

August 2013

Maybury and Sheerwater
Health Needs and Assets
Assessment
Full Report



Prepared by
Dr Nadeem Hasan,
Surrey Public Health

*"The only way to keep your health is
to eat what you don't want,
drink what you don't like, and
do what you'd rather not"*

- Mark Twain

Acknowledgements

Many thanks to the following individuals for support and assistance in the course of creating this report (in first name alphabetical order):

All the community assets who participated in the questionnaires

All the residents who participated in the semi-structured interviews

Bob Morgan (Woking Borough Council)

Dr Munira Mohamed (Sheerwater Health Centre)

Helen Atkinson (Surrey County Council, Public Health)

Jackie Sowerbutts (Surrey County Council Public Health)

Jon Walker (Surrey County Council Public Health)

Marcus Butlin (Surrey County Council Public Health)

Ruth Hutchinson (Surrey County Council Public Health)

Sue Barham (Woking Borough Council)

Shahnaz Bano (Surrey County Council, Public Health)

Sandra Scott (Woking SureStart Children's Centre)

List of abbreviations used

A&E	Accident and Emergency
AF	Atrial Fibrillation
APHO	Association of Public Health Observatories
CCG	Clinical Commissioning Group
CDPP	Cardiovascular Disease Primary Prevention
CHD	Coronary Heart Disease
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
COVER	Cover of Vaccination Evaluated Rapidly (dataset)
CVD	Cardio-Vascular Disease
CWI	Child Wellbeing Index
DAAT	Drug And Alcohol Team
DALY	Disability Adjusted Life Year
DCLG	Department of Communities and Local Government
DFLE	Disability Free Life Expectancy
DTaP	Diphtheria, Tetanus, and acellular Pertussis (vaccine)
ESRC	Economic and Social Research Council
GBD 2010	Global Burden of Disease study 2010
GCSE	General Certificate of Secondary Education
GMC	General Medical Council
GP	General Practitioner
Hib	Haemophilus influenzae type b (vaccine)
HIV	Human Immunodeficiency Virus
HNAA	Health Needs and Assets Assessment
HPA	Health Protection Agency
HPS	Health Protection Services
HSCIC	Health and Social Care Information Centre
IDACI	Income Deprivation Affecting Children Index
IDAOP	Income Deprivation Affecting Older People Index
IMD	Index of Multiple Deprivation
IPV	Inactivated Polio Vaccine
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LSOA	Lower Super Output Area
LVD	Left Ventricular Dysfunction
MI	Myocardial Infarction (heart attack)
MMR	Measles, Mumps and Rubella (vaccine)
MSOA	Middle Super Output Area
NCMP	National Child Measurement Programme

NEET	Not in Education, Employment, or Training
NICE	National Institute of Health and Care Excellence
NHS	National Health Service
NOO	National Obesity Observatory
NS-SEC	National Statistics Socio-Economic Class
NTA	National Treatment Agency
OCD	Obsessive Compulsive Disorder
ONS	Office of National Statistics
PANSI	Projecting Adult Needs and Service Information
PDU	Problematic Drug User
PHE	Public Health England
PHOF	Public Health Outcomes Framework
POPPI	Projecting Older People Population Information System
PPV	Pneumococcal Polysaccharide Vaccine
QoF	Quality and outcomes Framework
SSSI	Site of Special Scientific Interest
TIA	Transient Ischaemic Attack
WHO	World Health Organisation
YLD	Years Lost due to Disability for incident cases of the condition
YLL	Years of Life Lost due to premature mortality

Contents

Foreword	7
Executive summary	8
Recommendations	14
1. Introduction	20
1.1 Background	20
1.2 Key concepts	21
1.3 Aims and objectives	32
1.4 Key stakeholders	33
1.5 The Sheerwater Regeneration Plan	34
2. Demography	36
2.1 Maybury and Sheerwater: an overview	37
2.2 Population profile	40
2.3 Ethnicity	48
2.4 Religion	51
3. Deprivation, inequalities, and the wider determinants of health ..	54
3.1 Index of Multiple Deprivation 2010 (IMD 2010)	55
3.2 MOSAIC Public Sector people classification system	64
3.3 Specific indicators of deprivation	67
3.4 Life expectancy at birth	76
4. Behavioural risk factors	79
4.1 Smoking	80
4.2 Alcohol	85
4.3 Diet and exercise	90
4.4 Illicit drug use	98
4.5 Immunisations	102
4.6 Screening	107
4.7 Teenage pregnancy	111
5. Specific conditions	114
5.1 Prevalence of specific conditions	115
5.2 Prevalence of obesity	120
5.3 Cancer incidence	124
5.4 Emergency hospital admissions	125
5.5 All-age and premature mortality	127

6. Community feedback	131
6.1 Introduction to the methodologies used	132
6.2 Semi-structured interview with residents: framework of themes	133
6.3 Semi-structured interview with residents: responses	138
6.4 Questionnaire with community assets: identification of 'assets'	139
6.5 Questionnaire with community assets: structure of questionnaire and responses	144
7. Community assets	145
7.1 GP practices	145
7.2 District nurses and health visitors	145
7.3 Pharmacies	146
7.4 Dental surgeries	147
7.5 Woking SureStart Children's Centre	148
7.6 CornerHouse Mental Health Resource Centre	149
7.7 Sheerwater Youth Centre	150
7.8 Maybury Centre	150
7.9 Parkview/Sheerwater Community Centre	150
7.10 Other halls for hire	151
7.11 Linkable learning disability charity	151
7.12 St. Paul's and St. Michael's Churches	152
7.13 Emmanuel Chapel	152
7.14 Al-Birr and Shah Jahan Mosques	152
7.15 Green spaces	153
Conclusions and final thoughts	154

Foreword

Maybury and Sheerwater is an area of Woking with unparalleled cultural diversity. This stems from a rich history of immigration from all corners of the world: from Eastern Europe to East London, from South Asia to Africa. The northern border is a beautiful stretch of the Basingstoke Canal where residents can walk, cycle, and fish, and throughout the ward there is a palpable sense of community.

However, it is also one of the most deprived areas in Surrey, where life expectancy is 5 years less than the Surrey average, and up to 15 years less than the most affluent areas of Surrey. Through the work of Sir Michael Marmot we know that health inequalities result from social inequalities, and this is starkly illustrated in Maybury and Sheerwater. It is an area with relatively high unemployment, low income, low educational attainment, and overcrowded housing. This is seen to translate to higher rates of unhealthy behaviours like smoking and poor diet, and higher rates of chronic disease, emergency hospital admissions and premature mortality. Of particular concern are the high rates of child poverty and childhood obesity, which mean a significantly reduced quality of life for young people in the area. More can be done to tackle these inequalities, and more must be done.

One major project is the 'Sheerwater Regeneration Plan', a multi-million pound scheme to transform Sheerwater, and this report is a welcome addition to planning how to maximise its benefit to health and wellbeing. Similarly, we hope that all local partners will use the findings of the report to plan services to address health inequalities in the area. These partners include Woking Borough Council and Surrey County Council, North West Surrey CCG and NHS Surrey and Sussex Area Team, GP practices and pharmacies, and community centres and faith groups.

The focus in this report on supporting local community assets is to be particularly welcomed, as they play a central role in maintaining and improving the health and wellbeing of local residents. Winston Churchill famously said that "healthy citizens are the greatest asset any country can have", and we sincerely hope that this report can contribute to developing this particular asset in Maybury and Sheerwater.

RAY MORGAN, CHIEF EXECUTIVE OFFICER, WOKING BOROUGH COUNCIL

DR LIZ LAWN, CLINICAL CHAIR, NORTH WEST SURREY CLINICAL COMMISSIONING GROUP

HELEN ATKINSON, ACTING DIRECTOR OF PUBLIC HEALTH, SURREY COUNTY COUNCIL

Executive summary

Maybury and Sheerwater ward is the **second most deprived ward in Surrey**, known to experience more disease, and to have a lower life expectancy than the rest of Surrey. Due to the presence of these marked health inequalities, it has been designated a '**priority place**' for local stakeholders to work together to make a long-term and sustainable improvement in health outcomes.

However, despite forming a single ward, **Maybury and Sheerwater have different histories that inform their present day ethnic make-ups**, and indeed their differing health issues. Therefore, whilst they are considered as a single area for the purposes of this report (indeed small area statistics are difficult enough to draw firm conclusions from without cutting down the area further), planners and commissioners should keep in mind the different historical, social, and cultural differences that exist within the ward.

This report is a **health needs and assets assessment (HNAA)**, with the **specific aim**: "To work with the local community and key stakeholders to identify health needs, priorities, existing services and assets, and develop a platform to support future partnership work to reduce inequalities and improve the health of local residents." It takes a '**needs**' approach, looking at demographic, deprivation, and health data to identify where commissioners and planners need to focus additional attention; alongside which it takes an '**assets**' approach, looking at the resources and social capital available in the community that can be supported to meet those needs.

Sheerwater is in the early stages of a huge '**Sheerwater Regeneration Scheme**' being led by Woking Borough Council, which will see millions of pounds invested in the area, improving housing, roads, parks, shops, and community facilities. Maybury too has been earmarked for new housing and development. It is hoped that this **HNAA can feed into the process for these developments**, shaping the way that services are provided for the local community, leading to a **sustainable improvement in health and wellbeing**.

Before presenting the health issues facing the local population, it is important to understand the context of these health inequalities:

- First, **health inequalities arise from social inequalities**: the Marmot report presents with staggering clarity that poor health is a consequence of low income, poor education and skills, and poor housing. Models that seek to

quantify the determinants of health outcomes attribute 50% of health outcomes to a person's socio-economic status and physical environment, 30% to a person's health behaviours (e.g. smoking, alcohol, and diet), and only 20% to the clinical care they receive. **Maybury and Sheerwater has some of the poorest markers of social deprivation in Surrey**, and this accounts for a great deal of the poor health that they experience.

- Second, the **central importance of prevention** is starkly illustrated in the UK analysis of the Global Burden of Disease Survey 2010, which shows that all dietary and exercise components together are responsible for 14.3% of the burden of disease, smoking accounts for 11.8%, and alcohol is not far behind. **Maybury and Sheerwater experiences some of the highest rates of unhealthy behaviours in Surrey**, and improving these must be the cornerstone of any policy to address health inequalities.
- Finally, health is a broadly defined term, including not just physical, mental, and emotional wellbeing, but also the social networks that people rely upon to help them resist challenges to their health. This includes the provision of emotional support, practical support, and the development of a social environment that supports people to pursue their goals. An oft-quoted phrase is "changing 'i' to 'we' changes 'illness' into 'wellness'", but linguistic quips aside, **developing community cohesion and social capital must be a key part of any health improvement strategy**.

With regard to demography, the population of Maybury and Sheerwater is weighted heavily towards younger people compared with the regional and national averages, with a particularly large proportion (37.5%) of young working age adults aged 20-39. However, despite the older population forming a small proportion of the overall population, it is projected to grow in line with the regional and national population.

With regard to ethnicity, the British Pakistani population in Maybury and Sheerwater is significantly larger than the borough average (34.3% vs. 5.73%), and the (White) British population is correspondingly lower (37.02% vs. 74.94%). The religious make-up of Maybury and Sheerwater reflects the ethnicity profile, with a much higher proportion of Muslims than regionally or nationally (the highest in Surrey), and a higher proportion of Hindus (4th highest in Surrey)¹, with a consequently lower proportion of Christians.

¹ Source: Surrey-i local area profile for Maybury and Sheerwater using ONS Census 2011 data, available at <http://www.surreyi.gov.uk/DrillDownProfile.aspx?rt=37&rid=296722&pid=34> accessed 25th July 2013

With regard to deprivation and the social determinants of health, Maybury and Sheerwater is the second most deprived ward in Surrey, and contains the most deprived LSOA. Comparing nationally, it is significantly worse than the national average for the three key indicators of income deprivation, child poverty, and older people in deprivation. Additionally, the MOSAIC profile for Maybury and Sheerwater shows a much higher proportion of lower-income families than the Woking or Surrey average.

More specific indicators tell us that deprivation in children is a major problem, with poor childhood development and poor educational attainment. The major problems for adults are high unemployment, low incomes, and overcrowded housing, which are markedly worse than the rest of Woking and Surrey. Most crucially of all, **Maybury and Sheerwater has the lowest life expectancy of any ward in Woking, with residents dying on average 5 years younger than the average Surrey resident, and 9 years younger than the most affluent in Woking.** This difference is most marked in males, though is also true in females.

With regard to behavioural risk factors (smoking, alcohol, diet etc.), **smoking** remains the biggest cause of preventable deaths in Maybury and Sheerwater, and the prevalence is likely to be markedly above the Woking average. However, despite this the Stop Smoking service has historically found it very difficult to engage the local community in the service, and low numbers of attendees have meant that most clinics have had to close. Whilst Woking has a major problem with harmful levels of **alcohol** (in the worst 5% of local authorities), Maybury and Sheerwater is likely to have much lower levels than the rest of Woking. This is consistent with the ethnic/religious make-up of the population. However, Sheerwater (as distinct from Maybury) may have higher rates of alcohol related harm. The levels of **healthy eating** in Maybury and Sheerwater are lower than the Woking and Surrey average, and markedly lower than the England best levels. It is also the case that people want to do more **sport and exercise** but face barriers to doing so.

The proportion of the resident adult population who are in treatment with the **Drug and Alcohol Services** (DAAT) in Maybury and Sheerwater is over double the Surrey average, and over 1.5 times the Woking average. There is a higher proportion of clients in older age groups (45-54), despite the population being much younger than the Woking or Surrey average. The proportion of those in treatment for alcohol is relatively low, as would be expected from the ethnic/religious makeup of the ward, but worryingly there is a markedly higher proportion of clients in treatment for problematic drug use, which

include opiates and crack cocaine. Uptake of **childhood vaccinations** in Maybury and Sheerwater drops off between age 2 and the pre-school booster. Furthermore, vaccination uptake differs significantly between GP practices. Uptake of cervical **screening** is slightly below the national target, and uptake of bowel and breast screening is markedly below the national target. Uptake of screening also varies significantly from practice to practice. Maybury and Sheerwater is in the 4th highest decile of all wards nationally for **teenage pregnancies**, which is particularly worrying in a local authority that is in the 2nd lowest decile of all local authorities nationally. However, the absolute numbers are low, and it should be noted that the rate is not statistically significantly different from the England average.

With regard to specific conditions, the commonest conditions (by recorded prevalence) in Maybury and Sheerwater are: hypertension, diabetes, obesity, asthma, and depression. **The major condition where prevalence is higher than average is diabetes.** Additionally, there is marked variation in recorded prevalence between practices, and the modelled data for four major conditions indicate that there is significant underdiagnosis for some conditions in the community. This is particularly the case for COPD and hypertension, but is likely to apply to other conditions too. Adult **obesity** rates are higher in Maybury and Sheerwater than the Woking and Surrey average, and not significantly different from the England average. Most worryingly, **childhood obesity in Maybury and Sheerwater is the highest in Woking with 22.5% of year 6 children obese compared with 15.4% in Woking.**

Cancer incidence in Maybury and Sheerwater is not significantly different from the national average. However, when compared with the Surrey average, the incidences of colorectal cancer (linked to diet, exercise, weight, and smoking) and prostate cancer are significantly higher.

Emergency hospital admissions for chronic diseases and their complications are significantly worse in Maybury and Sheerwater than the national average, and even more so when compared with the Woking and Surrey averages. Emergency admission for heart attacks and COPD are over double the national rate, and the Woking and Surrey rates are lower than the national rate. This represents a **huge failure of prevention and management in the community, both self-management by patients and professional led management in primary care.** All-age all-cause **mortality** is also significantly higher than the Woking, Surrey, and the national average (in line with the level of deprivation). All-age mortality from respiratory diseases and premature mortality from circulatory diseases are both much higher as well.

Semi-structured interviews conducted with residents indicate that from their perspective, the **major health problems** include diabetes, heart disease, hypertension, and depression, alongside poor diet and low levels of exercise. **Access to health services** could be improved by increasing the availability of information on what pharmacists can manage, and by increasing the availability of after-hours GP appointments, improving the GP appointment booking system, and addressing some barriers with regard to privacy and confidentiality when booking GP appointments. **Additional services** to address the health issues in the community might include increased health promotion and delivery through the mosques, particularly after Friday prayers, and an improved service for supporting diabetics. **Approaches to helping residents improve their own health** could include tailored cooking classes and subsidised exercise opportunities.

Crucially, some residents felt that their focus was on earning enough money just to pay for their rent and food, and preferred to spend their very limited free time with their family. Accordingly, questions of what the council, NHS, or other organisations could do to improve their health missed the point that they don't feel as though they have the luxury of thinking about things like that. High rents, including in social housing, was their major concern.

Questionnaires conducted with community assets that provide services related to health highlighted the same **health issues** as the residents, specifically: diabetes and heart disease, poor diet and exercise, and poverty. They additionally added the issue of loneliness and boredom, which may feed into the issue of depression noted by some of the residents and reflected in the QoF prevalence. The extent to which these groups/assets were aware of each other was mixed, and a common suggestion was the development of a forum or formal network in the area for groups to understand each other better and be able to signpost to each other more easily. **Suggestions for new projects/approaches** included targeted interventions for young people around obesity/diet/diabetes/heart disease; more support for 16-25 year olds; and antenatal and postnatal support for new mothers in the community. The latter may tie in well to the potential roll-out of the Family Nurse Partnership in Surrey in the future. **Cultural barriers** were also identified, particularly around the difficulty in providing services to young women in the British/Asian community where men may be present, and the importance of privacy/confidentiality. Generally, it was widely noted that **service provision** was good, but improving the provision of information to residents would improve uptake of these services.

In common with the residents, service providers also noted the potential benefit of targeted cooking classes and dietary health promotion advice, highlighted the role of mosques in delivering health messages to the Muslim community, and referred to the potential benefits from examining the GP practice booking system and provision of late-hours appointments.

