities that they experience.

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