This report concludes with a description of the community assets, and some of the services provided. Each sub-section of this report also contains a summary, and a set of recommendations for how the evidence presented might be transformed into actions to improve the health of the residents. These recommendations are reproduced in the next section as a list, and **it is hoped that commissioners, planners, community assets, and all relevant stakeholders will be able to use the findings and recommendations of this report as a platform to support future partnership work to reduce inequalities and improve the health of local residents.**

Recommendations

Stakeholders (commissioners, planners, and community assets) **should be supported to:**

1. See the **young population profile** as an opportunity for targeting young people with primary prevention strategies, particularly around diet, exercise and smoking cessation, in order to prevent future morbidity and mortality.
2. Target **young people** in the early stages of chronic disease with focused early intervention and control of risk factors, in order to prevent the onset of complications and improve prognosis.
3. Ensure adequate service provision for other health issues affecting **younger people**, including sexual health, mental health, and musculoskeletal services.
4. Ensure robust planning and delivery of services for major health issues affecting **older people**, including the management of multiple chronic diseases, dementia and mental health issues, reducing falls and fractures, reducing excess winter morbidity and mortality, and reducing the need for hospital admissions for conditions that can be managed in the community.
5. Explore the central role that social care plays in achieving some of these goals, and how they may be addressed through greater integration between health and social care at the Health and Wellbeing Board, ensuring the needs of the **older population** can be met.
6. Explicitly take **ethnicity** into account when planning and delivering services, both with regard to the increased risk profile of certain disease (e.g. diabetes, cardiovascular disease, and genetic diseases), and with regard to cultural sensitivities and customs.
7. Understand the service implications of **religion**, with higher proportions of Muslims and Hindus in Maybury and Sheerwater than in the rest of Woking. Specific areas where this needs to be taken into account include the planning of beginning and end of life care, translation and interpretation services, and sensitivity to cultures and customs.

8. Incorporate relevant sources of **data** on deprivation, both composite indicators and specific indicators, when designing services and allocating funding to development projects to tackle deprivation.
9. Focus particularly on **child poverty and deprivation** in Maybury and Sheerwater. Poor development and educational attainment in childhood is likely to result in unemployment/underemployment, low incomes, and poor mental and physical health in adulthood. In turn, children that grow up in these families are more likely to suffer the same problem. Breaking this vicious cycle must be a priority.
10. Pay particular regard to issues relating to **housing** when designing local development plans, particularly overcrowding, which can have a detrimental effect on health and wellbeing.
11. Reduce **smoking** prevalence and uptake through a targeted approach in Maybury and Sheerwater.
12. Provide Stop **Smoking** services hand-in-hand with engaging with residents to encourage and support them to use these services. One example might include increasing the delivery of health improvement messages in key community spaces e.g. shops, churches and mosques, and leisure facilities.
13. Work together with schools to make an impact on the 9 out of 10 **smokers** who start before their 19th birthday. This may take the form of specific training for teachers, or a specific programme of health teaching delivered by health professionals.
14. Consider novel approaches to reducing **smoking** prevalence where traditional approaches fail, as cigarette smoking carries such a huge burden of health and economic costs.
15. Consider that whilst a targeted approach to **alcohol** harm reduction in Maybury and Sheerwater over and above a Woking-wide strategy is unlikely to be an effective use of resources, any strategy to improve the health of the local population must take into account the harms associated with high levels of alcohol consumption. Alcohol remains one of the biggest risk factors for ill health. Accordingly, stakeholders should ensure the effective implementation of a Surrey and Woking wide alcohol

harm reduction strategy, with Maybury and Sheerwater included in the delivery of that plan.

16. Carefully consider how to increase the proportion of residents that **eat healthily**. This merits a specific targeted approach for Maybury and Sheerwater, both with regard to the lower levels of healthy eating and poor health, and with regard to the ethnic make-up and specific dietary preferences.
17. Have regard to the motivators and barriers to uptake of sport and **exercise** described in the Sport England survey, and other local data, when planning strategies and interventions.
18. Develop a local strategy around both prevention and treatment for **drugs** and alcohol abuse, taking into account the root causes of drug and alcohol addiction, and working together to tackle these root causes.
19. Work together to support former **drug** users with employment, housing, and ongoing support in the community to support and sustain their recovery.
20. Work in partnership to increase uptake of **immunisations** through evidence based methods. This particularly applies to NHS Surrey and Sussex Area Team, together with North West Surrey CCG and individual GP practices, but they can be supported by council officers, elected members, nurseries, schools, and community groups and centres.
21. Ensure the uploading of accurate **immunisation** data routinely from GP practices to the UK COVER database to allow a more robust analysis than that permitted by the Open Exeter system, and better directed quality improvement.
22. Work together to develop and support initiatives to improve uptake of **screening** in Maybury and Sheerwater. This will result in early detection of these cancers, allowing treatment and significantly improved prognosis.
23. Consider teenage mothers and **teenage pregnancies** when planning service delivery, particularly with regard to education programmes targeted at schools and communities where this is a real issue.

24. Support the commissioning of Family Nurse Partnership in Surrey, targeting areas of deprivation where rates of **teenage pregnancy** are high alongside poor education, housing, and low income. This is a crucial, evidence-based programme in the fight to break the vicious inter-generational cycle of poverty and poor health.
25. Work together to identify the root causes for **under-diagnosis** in primary care, and address these to ensure that all patients with chronic conditions are managed appropriately to avoid complications and serious events.
26. Focus on **diabetes prevention and management**, as prevalence in Maybury and Sheerwater is higher than in Surrey or England, likely due to a mix of ethnicity factors and diet/exercise factors.
27. Ensure that services are available to support the health needs of the local community with regard to the prevalence of the **commonest conditions**, e.g. patient education and support programmes for long-term conditions
28. Prioritise action on **childhood obesity** in Maybury and Sheerwater, as these children are at significantly higher risk of poor physical health in adulthood, including diabetes, cardiovascular disease, and complications from these conditions.
29. Support assets in the community that work with **children and young people**, including nurseries, schools, and the Woking SureStart Centre, to further develop healthy behaviour promotion programmes, centred around diet, exercise, and parent health education programmes.
30. Consider that working together on the diet, exercise, smoking, and alcohol prevention agenda will translate into lower **cancer** incidences over time, in addition to the multitude of other health benefits.
31. Work together to develop a strategy to address the huge problem of markedly high **emergency admissions**. This may include using a framework of the three contributory factors of prevention, self-management, health professional led-management, and listing what can be done under each. From a prevention perspective, this may include further local work on Stop Smoking services, and diet and exercise health promotion. From a self-management perspective, this may include supporting local assets to develop work on community engagement and patient education programmes, and engaging community leaders in highlighting the

importance of self-management of chronic conditions. From a health professional led management perspective, this may include reviewing management pathways to ensure that patients are being logged on disease registers, managed in line with evidence-based guidance, and supported to manage their own conditions.

32. Work together to address the high **premature mortality** through tackling deprivation and developing and implementing the prevention and management strategies outlined in previous recommendations.

33. Take into account **resident feedback** in the HNAA, including:

- a. **GP practices** should consider making changes to appointment booking/availability in line with community feedback.
- b. Stakeholders should work in partnership to further develop relationships with **faith organisations and other non-health community groups** to explore further ways in which health might be improved through these groups.
- c. Commissioners and planners should consider the community feedback when planning local development and how health improvement might fit in with this. Key themes in this regard included the potential benefit of tailored **cooking classes** and subsidised access to **exercise facilities**.
- d. Finally, the council should work together with **housing** partners when planning re-development of the area to consider whether any options are available to reduce the burden of cost of housing, particularly social housing, for residents on very low relative incomes.

34. Take into account **community asset feedback** in the HNAA, including:

- a. Community assets should be supported to develop a **forum** (or equivalent) for sharing information about services that are available in the community. This would allow appropriate signposting and easier identification of gaps in service provision.
- b. A plan should be developed for improving the **knowledge and understanding that residents have** on what services are available and how to access them. This may include regular direct mailings, a

well-publicised website specifically for residents in Maybury and Sheerwater, or other appropriate options.

- c. Commissioners and planners should also work together to identify **specific projects** based around common themes that can be drawn from the quantitative and qualitative data. This could include work around diet, obesity, diabetes, or heart disease, particularly in young people. Using a targeted approach in this way would ensure that resources were used effectively, whilst potentially engaging the community more widely on the importance of healthy eating and having a healthy weight.
- d. Commissioners and planners should take into account the **cultural barriers** to accessing services that have been identified here when developing services. These include issues around gender segregation and privacy/confidentiality. They should also consider the **strength of community networks**, and include key assets in discussions around developing services e.g. how to increase delivery of health messages through faith organisations and how to tailor messages and health education (e.g. cooking classes) for specific ethnic groups.
- e. Finally, as recommended above, **GP practices** should consider changing the booking system/availability in line with feedback.

1. Introduction

1.1 Background

Following an **analysis of population and local data sets and 'heat maps' of deprivation** (around the themes of health and wellbeing, children and young people, economic development, safer and stronger communities), **Maybury and Sheerwater in Woking was identified as a priority place** for addressing inequalities.

The **'priority place' model** was developed by NHS Surrey and Surrey County Council in partnership with the districts and boroughs to highlight **areas where residents experience higher inequality and deprivation relative to the rest of Surrey**. The data clearly shows that **residents in these areas experience more disease than the rest of Surrey and are likely to die earlier**. This model has **three distinct aims**:

1. To make a long term and **sustainable improvement in outcomes** for the people living in each of the priority places
2. To build **stronger and more self-reliant communities**
3. To **pilot better ways of working together locally** that can then be rolled out to other places

A **key Joint Strategic Needs Assessment (JSNA)**

recommendation is for health needs assessments (HNAs) to be completed for all priority places, following the work done in Merstham and Stoke and Westborough, and this piece of work aims to complete that for Maybury and Sheerwater. A **HNA is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation to improve health and reduce inequalities**.



The HNA has been developed in line with best practice guidance from the National Institute of Health and Care Excellence (NICE)².

² 'Health needs assessment: A practical guide' NICE (2005), available at http://www.nice.org.uk/aboutnice/whoweare/aboutthehdg/hdapublications/health_needs_assessment_a_practical_guide.jsp accessed 25th July 2013. Prior to 1st April 2013, The National Institute of Health and Care Excellence was named the National Institute for Health and Clinical Excellence.

1.2 Key concepts

This report has been developed in line with current models of best practice, and accordingly covers a range of **conceptual frameworks**, each of which will be discussed in turn.

Conceptual frameworks relevant to this report

1. Contemporary formulations of 'health'
2. The social determinants of health and health inequalities
3. Combining an needs-based approach with an asset-based approach to improving health
4. The current state of health of the UK population

1.2.1 Contemporary formulations of health

The WHO definition of health is:

“a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”³

and has not been amended since 1948. At the time it was groundbreaking, due to the fact that it was the first major declaration that **health was no longer to be regarded in negative terms, as merely the absence of disease, but in fact as a positive concept that emphasises mental and social wellbeing.**

This definition of health as a positive concept is applied in this report, but is extended further in line with contemporary changes in health and healthcare. More recently, the WHO definition of 'complete' physical, mental, and social well-being has been challenged in light of the rise of chronic disease, as most people would now be categorised as 'unhealthy'. Accordingly, there have been calls for the definition of health to be changed to emphasise not 'complete well-being', but instead **the ability to adapt and self manage in the face of social, physical, and emotional challenges.**⁴ This broadening of the definition of health to emphasise **social resources and the**

³ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

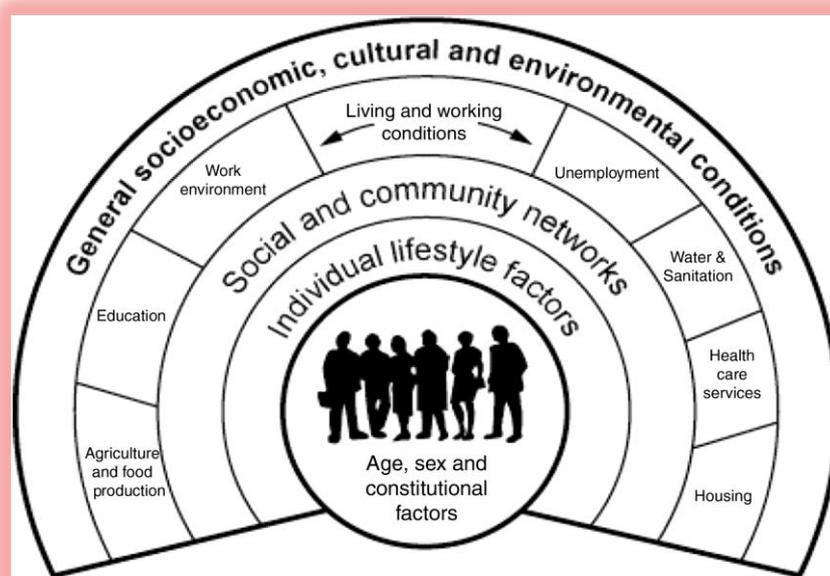
⁴ Huber M, Knottnerus JA, Green L, et al. 'How should we define health' BMJ 2011; 343:d4163

capacity of individuals to cope with their environment is to be welcomed, and is directly reflected in the concept of the social determinants of health.

1.2.2 The social determinants of health and health inequalities

Dahlgren and Whitehead (1991)⁵ represented the **complex, multi-layered relationship between the individual, their environment, and their health** as follows:

Figure 1: Dahlgren and Whitehead's model of the determinants of health⁴



At the centre is the individual with their **'fixed' risk factors** determined by their age, sex, and genetic makeup. The second layer is their **personal lifestyle (modifiable) risk factors** that can improve or damage their health, e.g. diet, exercise, smoking, and alcohol intake. The third layer is their **social position and community networks**, which when strong can provide a source of support and resilience, and when weak can have a negative effect on health. The fourth layer includes the **wider social determinants of health**, such as access to food, water, sanitation, housing, education, employment, and transport. In the outer layer are the economic, political, cultural, and environmental conditions present in **society as a whole**. All of these influences impact on health and health inequalities, and need to be considered when investigating the health status and health needs of a population.

⁵ Whitehead M, Dahlgren G 'What can be done about inequalities in health?' The Lancet 1991; 338:1059-63

Following on from this, in November 2008 Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The report, '**Fair Society, Healthy Lives**'⁶ was published in February 2010, and had 9 key messages:

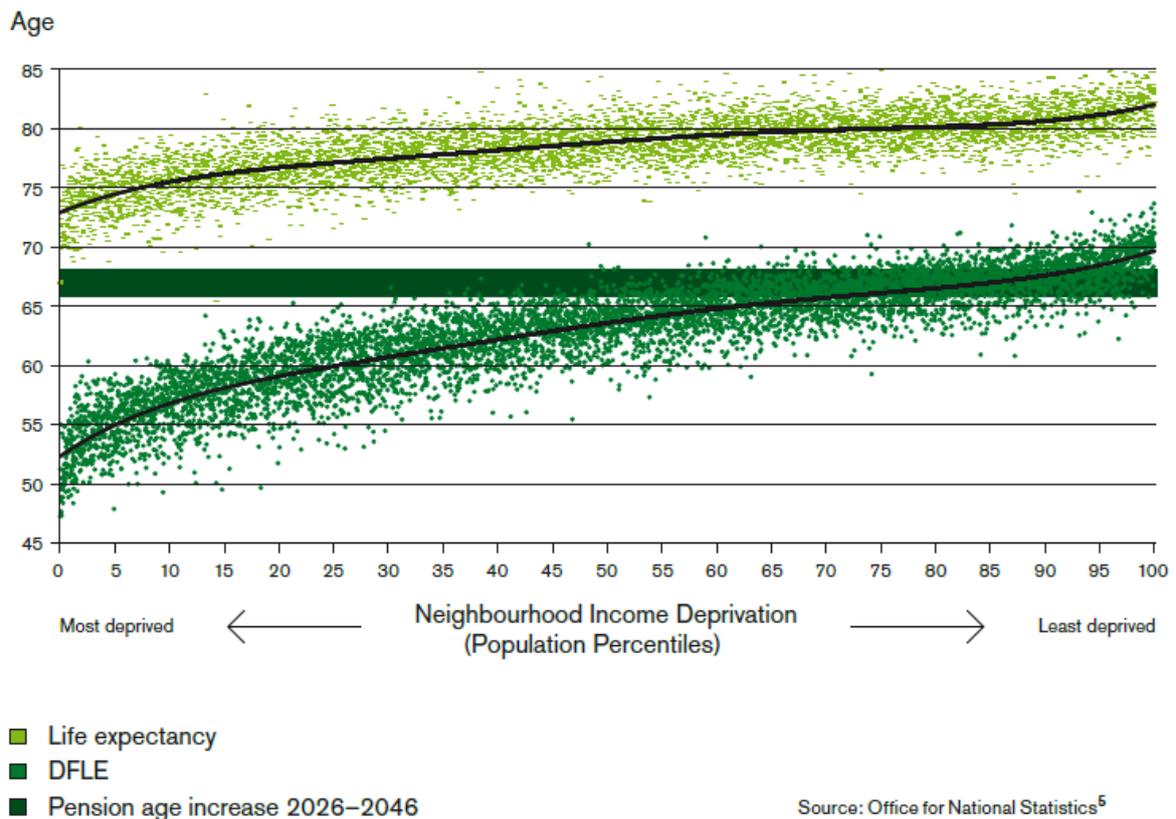
1. Reducing health inequalities is a matter of **fairness and social justice**.
2. **There is a social gradient in health** – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health.
3. **Health inequalities result from social inequalities**. Action on health inequalities requires action across all the social determinants of health.
4. To reduce the steepness of the social gradient in health, actions must be universal, but with a **scale of intensity that is proportionate to the level of disadvantage**.
5. Reducing health inequalities will have **economic benefits** in reducing losses from illness associated with health inequalities, including productivity losses, reduced tax revenue, higher welfare payments, and increased treatment costs.
6. Economic growth is not the most important measure of our country's success. **The fair distribution of health, well-being and sustainability are important social goals**.
7. Reducing health inequalities will require action on **six policy objectives**:
 - a. **Give every child the best start in life**
 - b. **Enable all children, young people, and adults to maximise their capabilities and have control over their lives**
 - c. **Create fair employment and good work for all**
 - d. **Ensure a healthy standard of living for all**
 - e. **Create and develop healthy and sustainable places and communities**
 - f. **Strengthen the role and impact of ill health prevention**
8. Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors, and community groups. **National policies will not work without effective local delivery systems focused on health equity in all policies**.
9. **Effective local delivery requires participatory decision-making at local level**. This can only happen by empowering individuals and local communities.

⁶ Marmot Review. Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post 2010. London: Marmot Review; 2010. Available at <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review> accessed 25th July 2013

Following the publication of the Marmot Review, **it has been widely accepted that there is a strong association between health inequalities and other measures of deprivation including income, unemployment, and poor housing**. This is starkly illustrated on the following graphs reproduced from the report, the first of which shows that as neighbourhood income falls, life expectancy and healthy life expectancy fall significantly, and the second of which shows that morality rates are significantly higher in lower social-economic classes:

Figure 2: Reproduced from the Marmot Review⁷

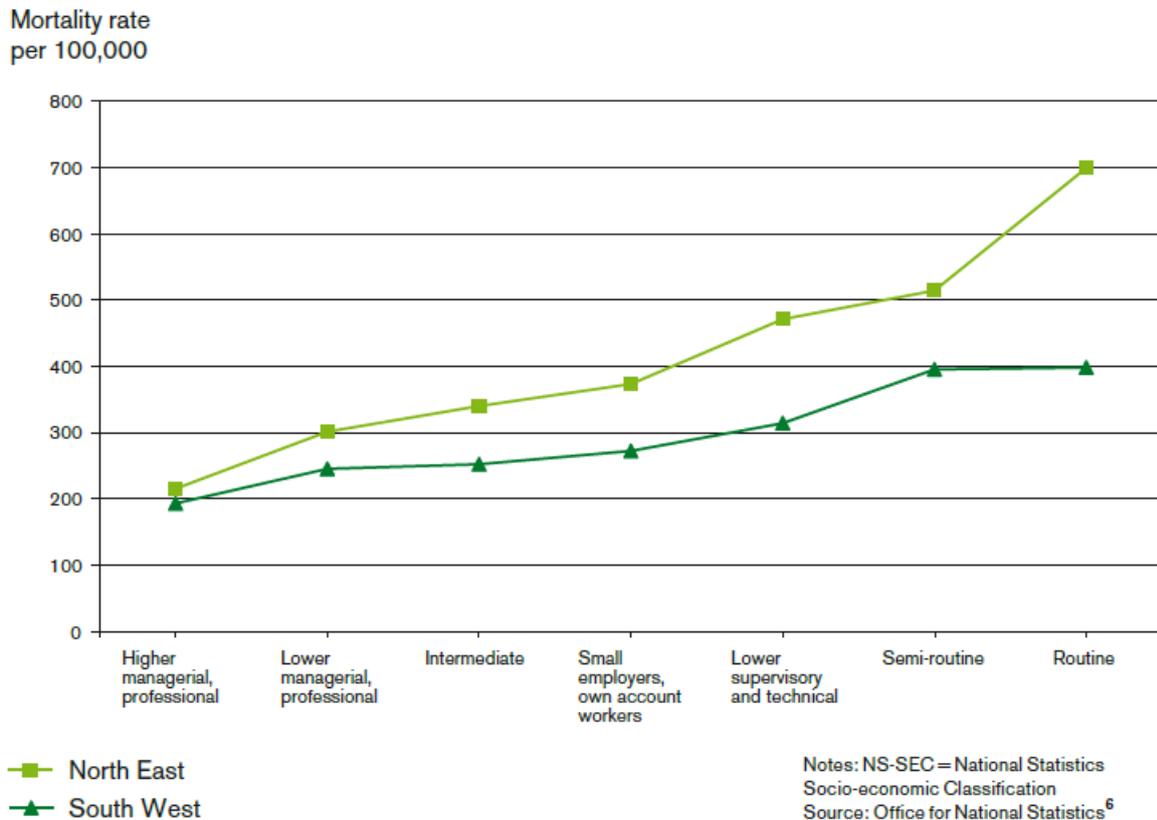
Figure 1 Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003



⁷ Marmot Review. Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post 2010. London: Marmot Review; 2010. Available at <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review> accessed 17th May 2013

Figure 3: Reproduced from the Marmot Review⁸

Figure 2 Age standardised mortality rates by socioeconomic classification (NS-SEC) in the North East and South West regions, men aged 25–64, 2001–2003



In response to this the Government published its public health White Paper ‘**Healthy Lives, Healthy People**’⁹, which **embraced the wider social determinants of health** and the ‘**life course approach**’ proposed by the Marmot Review, alongside empowering individuals to make healthy choices and giving communities the tools to address their own needs.

⁸ Marmot Review. Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post 2010. London: Marmot Review; 2010. Available at <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review> accessed 25th July 2013

⁹ White Paper: Healthy Lives, Healthy People: our strategy for public health in England. HM Government, 2010. Available at <https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england> accessed 25th July 2013

More recently, the commitment to addressing inequalities are present in:

1. The **Health and Social Care Act 2012**,¹⁰ which enshrines in legislation for the first time **explicit duties to reduce inequalities in access to and benefits from healthcare services** on the Secretary of State for Health, the NHS Commissioning Board (now NHS England), and clinical commissioning groups (CCGs).
2. The national **Public Health Outcomes Framework (PHOF) 2013-2016**,¹¹ which includes two high-level outcomes to be achieved across the public health system:

- a. Increased healthy life expectancy
- b. **Reduced differences in life expectancy and healthy life expectancy between communities**

3. **Department of Health background material** on the context of the new legislation¹²:

- “1. **The fundamental principle of the NHS**, to be open to all based on need not ability to pay, **is one based on reducing inequalities in healthcare**. The Government fully endorses this principle and seeks to strengthen it.
2. **Currently, there is unjustified variation in many spheres of the health service**, including access, quality and outcomes of care, and **relative to particular social determinants of health**.
3. The plans for modernisation address these challenges head on. **The Government recognises the causes of inequalities in health are wide and diverse. As such, actions to reduce inequalities are being taken across the system.**”

Looking further afield, the US County Health Rankings looks at the health of every county in the US, and illustrates how much of what affects health occurs outside the doctor's office.¹³ It was recently cited by Duncan Selbie, Chief Executive of Public Health England, as a clear indicator of how small

¹⁰ Health and Social Care Act 2012 (c.7). Available at

http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf accessed 25th July 2013

¹¹ Part 1: A public health outcomes framework for England, 2013-2016. Department of Health, 2013. Available at <https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency> accessed 25th July 2013

¹² Factsheet C2: Reducing health inequalities – The Health and Social Care Bill, 2011. Available at

<http://media.dh.gov.uk/network/18/files/2011/10/C2-Tackling-inequalities-in-healthcare.pdf> accessed 25th July 2013

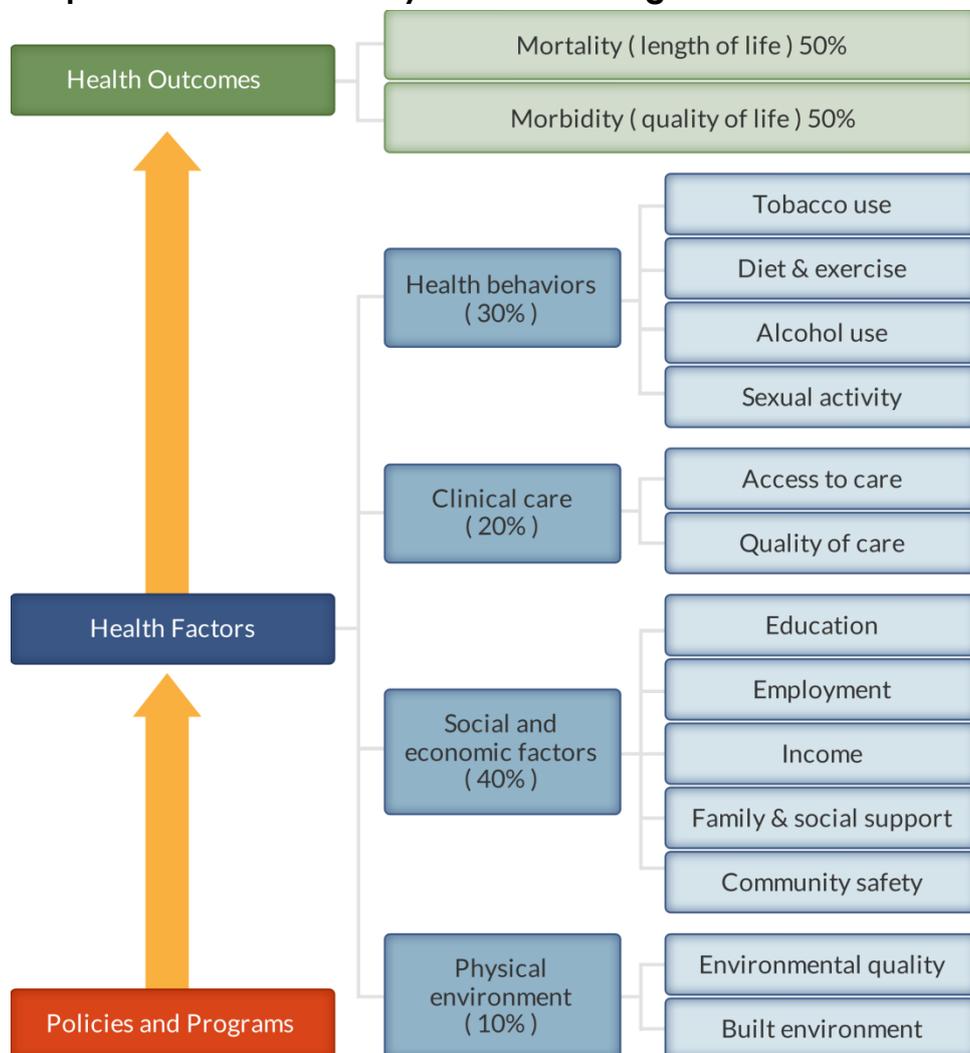
¹³ County Health Rankings and Roadmaps. Available at <http://www.countyhealthrankings.org/> accessed 25th July 2013

the impact of healthcare provision actually is on the health of the population. The weighting for factors contributing to health outcomes (based on a systematic review of published data on the relative contributions of various factors to health outcome) is:

- **Social and economic factors: 40%**
- **Health behaviours: 30%**
- **Clinical care: 20%**
- **Physical environment: 10%**

The breakdown can be seen in the figure 4, reproduced from their website:

Figure 4: Reproduced from County Health Rankings website¹⁴



County Health Rankings model ©2012 UWPHI

¹⁴ Available at <http://www.countyhealthrankings.org/about-project/rankings-background> accessed 25th July 2013

In summary, **it is now well established that addressing health inequalities is central to improving the health of the population, and that action on the social determinants of health is essential to tackling health inequalities.**

Accordingly, this report will focus not only on the lifestyle risk factors for disease and the prevalence of these diseases, but also on the social determinants of poor health, in order to develop robust recommendations for improving health and reducing health inequalities in the population of Maybury and Sheerwater.

1.2.3 Combining a needs-based approach with an asset-based approach to improving health

The traditional approach to conducting HNAs focuses on the **'needs'** of individuals and communities in terms of **'deficits'** in health and wellbeing. Once these have been identified, services run by professionals are designed to address these deficits and 'fix' the problems. In this model, the individuals and communities become **passive recipients** of these services. This approach raises many issues around the **cost, efficiency, and sustainability** of improving the health of local populations, particularly with regard to the **disempowerment and dependence of service users.**

As noted above, there has been change in focus in contemporary discourse around the meaning of health towards the **ability of individuals and communities to adapt and manage changes in health and wellbeing in the face of challenges, utilising social and community networks as a source of support and resilience.** Additionally, the Marmot Review explicitly highlights the importance of **empowering individuals and communities** in addressing health inequalities.

Accordingly, there has been a shift away from focusing purely on the 'needs' or 'deficits' in the local population, to also looking at the **capabilities and capacity in these communities.** This is what is referred to as an **'asset-based' approach:**

Characteristics of an asset-based approach:¹⁵

- Assets can be described as the **collective resources which individuals and communities have at their disposal**, which protect against negative health outcomes and promote health status.
- An asset based approach makes visible and values the **skills, knowledge, connections and potential in a community**. It promotes **capacity, connectedness and social capital**.
- It offers the potential to enhance both the quality and longevity of life through **focusing on the resources that promote the self-esteem and coping abilities of individuals and communities**.

This report therefore seeks to combine these approaches. It will consider the needs of the population (in terms of demographics, lifestyle risk factors, disease prevalence, and social determinants of health), alongside considering the assets in the population (in terms of the capacities, skills, and aspirations of the community). **The final recommendations are based upon a combination of 'needs and asset assessment', with the goal of allowing effective participatory decision-making in future service planning and strengthening.**

1.2.4 The current state of health of the UK population

The **Global Burden of Disease Study 2010** (GBD 2010) is the **largest study every undertaken** to quantify the comparative magnitude of health loss to diseases, injuries, and risk factors by age, sex, and geography over time. The **UK analysis was published in March 2013¹⁶** and presents results for **259 diseases and injuries**, and **67 risk factors** or clusters of risk factors relevant to the UK. It also **compares the state of health in the UK today with back in 1990** when the previous GBD was conducted, and looks at the UK's rank for leading causes compared with 18 other high income countries (15 western European countries, the USA, Canada and Australia) in 1990 and 2010.

The results show that whilst overall health has improved in the UK in terms of both mortality and disability (life expectancy has increased by 4.2 years from 1990 to 2010), **the UK continues to perform significantly worse than other high**

¹⁵ 'Asset based approaches for health improvement: redressing the balance'. October 2011, Glasgow Centre for Population Health. Briefing Paper 9, Concepts Series. Available at http://www.gcph.co.uk/assets/0000/2627/GCPH_Briefing_Paper_CS9web.pdf accessed 25th July 2013

¹⁶ Murray CL et al. UK health performance: findings of the Global Burden of Disease Study 2010. *Lancet* 2013; 381:997-1020

income countries, remaining in the bottom half of the rankings, and its position has worsened in 2010 compared with 1990. Basically, **though health in the UK has improved over the last 20 years, health in the rest of the developed world has improved much faster**. Notably, the UK was significantly below the mean for age-standardised death rates, age-standardised years of life lost due to premature mortality, and life expectancy at birth.

The most important findings were:

Top 10 causes of premature mortality all ages (YLLs)¹⁷	Top 10 causes of premature mortality age 20-54 (YLLs)¹⁶	Top 10 causes of disability (YLDs)¹⁸
1. Ischaemic heart disease	1. Ischaemic heart disease	1. Low back pain
2. Lung cancer	2. Self harm	2. Falls
3. Stroke	3. Cirrhosis	3. Major depressive disorder
4. Chronic obstructive pulmonary disease	4. Breast cancer	4. Neck pain
5. Lower respiratory tract infections	5. Road injury	5. Other musculoskeletal disorder
6. Colorectal cancer	6. Drug use disorders	6. Anxiety disorders
7. Breast cancer	7. Lung cancer	7. Chronic obstructive pulmonary disease
8. Self harm	8. Stroke	8. Drug use disorders
9. Cirrhosis	9. Colorectal cancer	9. Asthma
10. Alzheimer's disease	10. Lower respiratory tract infections	10. Migraine

UK performs better than average compared with other high-income countries	UK performs worse than average compared with other high-income countries
Road injury	Ischaemic heart disease
Diabetes	COPD
Liver cancer	Lower respiratory tract infections
Chronic kidney disease	Breast cancer
	Other cardiovascular and circulatory disorders
	Oesophageal cancer
	Preterm birth complications
	Congenital anomalies
	Aortic aneurysm

¹⁷ YLLs = Years of life lost due to premature mortality in the population

¹⁸ YLDs = Years lost due to disability for incident cases of the health condition

Additionally, it should be noted that the contribution of **Alzheimer's disease** to all-age mortality in the UK **has increased by 137%** since 1990, **cirrhosis by 65%**, and **drug use disorders by 577%**. The **major causes of disability can be grouped as musculoskeletal disorders (31.5% of DALYs¹⁹) and mental and behavioural disorders (21.5% of DALYs).**

The relative contribution of risk factors to the burden of disease can be seen in the figure below, reproduced from the original paper. Note particularly that **the 5 top risk factors are tobacco smoking, hypertension, high BMI, physical inactivity, and alcohol.** All dietary and exercise components together account for 14.3% of DALYs, smoking accounts for 11.8% of DALYs, and hypertension accounts for 9.0% of DALYs. These findings should weigh heavily on the minds of commissioners and planners when looking at interventions to improve the health of the population.

Figure 5: Reproduced from Murray CL et al. UK health performance: findings of the Global Burden of Disease Study 2010. Lancet 2013; 381:997-1020

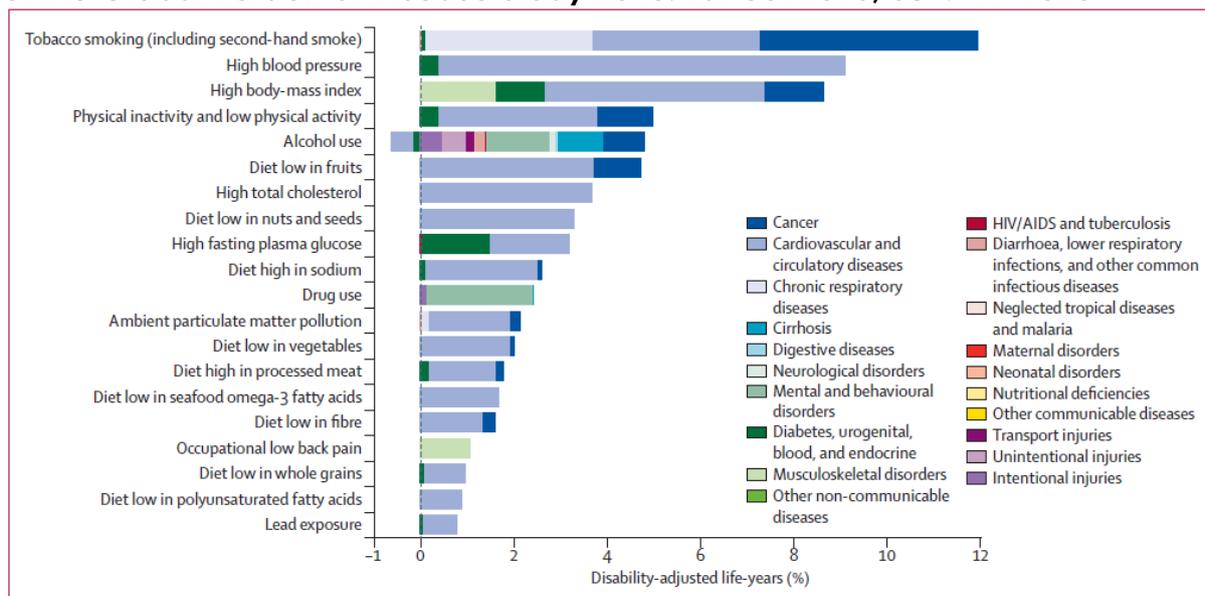


Figure 7: Burden of disease attributable to 20 leading risk factors for both sexes in 2010, expressed as a percentage of UK disability-adjusted life-years
The negative percentage for alcohol is the protective effect of mild alcohol use on ischaemic heart disease and diabetes.

Particular attention will be given in this HNA to the causes of premature mortality, disability, and risk factors identified as most important for the UK population. Additionally, areas where the UK performs worse than average compared with other high-income countries should be a focus for improvement.

¹⁹ DALYs = Disability adjusted life years, or one lost year of 'healthy life'. It is the sum of YLLs = years of life lost due to premature mortality in the population, and YLDs = years lost due to disability for incident cases of the health condition. The sum of DALYs is a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability.

1.3 Aims and objectives

The **overall aim** of the HNA is:

“To work with the local community and key stakeholders to identify health needs, priorities, existing services and assets, and develop a platform to support future partnership work to reduce inequalities and improve the health of local residents.”

The **specific objectives** of the HNA are:

1. To **identify the health needs** and health status of the community.
2. To **provide a comparison with the current service provision.**
3. To establish **how to address any gaps/duplications** in services and **improve efficiency** of resource utilisation.
4. To **identify existing assets**, particularly within the community, that could be strengthened to most efficiently and appropriately improve health outcomes.
5. To provide evidence **to support future partnership work** on health improvement.
6. Ultimately to **increase life expectancy and healthy life expectancy, alongside reducing inequalities** in Maybury and Sheerwater.

1.4 Key stakeholders

Key stakeholders that were identified include:

- | | |
|--|---|
| <ol style="list-style-type: none"> 1. The residents of Maybury and Sheerwater | <ol style="list-style-type: none"> 2. Surrey County Council and Health and Wellbeing Board (including Surrey Public Health) |
| <ol style="list-style-type: none"> 3. Woking Borough Council | <ol style="list-style-type: none"> 4. Woking Local Strategic Partnership ('The Woking Partnership') |
| <ol style="list-style-type: none"> 5. NHS North West Surrey Clinical Commissioning Group | <ol style="list-style-type: none"> 6. NHS Surrey and Sussex Area Team |
| <ol style="list-style-type: none"> 7. Woking SureStart Children's centre | <ol style="list-style-type: none"> 8. Local schools: <ol style="list-style-type: none"> a. Broadmere Community Primary School b. Maybury Primary School c. New Monument Primary School d. Bishop David Brown Secondary School |
| <ol style="list-style-type: none"> 9. GP practices: <ol style="list-style-type: none"> a. College Road Surgery b. The Maybury Surgery c. Sheerwater Health Centre d. District nurses and health visitors for Maybury and Sheerwater, based out of West Byfleet | <ol style="list-style-type: none"> 10. Other healthcare providers: <ol style="list-style-type: none"> a. Waterside Dental Centre b. Macrocare Dental Surgery c. Bridge Pharmacy d. May and Thompson Pharmacy e. St. Peter's Hospital |
| <ol style="list-style-type: none"> 11. Community centres: <ol style="list-style-type: none"> a. Maybury Centre b. Parkview/Sheerwater Community Centre | <ol style="list-style-type: none"> 12. Community groups/faith institutions: <ol style="list-style-type: none"> a. Emmanuel Chapel b. St Paul's Church c. St Michael's Church d. Shah Jahan Mosque e. Al-Birr Mosque (Masjid Al-Birr) f. Cornerhouse Mental Health Resource Centre g. Woking and Maybury Sports Club h. Woking Asian Business Forum i. Surrey Disabled People's Partnership j. Linkable (charity for children and adults with learning disabilities) |

1.5 The Sheerwater Regeneration Plan²⁰

The Sheerwater Regeneration Plan is a multi-million pound investment to transform Sheerwater by Woking Borough Council in partnership with New Vision Homes. Proposals received extensive cross-party support at the meeting of the Council on 9th May, 2013, and the 'masterplanning stage' is projected to take 18-24 months, with the whole project expected to take at least seven years.

The Regeneration Plan forms part of the backdrop for this report, as it will have a substantial impact on the social determinants of health (e.g. housing, employment, income, access to green space), health behaviours (particularly the provision of exercise facilities) and the provision of health services in Sheerwater.

Notably, the scheme aims to provide approximately 500 new homes and replace around 500 existing homes in the area, which the Council notes are expected to be 'family-friendly, environmentally sustainable, energy efficient, accessible, safe, and meet the needs of current and future residents'.

Additionally, the Council note that the development could include:

- A new retail centre
- Mixed-use leisure centre building and social facilities
- New school sports facilities
- An improved athletics track
- Football pitches, cricket pitch/nets and all weather multi-use outdoor sports pitches
- Multi-use games area, skate park and play facilities
- A centrally located park
- A public square and public realm improvements
- The provision of a community centre, health centre, nursery, sheltered housing and youth centre
- Better transport links through improved cycling and walking routes to and from Woking Town Centre and West Byfleet
- Community allotments.
- Education, training and local employment opportunities
- infrastructure including improvements to existing highways

²⁰ Source: <http://www.woking.gov.uk/news/archive?item=000051AF60A0.C0A801BA.000054A7.0008> accessed 30th August 2013

All of these have the potential to hugely improve health and wellbeing in Sheerwater, and indeed in Maybury.

The scheme is currently in its consultation phase, engaging with residents to gather their views to develop a 'shared vision'. The Council has also developed plans for Maybury, and it is hoped that the findings of this HNAA can feed into the Regeneration Plan, and provide a platform for the Council to develop the plan in line with the health needs of the local community.



Images taken from Woking Borough Council website, as per footnote 20

2. Demography

This chapter considers the age and sex of the population today, the future projections of the population profile, and the ethnicity and religion of the population. The risk of chronic disease rises with age, and is affected by gender and ethnicity. Accordingly, these demographic indicators provide a guide as to the likely level of risk and demand for different healthcare services in the population, and corresponding costs. They also highlight the need for increased awareness of issues affecting the local population, e.g. the needs of older people, and the provision appropriate beginning and end of life care for different religious groups. Examples of the impact of demographic factors include:

- Age:** Older people report more illness and use health services more frequently than younger people. This is due to: biological factors including a higher prevalence of chronic disease, multiple co-morbidities, and the presence of late stage disease with complications; material factors including excess winter morbidity linked to poverty; and social factors including social isolation.
- Gender:** Life expectancy and healthy life expectancy is greater for women than men at all ages. However, whilst men are more likely than women to smoke and drink heavily and have a higher incidence of cardiovascular disease and accidents/injuries, women are more likely to be diagnosed with mental illness including depression and anxiety.²¹
- Ethnicity:** Different ethnic groups have different prevalences of certain diseases, health seeking behaviours, and beliefs about illness. Examples include a higher prevalence of cardiovascular disease and type 2 diabetes in South Asian and Afro-Caribbean patients, a higher prevalence of mental illness in Afro-Caribbean patients, and a lower prevalence of cancer in black and ethnic minority groups (largely attributable to a lower prevalence of lung cancer due to lower levels of smoking). South Asian populations have a high level of health service usage, and Chinese populations have the lowest levels of health service usage.²²

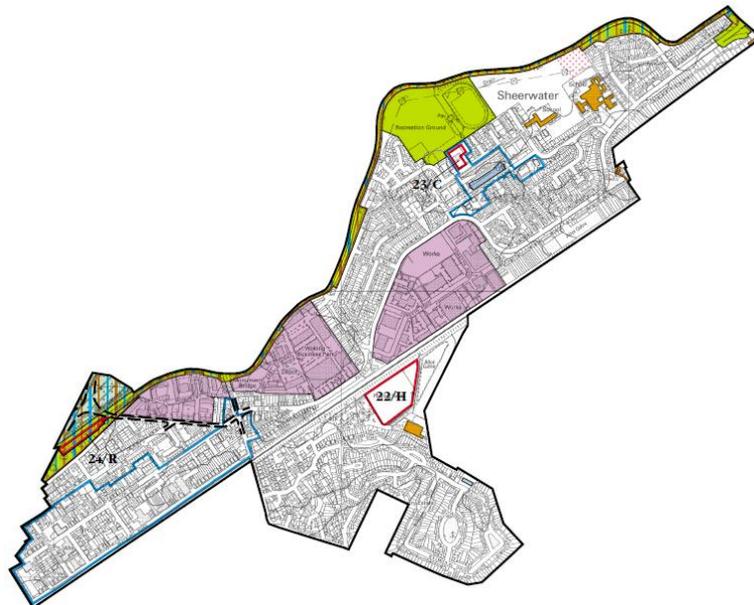
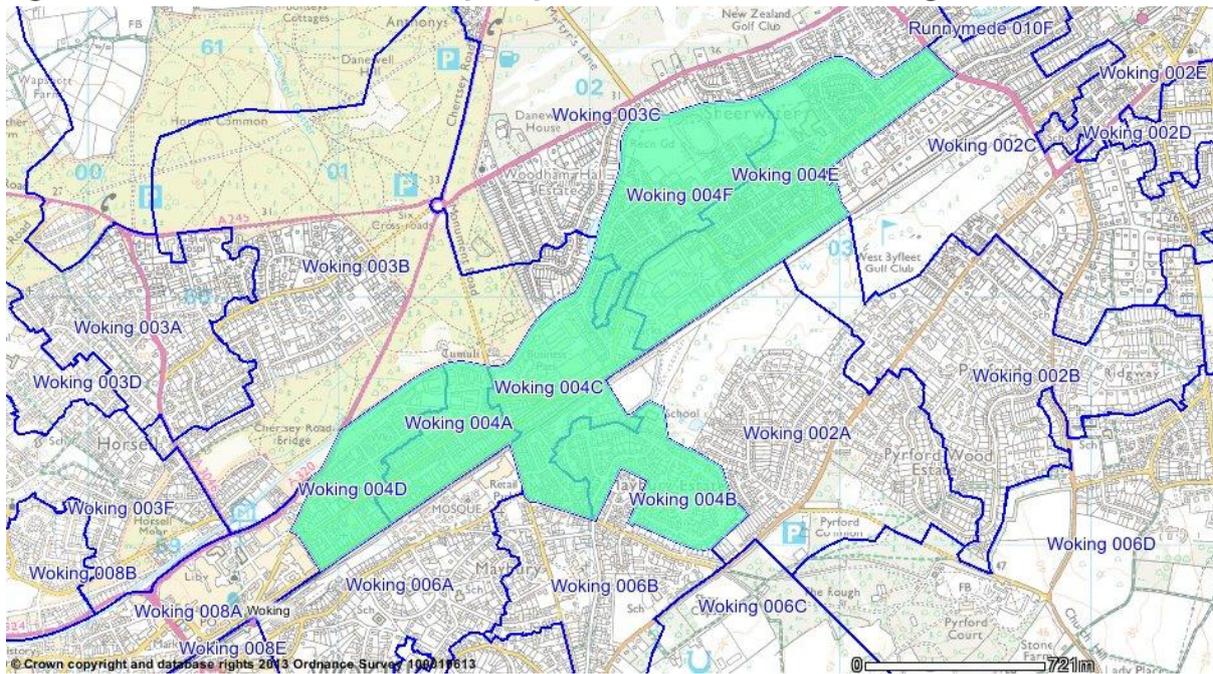
²¹ The effects of gender on health are complex and is the subject of a large body of literature, see for example Deeks A et al. The effects of gender and age on health related behaviours. BMC Public Health 2009; 9:213 available at <http://www.biomedcentral.com/1471-2458/9/213> accessed 25th July 2013

²² Further details are available at <http://www.patient.co.uk/doctor/Diseases-and-Different-Ethnic-Groups.htm> accessed 25th July 2013

2.1 Maybury and Sheerwater: an overview

Maybury and Sheerwater is an electoral ward and middle super output area (MSOA) in the borough of Woking, which sits in the county of Surrey. It is made up of 6 lower super output areas (LSOAs), which are geographical areas with a population of between 1,000 and 3,000 people, and between 400 and 1,200 households. The total recorded population of Maybury and Sheerwater in the 2011 Census was 10,574.

Figure 6: Electoral ward of Maybury and Sheerwater showing LSOAs²³



²³ Source: Surrey Maps and Data, available at <http://maps.surreycc.gov.uk/maps/viewer.asp> accessed 25th July 2013. Second map from <http://www.woking.gov.uk/planning/policy/localplan1999/maybury/mayburypdf.pdf> accessed 25th July 2013

Despite being a single ward/MSOA, the historical contexts of the development of Maybury and Sheerwater differ markedly, and this should be borne in mind by planners and commissioners. The following extracts are from a piece of work carried out by the University of Surrey in 2009 funded by the Economic and Social Research Council (ESRC).²⁴ It provides a rich insight into the local community, and is an unique resource for stakeholders to understand local perspectives.

Extract from 'Communities within communities: reflections on belonging, ethnicity and neighbourhood relations in Maybury-Sheerwater, Woking'

The ward consists of three distinct neighbourhoods: The Walton Road area, Maybury estate, and Sheerwater estate.

Walton Road area (Maybury)

The Walton Road area dates back to the late nineteenth century. The area was built at the same time as the town centre and provided terraced housing, that was relatively “cheap” compared to the rest of Woking. Over the years, the small industries and Victorian buildings, characteristic of the area, have gradually been redeveloped into private dwellings, mainly flats. Historically and in the present, this part of Woking is the place where newcomers settle, in particular immigrants from abroad. Our interviewees explained that Italian-Sicilian and Pakistani immigrants settled here in the 1950s and 1960s, and an increasing number of Eastern European, African, and Asian immigrants have moved in over the last five to ten years.

Sheerwater estate

Residents from the Sheerwater estate told us that the area was developed in the early 1950s by London County Council, later renamed as the Greater London Council (GLC). The estate provided council housing for white English people displaced from London during the Second World War. The Greater London Council managed the estate up to 1980 when Woking Borough took over. According to local white English residents, the estate is now becoming increasingly ethnically diverse, with more British Asian families moving in.

²⁴ Source: Jensen O and Tyler K. Communities within communities: reflections on belonging, ethnicity and neighbourhood relations in Maybury-Sheerwater, Woking. 2009, ESRC available at <http://www.esrc.ac.uk/my-esrc/grants/RES-000-22-2796/outputs/read/674f40b3-8977-41de-b23b-5bcc752e1629> accessed 29th August 2013

Maybury estate

From speaking with people on the Maybury estate we have been able to construct the following picture of this area. The estate was a council estate developed by Woking Borough in the 1950s to house people from the borough. We were told by local white English residents that since the mid-to-late 1970s an increasing number of British Asian Pakistanis have moved onto the estate where they, according to residents and housing officers, now constitute a majority.

Introducing local residents

... Over time, a high number of Italian-Sicilian immigrants moved into employment as gardeners in private houses, and one interviewee estimated that 70% of immigrants either owned or worked for private gardening or landscaping businesses. Similarly, an increasing number of British Asians found employment in the taxi and catering businesses. Since the early 1970s, numerous Asian-run taxi companies have emerged, gradually expanding operations beyond Woking, and by 2008 an estimated one in four of British Asian men from Woking were employed in the taxi business.

Over time, the second and third generations across the three ethnic groups have acquired higher levels of formal education compared to older generations. In addition, by contrast to the older generations who lived and worked locally, most members of the younger generations work outside of Woking. Many first generation Italian-Sicilians, who are now entering retirement, have moved out of the ward with their families, while many British Pakistanis families have remained, in especially the Walton Road area and Maybury estate areas. According to many interviewees, one reason for this is the proximity of the Shahjehan (*sic*) mosque, built in 1889 as the first purpose-built mosque in Britain and viewed by many British Muslims that live in Woking as the heart of their community. Other interviewees suggested that the availability of comparatively “cheap” housing in the ward was the reason that they stayed in the area. While many of the Londoners, who moved to Sheerwater, now have passed away, some of the original settlers and their families remain in the area.

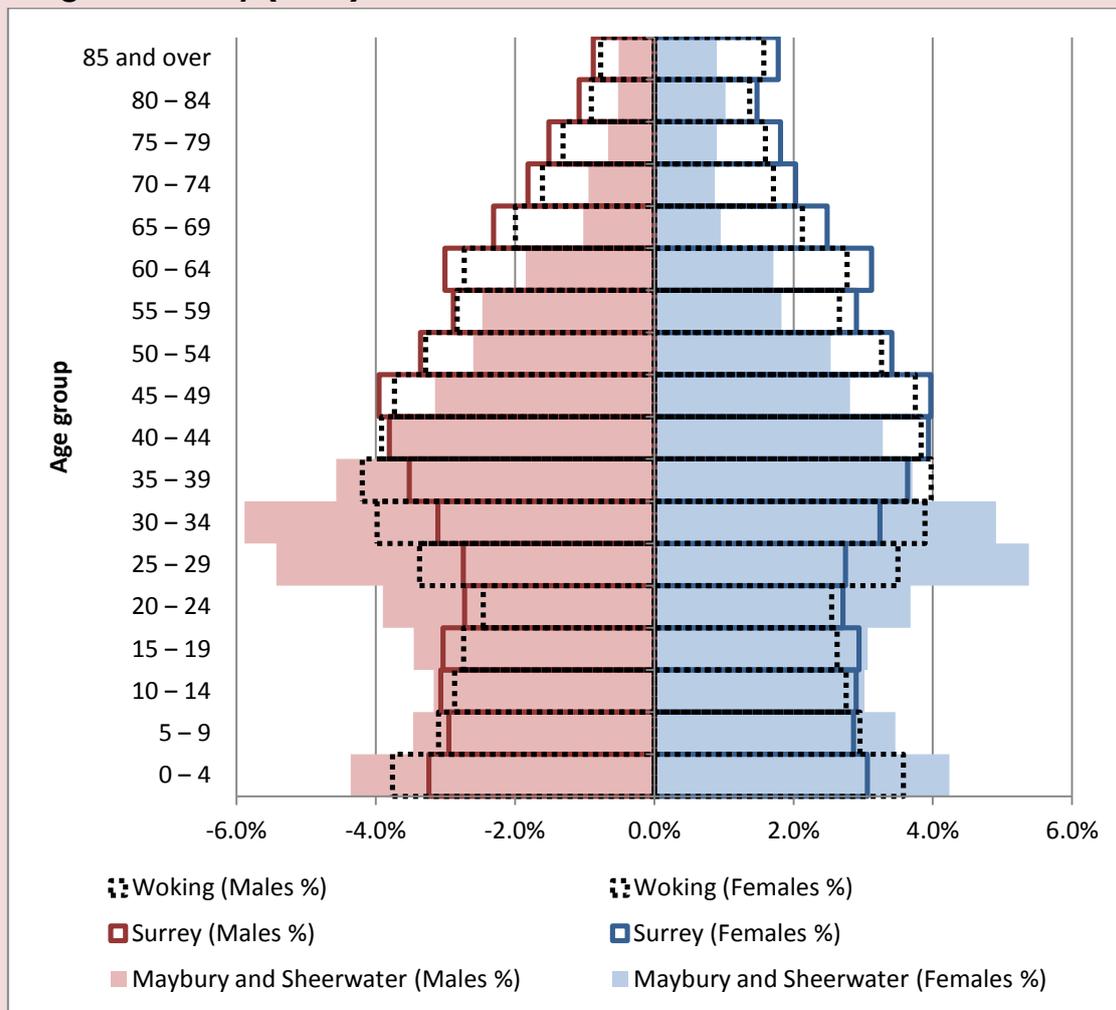
2.2 Population profile

2.2.1 Current population profile

The population profile based upon the 2011 census show that the population of Maybury and Sheerwater is markedly younger than the populations of Woking, Surrey and the population of England. Maybury and Sheerwater has the 2nd smallest proportion of over 65s in Surrey (out of 206 wards) at 8.3%.²⁵ Notably, there is a:

- Significantly greater proportion of young children 0-9 years old
- Significantly greater proportion of young adults 20-39 years old
- Significantly smaller proportion of all adults over 45 years old

Figure 7: Population pyramid for Maybury and Sheerwater compared with Woking and Surrey (2011)²⁶

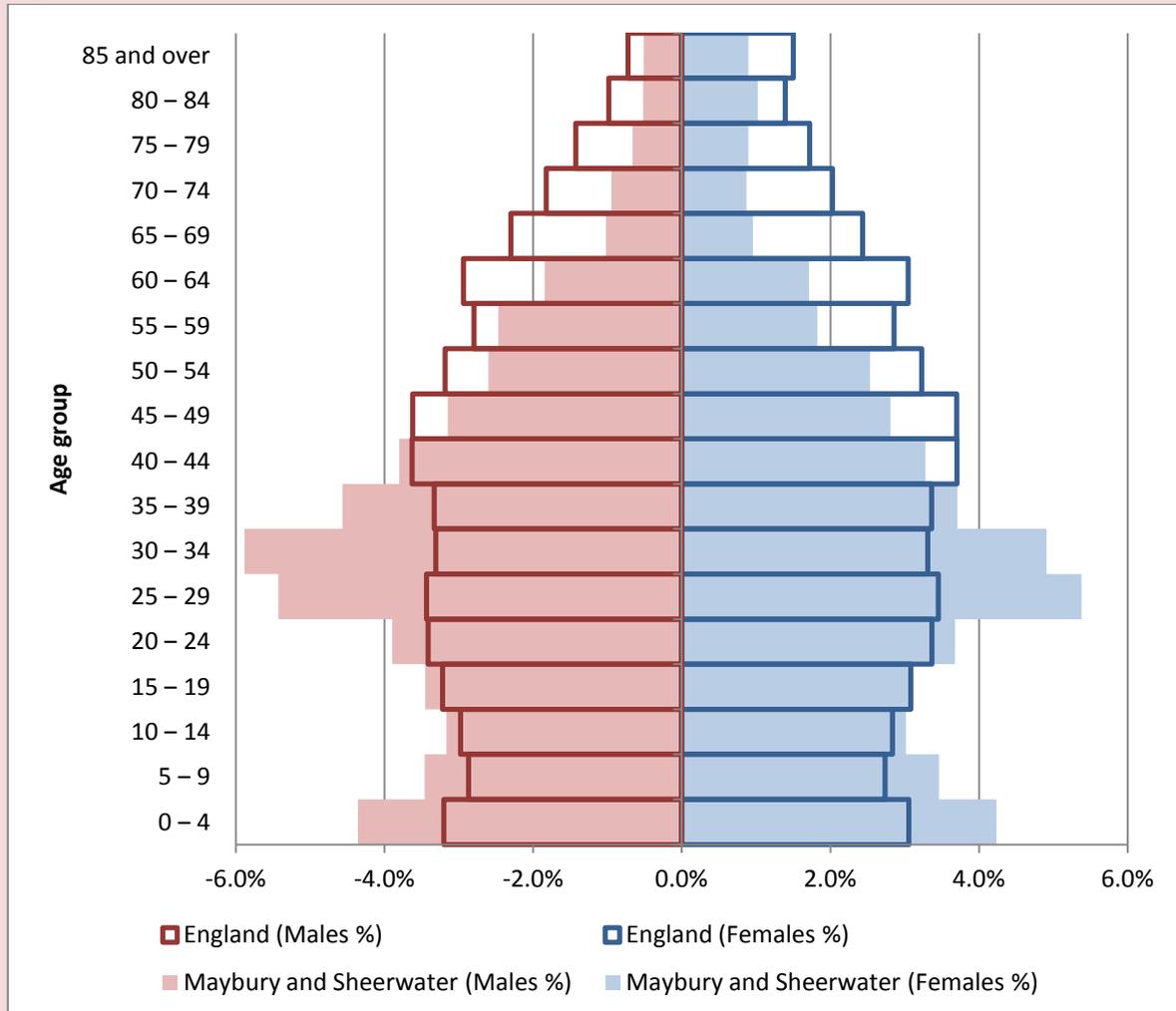


²⁵ Source: Surrey-i local area profile for Maybury and Sheerwater using ONS Census 2011 data, available at <http://www.surreyi.gov.uk/DrillDownProfile.aspx?rt=37&rid=296722&pid=34> accessed 25th July 2013

²⁶ Source: ONS Census, 2011, raw data available at <http://www.ons.gov.uk/ons/datasets-and-tables/index.html> accessed 25th July 2013

The comparison with the population pyramid for England shows a similar difference in shape, with the Surrey population having a higher proportion of over 40s than the national average.

Figure 8: Population pyramid for Maybury and Sheerwater compared with England (2011)²⁷



²⁷ Source: ONS Census, 2011, raw data available at <http://www.ons.gov.uk/ons/datasets-and-tables/index.html> accessed 8th May 2013

The raw values for population by 5 year age band, and comparison with regional and national proportions can be seen in the figure 9.

Figure 9: Population by 5-year age band, with regional and national comparison (2011)²⁸

↓/↑ indicates proportion is lower/higher than in Maybury and Sheerwater

Age group	Maybury and Sheerwater	Maybury and Sheerwater %	Woking %	Surrey %	England %
All ages	10,574	100	100	100	100
0-4	909	8.6	7.3 ↓	6.3 ↓	6.3 ↓
5-9	732	6.9	6.1 ↓	5.8 ↓	5.6 ↓
10-14	654	6.2	5.6 ↓	6.0 ↓	5.8 ↓
15-19	689	6.5	5.4 ↓	6.0 ↓	6.3 ↓
20-24	801	7.6	5.0 ↓	5.4 ↓	6.8 ↓
25-29	1,143	10.8	6.9 ↓	5.5 ↓	6.9 ↓
30-34	1,141	10.8	7.9 ↓	6.3 ↓	6.6 ↓
35-39	875	8.3	8.2 ↓	7.2 ↓	6.7 ↓
40-44	749	7.1	7.7 ↑	7.7 ↑	7.3 ↑
45-49	630	6.0	7.5 ↑	7.9 ↑	7.3 ↑
50-54	543	5.1	6.5 ↑	6.8 ↑	6.4 ↑
55-59	454	4.3	5.5 ↑	5.8 ↑	5.7 ↑
60-64	376	3.6	5.5 ↑	6.1 ↑	6.0 ↑
65-69	209	2.0	4.1 ↑	4.8 ↑	4.7 ↑
70-74	192	1.8	3.3 ↑	3.8 ↑	3.9 ↑
75-79	165	1.6	2.9 ↑	3.3 ↑	3.1 ↑
80-84	163	1.5	2.3 ↑	2.6 ↑	2.4 ↑
85+	149	1.4	2.3 ↑	2.7 ↑	2.2 ↑

In summary, the population of Maybury and Sheerwater is weighted heavily towards younger people compared with the regional and national averages, with a particularly large proportion (37.5%) of young working age adults aged 20-39.

The recommendations are:

1. Stakeholders should see the population profile as an opportunity for targeting young people with primary prevention strategies, particularly around diet, exercise and smoking cessation in order to prevent future morbidity and mortality.
2. Stakeholders should target young people in the early stages of chronic disease with focused early intervention and control of risk factors, in order to prevent the onset of complications and improve prognosis.

²⁸ Source: ONS Census, 2011, raw data available at <http://www.ons.gov.uk/ons/datasets-and-tables/index.html> accessed 25th July 2013

3. Stakeholders should also ensure adequate service provision for other health issues affecting younger people, including sexual health, mental health, and musculoskeletal services.

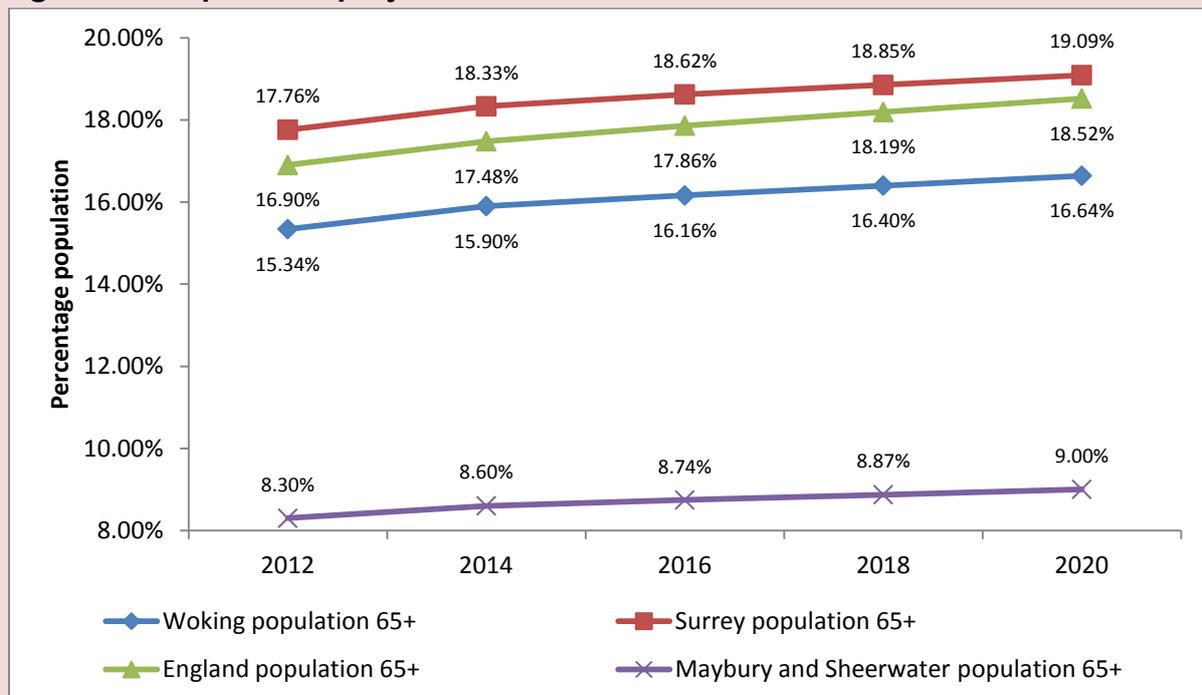
2.2.2 Population projections

Population projections from the Projecting Older People Population Information System (POPPI) and the Projecting Adult Needs and Service Information (PANSI) databases are only available down to the local authority level, and not down to 'ward' level. Accordingly, projections are provided here for Woking compared to Surrey and England. A synthetic estimate has been made for the population projection for Maybury and Sheerwater, assuming that each age group will change in the same proportion as the rest of Woking. However, it should be noted that this is only a very crude estimate and should be treated as such.

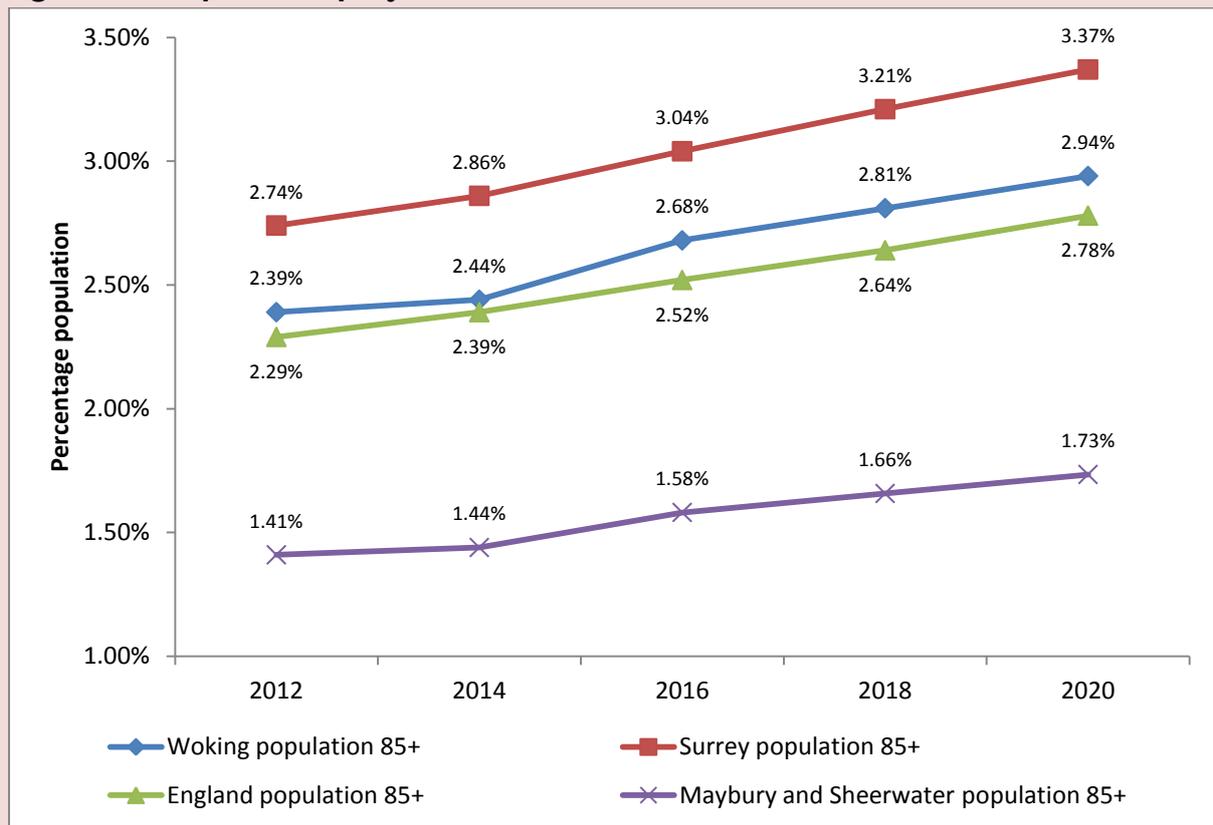
2.2.2.1 Population projection for older people

England has an ageing population, with the proportion of over 65s and over 85s projected to increase over the next decade. The population of Surrey is already older than the national average, but is ageing at approximately the same rate, and the population of Woking is younger than the national average. The projections for the over 65 population and over 85 populations can be seen in the charts below, alongside the synthetic estimate for the projections for the population of Maybury and Sheerwater.

Figure 10: Population projection for over 65s between 2012 and 2020²⁹



²⁹ Source: POPPI database, available at <http://www.poppi.org.uk/index.php?pageNo=315&areaID=8640&loc=8640> accessed 25th July 2013

Figure 11: Population projection for over 85s between 2012 and 2020³⁰

In summary, the older population of Maybury and Sheerwater, in line with the regional and national population, is likely to grow as a proportion of the whole population, with implications for service planning and delivery, healthcare priority setting, and spending. However, the over 65 and over 85 populations are likely to remain small proportions of the overall population.

The recommendations are:

1. To ensure robust planning and delivery of services for major health issues affecting older people, including the management of multiple chronic diseases, dementia and mental health issues, reducing falls and fractures, reducing excess winter morbidity and mortality, and reducing the need for hospital admissions for conditions that can be managed in the community.
2. The central role that social care plays in achieving some of these goals can be addressed through greater integration between health and social

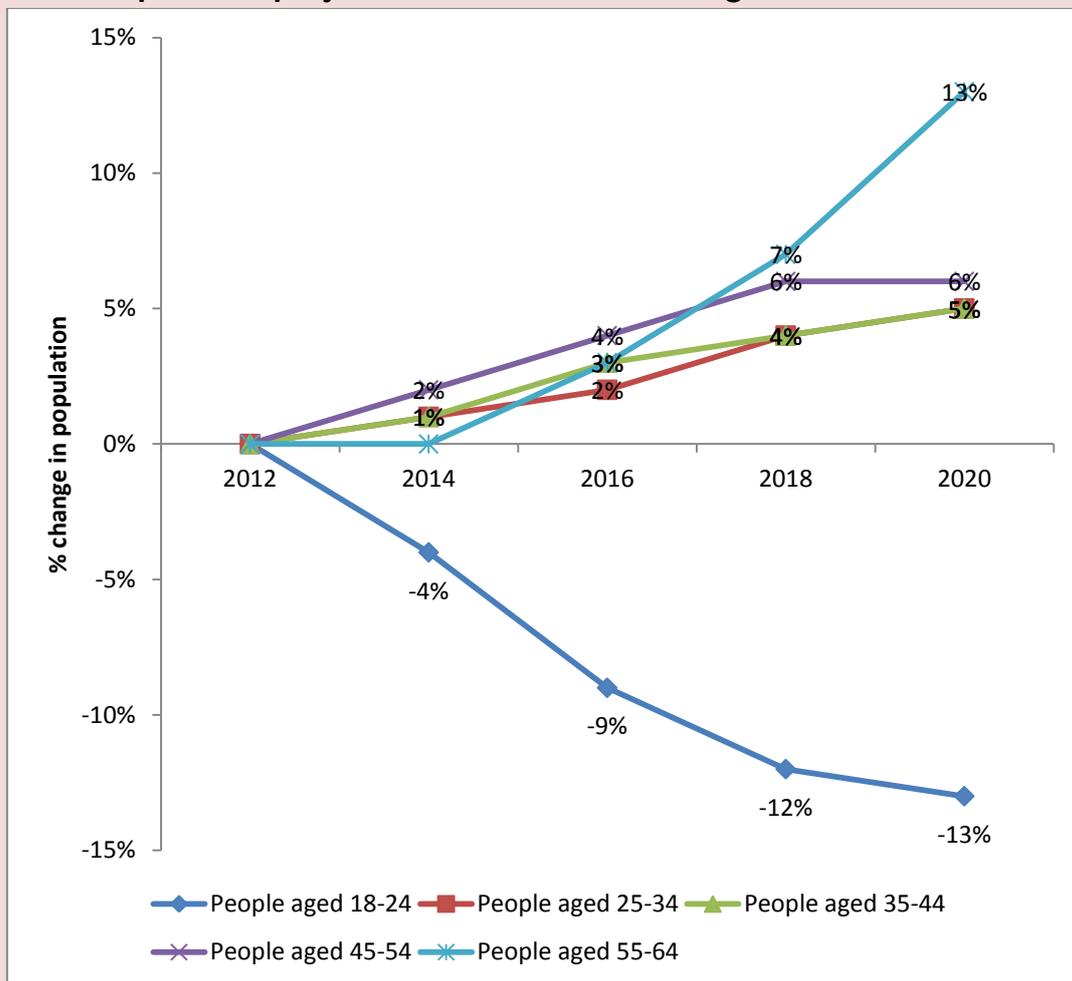
³⁰ Source: POPPI database, available at <http://www.poppi.org.uk/index.php?pageNo=315&areaID=8640&loc=8640> accessed 25th July 2013

care at the Health and Wellbeing Board, ensuring the needs of the older population can be met, noting however that the proportion of the local population over 65 is the 2nd lowest in Surrey, and the projected increases are modest.

2.2.2.2 Population projection for adults aged 18-64

The population projections for each 10 year age group for adults in Woking can be seen in figure 12. Again, please note that as demonstrated in figure X, the population profile of Maybury and Sheerwater differs markedly from that of Woking, so this data should be interpreted with caution. In line with the general trend for an ageing population, the largest growth will be in the 55-64 age group, there will be growth in 25-54 year olds, and there will be a reduction in the number of 18-24 year olds. However, as Maybury and Sheerwater has the 12th highest proportion of 18-24 year olds in Surrey (out of 206 wards),³¹ the local picture may be very different.

Figure 12: Population projection for adults in Woking between 2012 and 2020³²



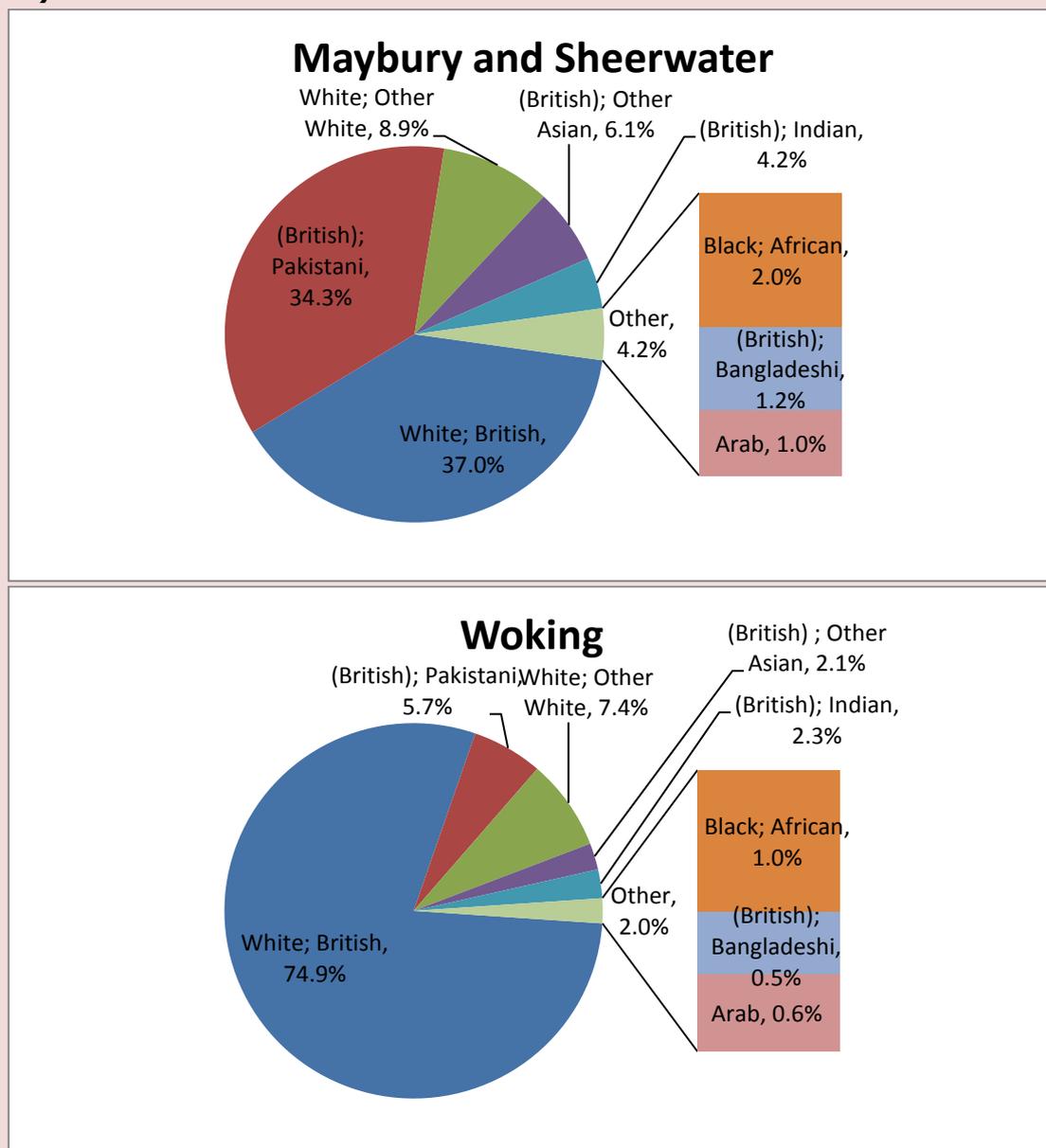
³¹ Source: Surrey-i local area profile for Maybury and Sheerwater using ONS Census 2011 data, available at <http://www.surreyi.gov.uk/DrillDownProfile.aspx?rt=37&rid=296722&pid=34> accessed 25th July 2013

³² Source: PANSI database, available at <http://www.pansi.org.uk/index.php?pageNo=383&areaID=8617&loc=8617> accessed 25th July 2013

2.3 Ethnicity

The ethnicity of Maybury and Sheerwater differs markedly from Surrey and England, mainly due to the very large (British) Pakistani population (the highest in Surrey out of 206 wards).³³ However, there are also significant (British) Indian, Bangladeshi, other Asian, and (Black) African populations. A breakdown of the ethnic distribution of Maybury and Sheerwater, Woking, Surrey, and England can be seen in figures 13 and 14.

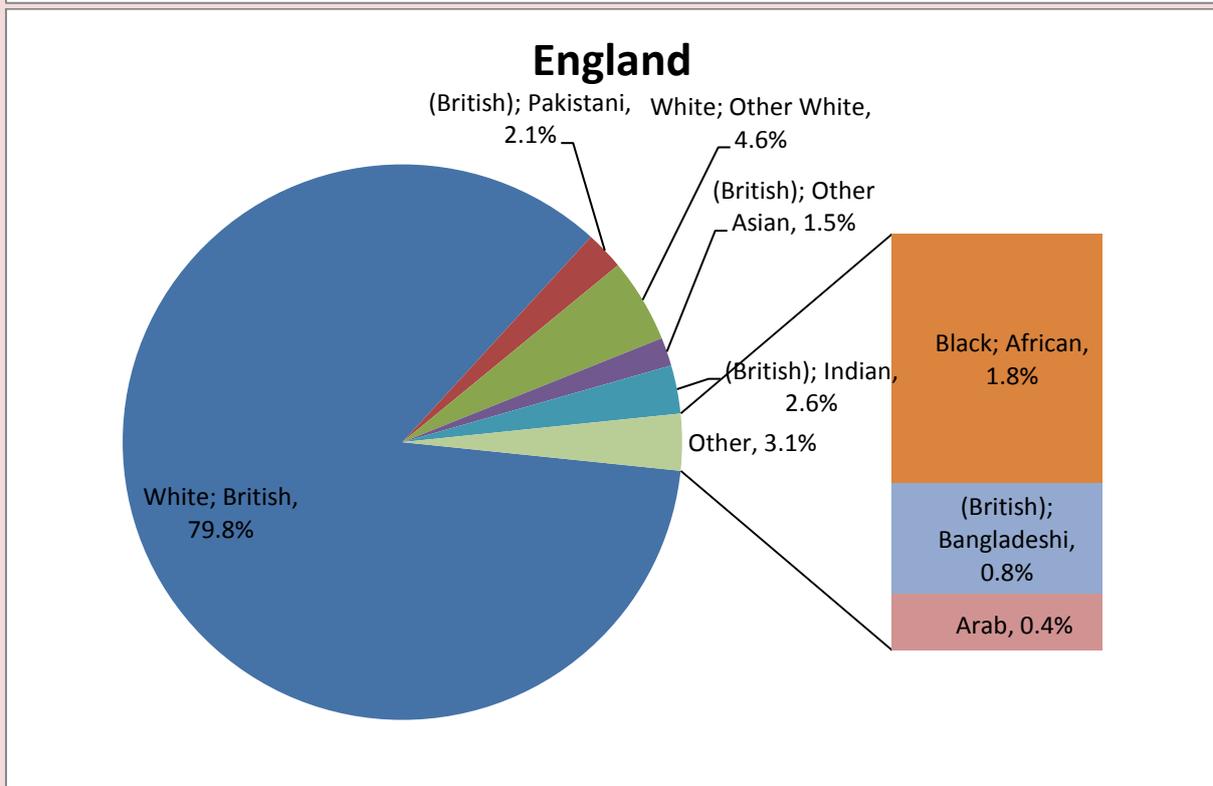
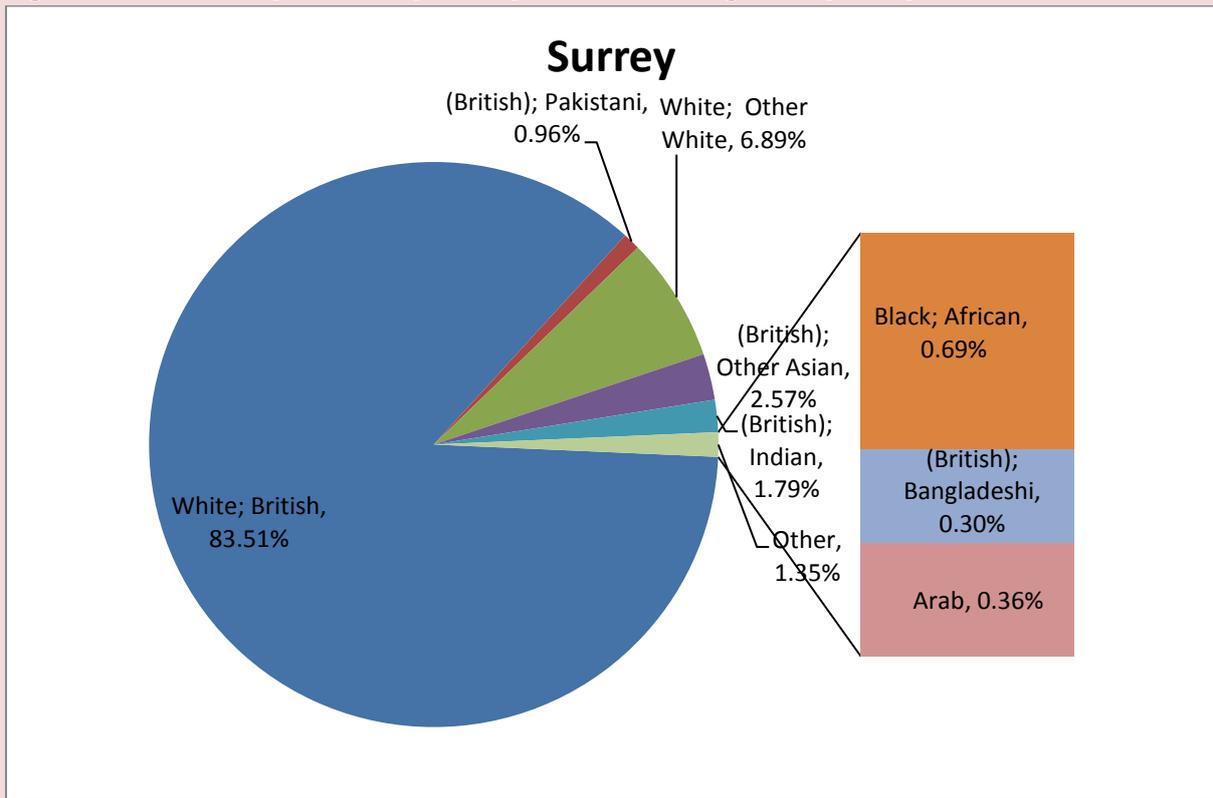
Figure 13: Ethnicity in Maybury and Sheerwater compared with Woking (2011)³⁴



³³ Source: Surrey-i local area profile for Maybury and Sheerwater using ONS Census 2011 data, available at <http://www.surreyi.gov.uk/DrillDownProfile.aspx?rt=37&rid=296722&pid=34> accessed 25th July 2013

³⁴ Source: ONS Census, 2011, raw data available at <http://www.ons.gov.uk/ons/datasets-and-tables/index.html> accessed 25th July 2013

Figure 14: Ethnicity in Surrey compared with England (2011)³⁵



³⁵ Source: ONS Census, 2011, raw data available at <http://www.ons.gov.uk/ons/datasets-and-tables/index.html> accessed 25th July 2013

The raw numbers by ethnicity in Maybury and Sheerwater can be seen in figure X:

Figure X: Population of Maybury and Sheerwater by ethnicity³⁶

Ethnicity	Number
All residents	10574
White/British	3,915
British/Pakistani	3,627
White/Other white	943
British/Other Asian	648
British/Indian	440
Black/African	210
British/Bangladeshi	131
Arab	102
All other ethnicities	<100

In summary, whilst Woking borough has a higher proportion of (British) Pakistanis than the regional average (5.73% vs. 0.96%) or national average (5.73% vs. 2.10%), the proportion in Maybury and Sheerwater is significantly higher than the borough average (34.3% vs. 5.73%). Accordingly, the (White) British population in Maybury and Sheerwater is significantly lower than the borough average (37.02% vs. 74.94%).

The recommendation is:

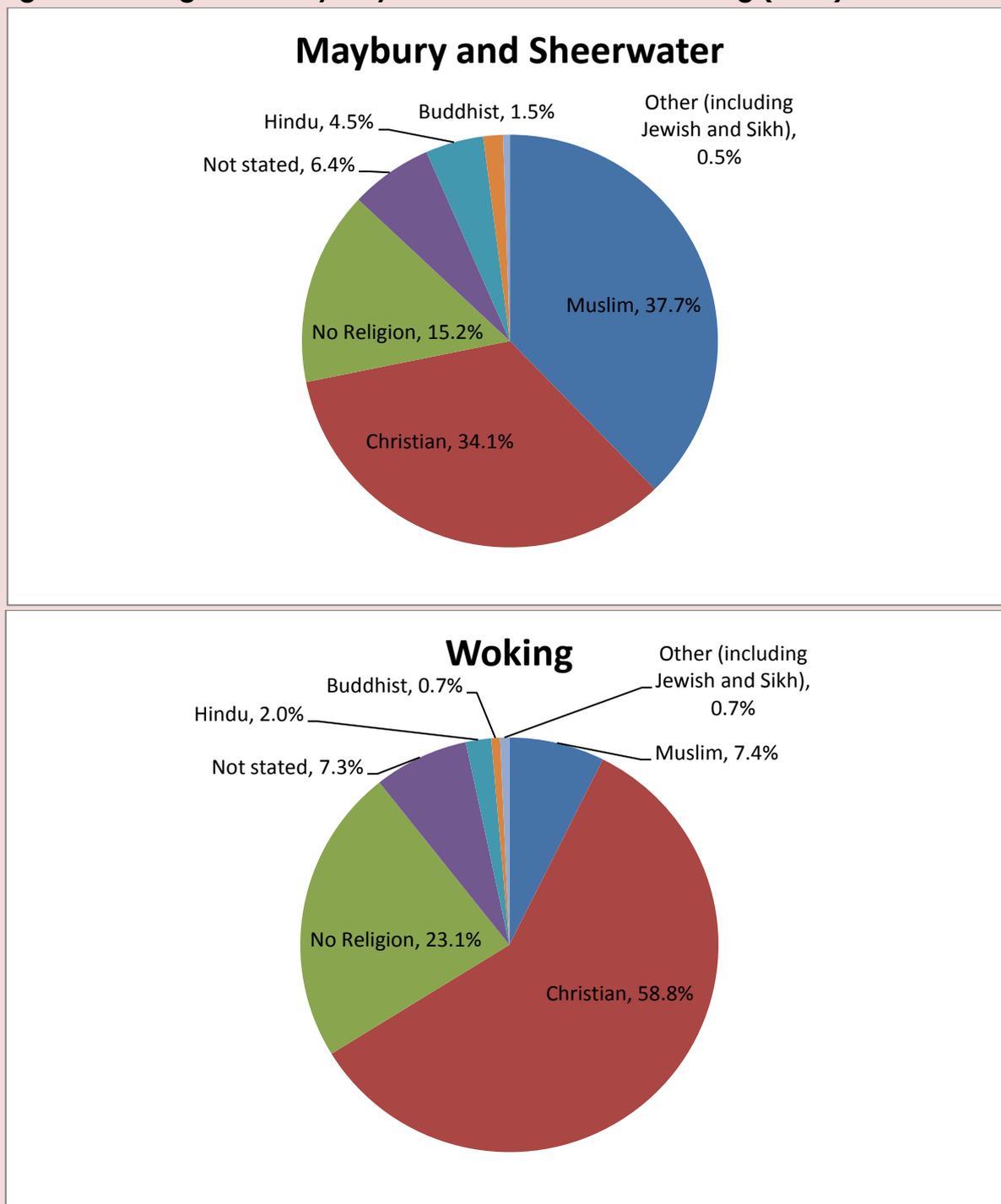
- All stakeholders should ensure that ethnicity is explicitly taken into account when planning and delivering services, both with regard to the increased risk profile of certain disease (e.g. diabetes, cardiovascular disease, and genetic diseases), and with regard to cultural sensitivities and customs.

³⁶ Source: ONS Census, 2011, raw data available at <http://www.ons.gov.uk/ons/datasets-and-tables/index.html> accessed 25th July 2013

2.4 Religion

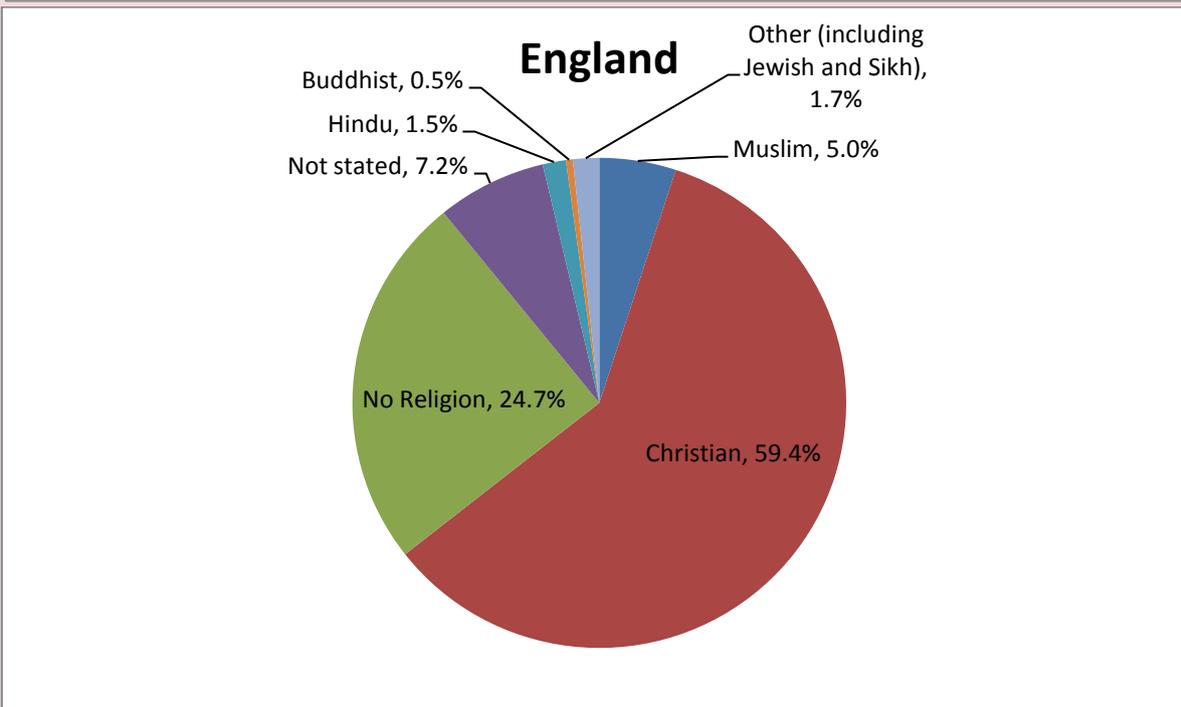
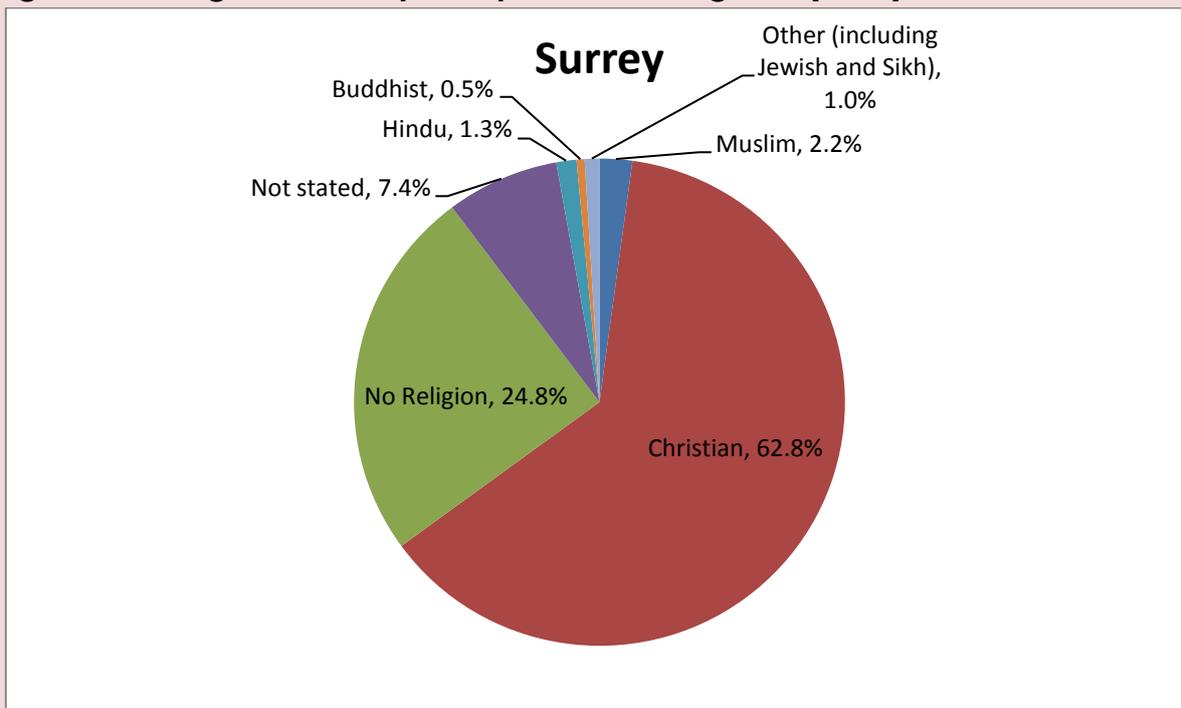
The data on the religious makeup of Maybury and Sheerwater is presented with comparisons to Woking, Surrey, and England in figures 15 and 16:

Figure 15: Religion in Maybury and Sheerwater vs. Woking (2011)³⁷



³⁷ Source: ONS Census, 2011, raw data available at <http://www.ons.gov.uk/ons/datasets-and-tables/index.html> accessed 25th July 2013

Figure 16: Religion in Surrey compared with England (2011)³⁸



³⁸ Source: ONS Census, 2011, raw data available at <http://www.ons.gov.uk/ons/datasets-and-tables/index.html> accessed 25th July 2013

The raw numbers by religion in Maybury and Sheerwater can be seen in figure 17:

Figure 17: Population of Maybury and Sheerwater by religion³⁹

Religion	Number
All residents	10574
Muslim	3991
Christian	3602
No religion	1607
Not stated	679
Hindu	477
Buddhist	162
Sikh	24
Jewish	8
Other	24

In summary, the religious make-up of Maybury and Sheerwater reflects the ethnicity data discussed above: there is a much higher proportion of Muslims than regionally or nationally (the highest in Surrey), and a higher proportion of Hindus (4th highest in Surrey)⁴⁰, with a consequently lower proportion of Christians.

The recommendations are:

1. Planners and commissioners should have regard, when planning service delivery, that there are higher proportions of Muslims and Hindus in Maybury and Sheerwater than is the case in the rest of Woking.
2. Specific areas where this needs to be taken into account include the planning of beginning and end of life care, translation and interpretation services, and sensitivity to cultures and customs.

³⁹ Source: ONS Census, 2011, raw data available at <http://www.ons.gov.uk/ons/datasets-and-tables/index.html> accessed 25th July 2013

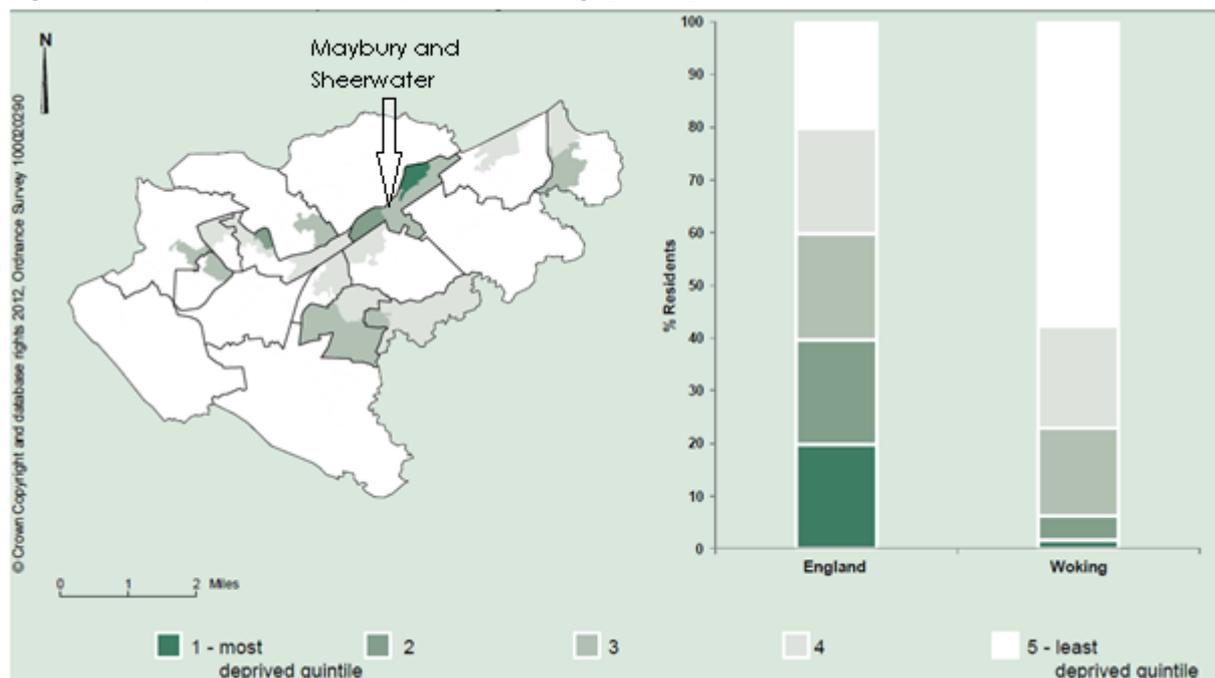
⁴⁰ Source: Surrey-i local area profile for Maybury and Sheerwater using ONS Census 2011 data, available at <http://www.surreyi.gov.uk/DrillDownProfile.aspx?rt=37&rid=296722&pid=34> accessed 25th July 2013

3. Deprivation, inequalities, and the wider determinants of health

Following on from the discussion section 1.2.2, the importance of considering deprivation is that there is a strong association between health inequalities and other measures of deprivation: low income, low-skilled employment, and poor housing all lead to a lower life expectancy and lower healthy life expectancy. The deprivation profile has been built from: the Index of Multiple Deprivation (2010), the MOSAIC people classification system; additional data relating to specific areas of deprivation; and an overview of life expectancy at birth in Maybury and Sheerwater compared with Woking.

As an introductory overview, the following map is reproduced from the Woking Local Authority 2012 Health Profile developed by the English Public Health Observatories working in partnership.

Figure 18: Deprivation map for Woking (2012)⁴¹



This figure shows that relative to the England average, Woking as a whole is relatively less deprived. 60% of the local population are in the least deprived quintile, and only 5% of the local population are in the 2 most deprived quintiles. Maybury and Sheerwater ward is notable as the only ward where there are people living in the most deprived quintile nationally, and all residents are in the top 3 most deprived quintiles.

⁴¹ Source: APHO Health Profile 2012, available at http://www.apho.org.uk/default.aspx?QN=HP_METADATA&ArealD=50594 accessed 25th July 2013

3.1 Index of Multiple Deprivation 2010 (IMD 2010)

The Department of Communities and Local Government (DCLG) has collected calculated local measures of deprivation in England since the 1970s, and these were last published at the LSOA level in 2010, using data from 2008. Because deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, this index looks at multiple distinct domains to build up a more complete picture.⁴²

The seven domains used in IMD 2010 are:

1. Income deprivation (weighting 22.5%), a sum of:
 - Adults and children in Income Support families, Income-Based Jobseeker's Allowance families, Pension Credit (Guarantee) families, and Child Tax Credit families.⁴³
 - Asylum seekers in England in receipt of subsistence support, accommodation support, or both.
2. Employment deprivation (weighting 22.5%), a sum of:
 - Claimants of Jobseeker's Allowance, Incapacity Benefit, Severe Disablement Allowance, Employment Support Allowance.
 - Participants in New Deal.
3. Health deprivation and disability (weighting 13.5%), a sum of:
 - Years of Potential Life Lost, Comparative Illness and Disability Ratio, Measures of acute morbidity, and Proportion of adults under 6- suffering from mood or anxiety disorders.
4. Education, skills, and training (weighting 13.5%), a sum of:
 - Average score of English, maths, and science Key Stage 2 and 3 exams, average capped points score of GCSE or equivalent exams.
 - Proportion of young people not staying on in education above age 16, secondary school absence rate, and proportion of those under 21 not entering higher education.
 - Proportion of adults aged 25-54 with no or low qualifications.

⁴² Description as provided in the previous release of the English Indices of Deprivation 2010, 24th March 2011, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/6871/1871208.pdf accessed 25th July 2013

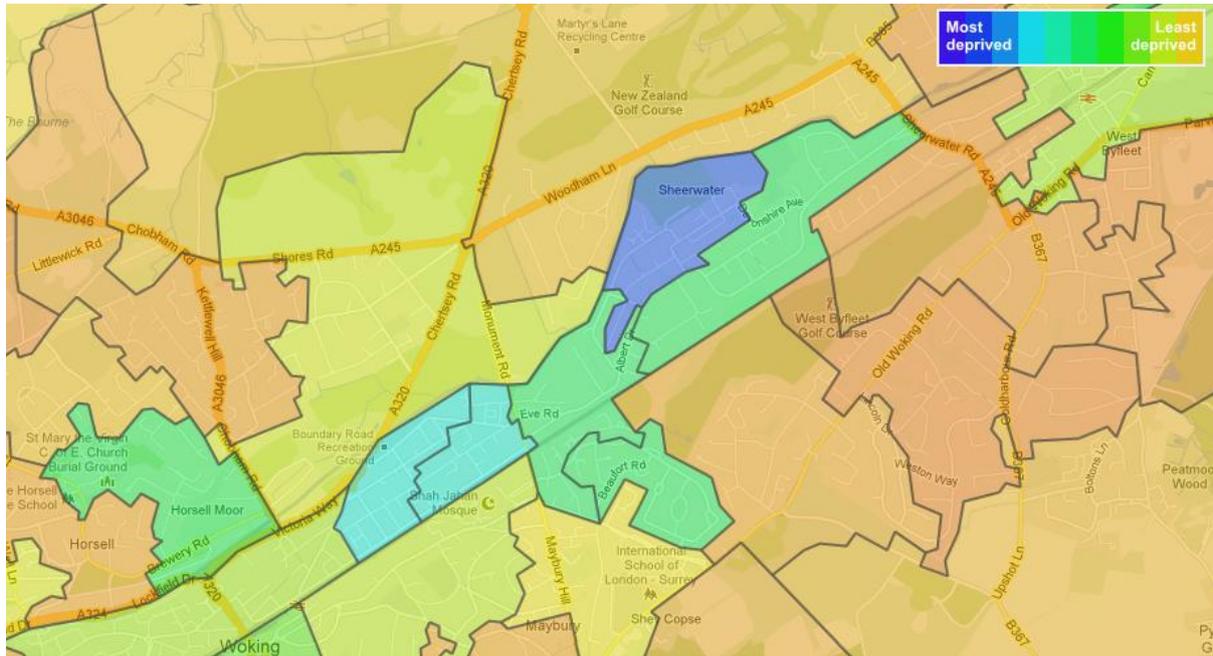
⁴³ Who are not in receipt of Income Support, Income-Based Jobseeker's Allowance or Pension Credit, and whose equivalised income (excluding housing benefits) is below 60% of the median before housing costs

5. Barriers to housing and services (weighting 9.33%), a sum of:
 - Household overcrowding, homelessness, difficulty of access to owner-occupation.
 - Road distance to a GP surgery, supermarket or convenience store, primary school, and post office.
6. Crime (weighting 9.33%), a sum of:
 - Reported violent crimes, burglaries, thefts, and criminal damage.
7. Living environment (weighting 9.33%), a sum of:
 - Social and private housing in poor condition and houses without central heating.
 - Outdoor air quality and road traffic accidents.

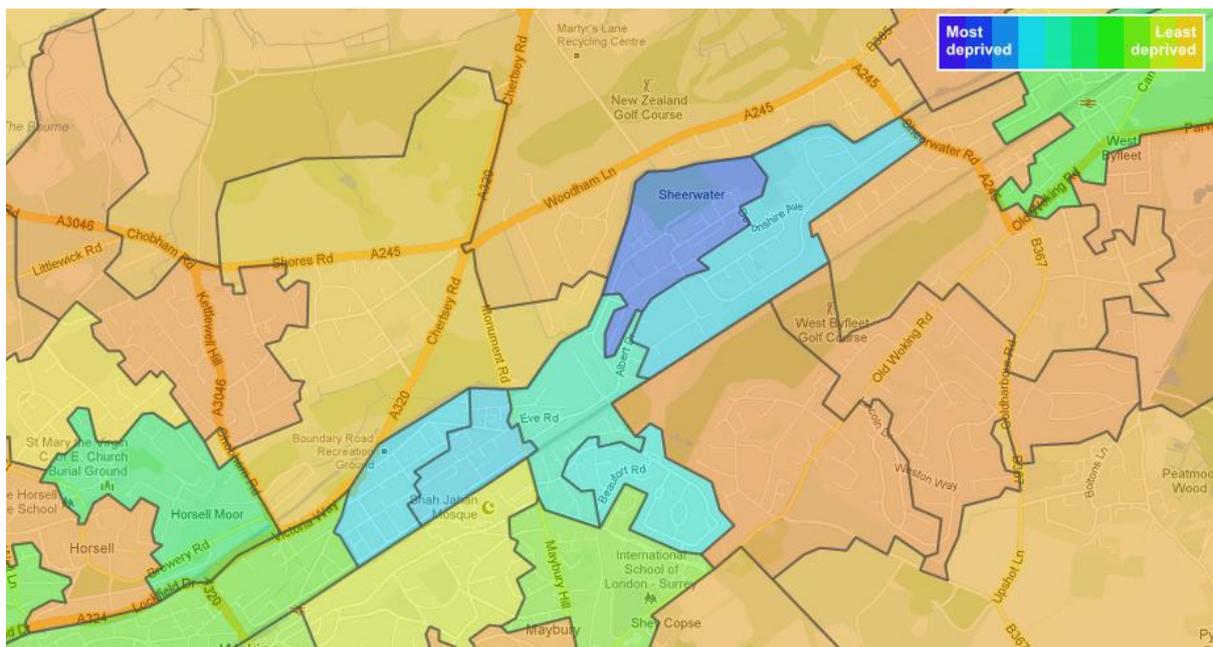
In addition to these 7 domains, 2 supplementary indices concerning income deprivation are also produced: the Income Deprivation Affecting Children Index (IDACI) and the Income Deprivation Affecting Older People Index (IDAOPI). These represent the proportions of children aged 0-15 and older people aged over 60 respectively living in income deprived households.

'Heatmaps' have been created for each of the domains,⁴⁴ and for the overall IMD score for the LSOAs in Maybury and Sheerwater relative to the surrounding LSOAs, and are reproduced below. They provide a quick at-a-glance view of the relative deprivation in Maybury and Sheerwater.

1. Overall IMD 2010 score:

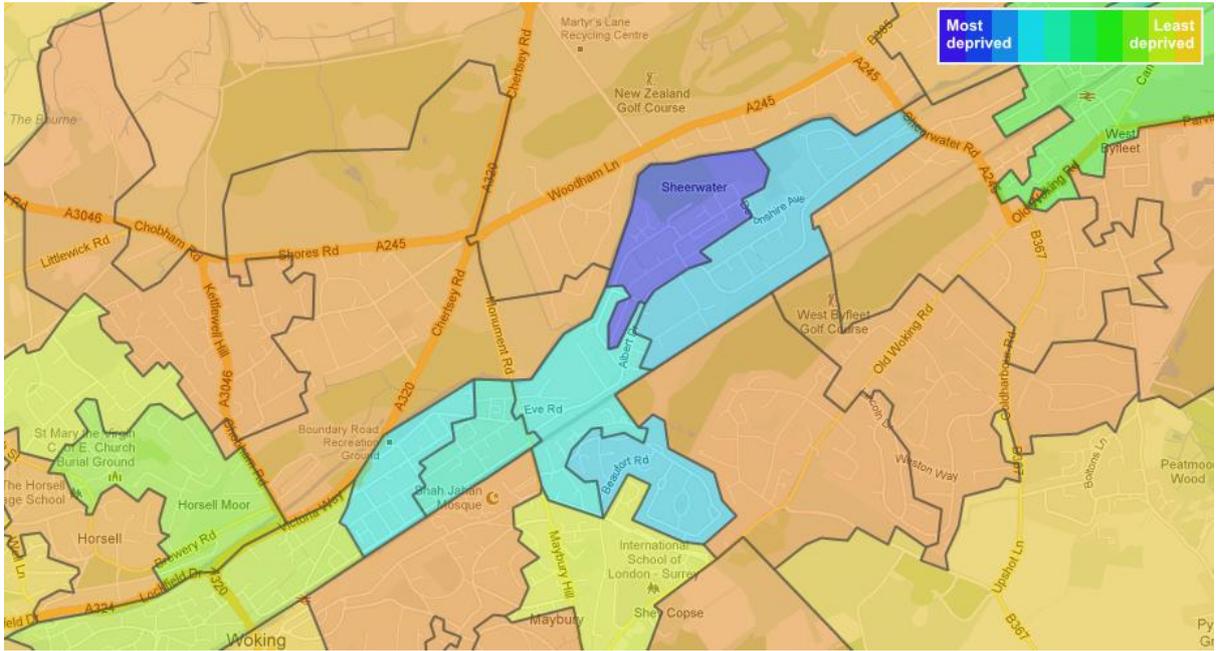


2. Income domain:

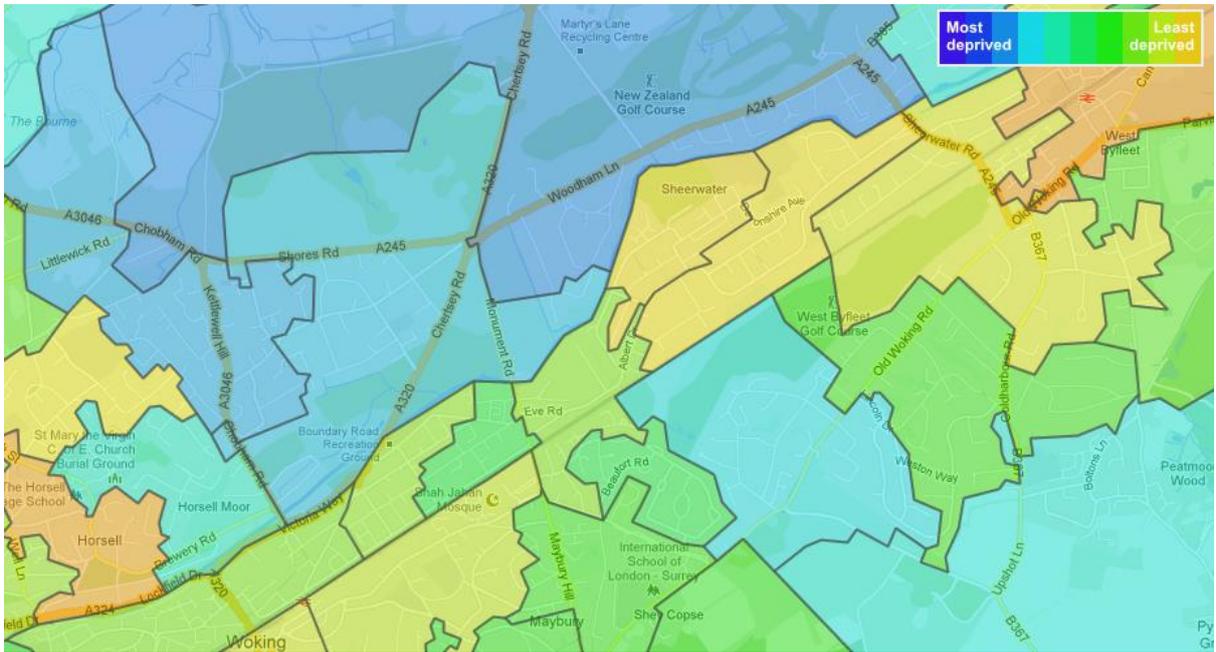


⁴⁴ Source: <http://opendatacommunities.org/deprivation/map> accessed 25th July 2013

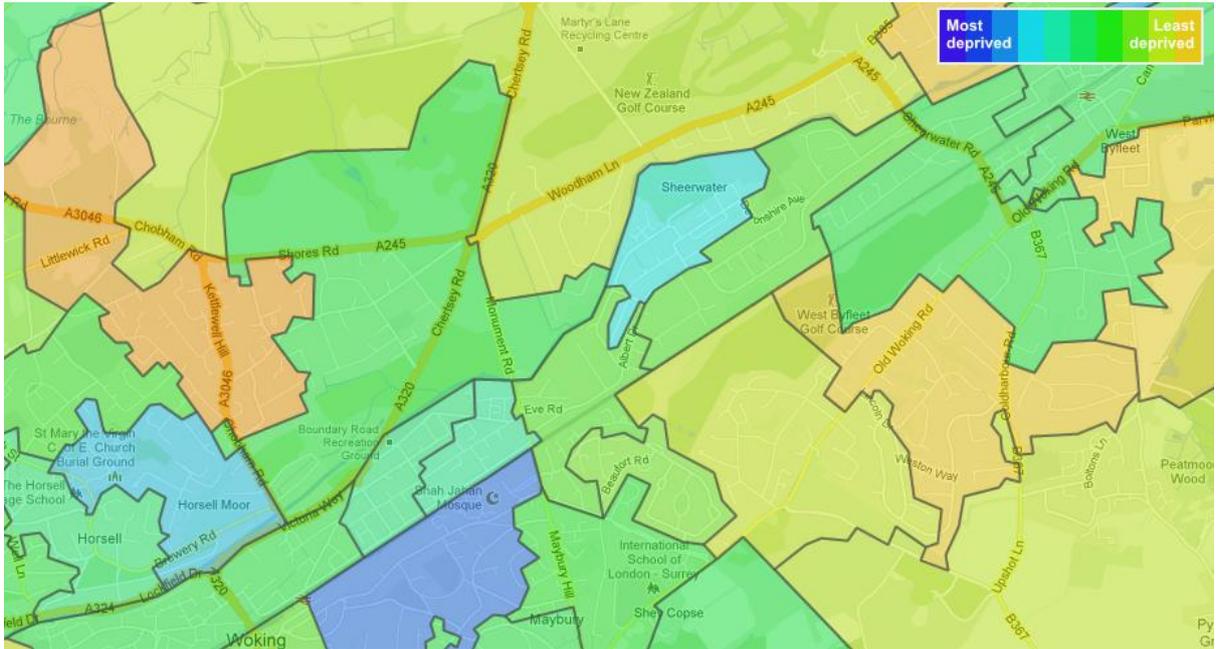
5. Education, skills, and training domain:



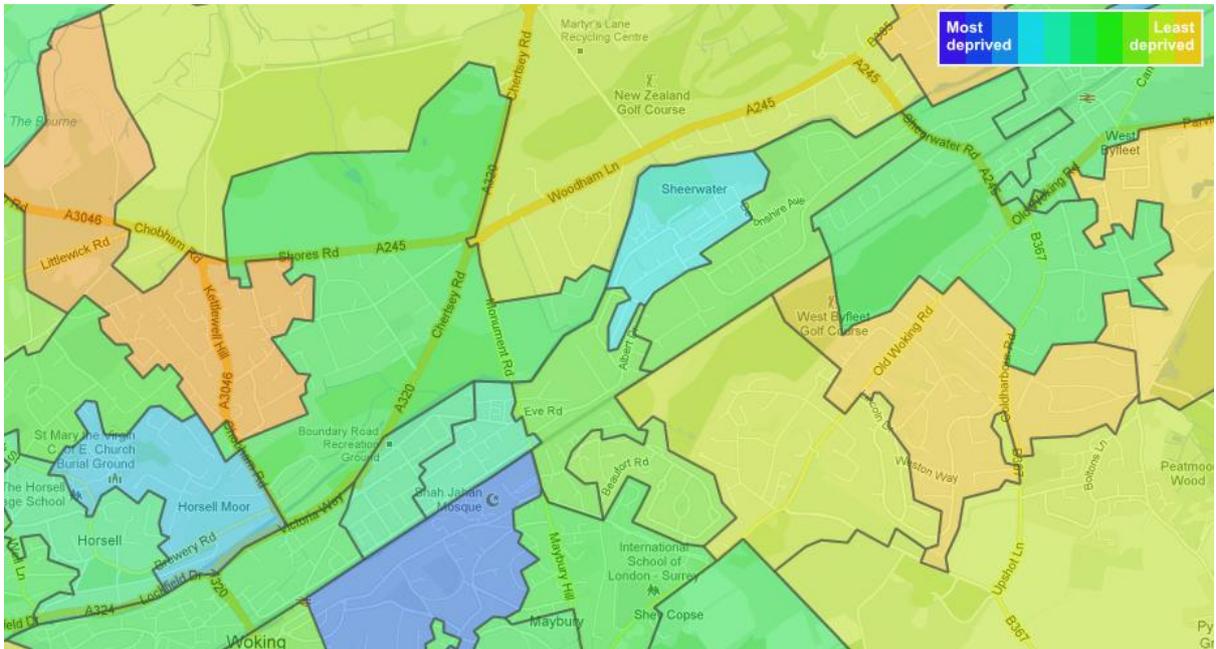
6. Barriers to housing and services domain:



7. Crime domain:



8. Living environment domain:



The following table provides the overall IMD score and rank in Surrey in 2010 for Maybury and Sheerwater ward, and each of the LSOAs within the ward, and compares these with 2007.⁴⁵ For score data, the higher the score the higher the level of deprivation. For rank data, the lower the rank the higher the level of deprivation (1=most deprived, 206=least deprived for wards, 709=least deprived for LSOAs).

Figure 19: Overall IMD score and Surrey rank for Maybury and Sheerwater ward and its constituent LSOAs in 2010 and 2007⁴⁶

	IMD score 2010	IMD 2010 rank in Surrey	IMD score 2007	IMD 2007 rank in Surrey
Maybury and Sheerwater ward	22.75	2↔	21.88	2
LSOA Woking 004A	23.69	21↓	21.74	30
LSOA Woking 004B	16.68	77↑	17.18	67
LSOA Woking 004C	16.98	71↓	16.06	73
LSOA Woking 004D	24.12	19↑	24.63	18
LSOA Woking 004E	16.70	75↓	14.36	93
LSOA Woking 004F	41.22	1↔	41.09	1

The IMD ranking for Maybury and Sheerwater stayed the same between 2007 and 2010 as the second most deprived ward in Surrey, with an increase in the overall IMD score from 21.88 to 22.75. In 2007 the most deprived ward was Stanwell North which improved to 5th most deprived ward in 2010. In 2010 the most deprived ward was Preston, which had fallen from being the 4th most deprived ward in 2007.

For 3 of the LSOAs in the ward, the IMD score increased and the relative rank within Surrey worsened. For 2 of the LSOAs the IMD score fell and the relative rank within Surrey improved. For LSOA Woking 004F, the IMD score marginally worsened and it remained the most deprived LSOA in the whole county.

These data show that whilst Maybury and Sheerwater ward remains the second most deprived ward in Surrey, there is relative deprivation even within the ward at LSOA level, with the most deprived LSOA in Surrey significantly more deprived than the ward population-weighted average (41.22 vs. 22.75).

⁴⁵ IMD 2010 data is calculated at LSOA level. The ward level data has been calculated from population weighted averages using the appropriate population datasets, and provides a more accurate picture than previously calculated ward-level data which was not population weighted. Accordingly, where a disparity exists between this and previous data, this data should be considered as more accurate.

⁴⁶ Source: English Indices of Deprivation 2010 and 2007, Department for Communities and Local Government, available at <https://www.gov.uk/government/publications/english-indices-of-deprivation-2010> accessed 25th July 2013

The next table provides a breakdown of each of the domains and two supplementary domains for Maybury and Sheerwater ward, and compares IMD 2010 scores and ranks with IMD 2007 scores and ranks.

Figure 20: IMD scores and Surrey rank for each domain and 2 supplementary domains for Maybury and Sheerwater ward⁴⁷

Individual domain	IMD score 2010	IMD 2010 rank in Surrey (1=worst)	IMD score 2007	IMD 2007 rank in Surrey (1=worst)
Income	0.19	1↔	0.20	1
Employment	0.10	1↓	0.10	2
Health, deprivation, and disability	0.31	1↔	0.22	1
Education, skills, and training	30.96	5↓	28.39	6
Barriers to housing and services	13.81	156↓	13.30	158
Crime	-0.09	41↑	-0.23	33
Living environment	17.56	43↑	19.83	25
Income deprivation affecting children	0.26	4↔	0.26	4
Income deprivation affecting older people	0.33	1↔	0.31	1

Maybury and Sheerwater ward is the most deprived ward in four domains: income, employment, health, deprivation and disability, and income deprivation affecting older people; and in the top 5 most deprived wards for education, skills and training, and income deprivation affecting children. Most of the domains were similarly ranked in 2007, with a slight worsening in employment, education, skills, and training, and barriers to housing and services, and a slight improvement in crime and living environment.

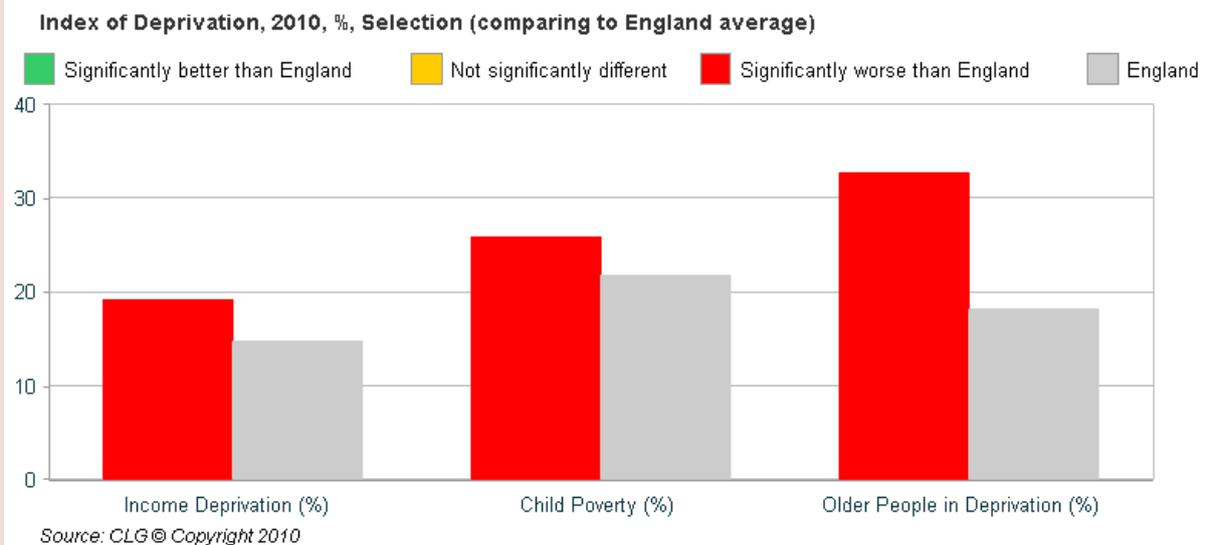
A complementary picture is provided by the Public Health England Local Health Profile for Maybury and Sheerwater ward, as illustrated in figure 21.

⁴⁷ Source: English Indices of Deprivation 2010 and 2007, Department for Communities and Local Government, available at <https://www.gov.uk/government/publications/english-indices-of-deprivation-2010> accessed 25th July 2013

Figure 21: Key indicators of deprivation in Maybury and Sheerwater⁴⁸

Indicator	Selection	Local Authority Lower Tier (Woking)	Local Authority Upper Tier (Surrey)	England
Income Deprivation (%)	19.2	7.9	6.8	14.7
Child Poverty (%)	25.9	11.9	10	21.8
Older People in Deprivation (%)	32.7	10.8	9.3	18.1

Source: CLG © Copyright 2010



This clearly shows that in the domains of income deprivation, child poverty, and older people in deprivation, Maybury and Sheerwater is statistically significantly worse than the national average, and even more so compared with the Surrey and Woking averages which are lower than the national average.

In summary, Maybury and Sheerwater remained the second most deprived ward in Surrey on the IMD from 2007 to 2010, and contains the most deprived LSOA. Comparing nationally, it is significantly worse than the national average for the three key indicators of income deprivation, child poverty, and older people in deprivation.

The recommendation is:

- Planners and commissioners should have regard to this data when designing services and allocating funding to tackle deprivation.

⁴⁸ Source: PHE Local Health Profile for Maybury and Sheerwater, available at http://www.localhealth.org.uk/GC_prepport.php?lang=en&s=106&view=map4&id_rep=r03&sellid0=6469&nivgeo=ward_2011 accessed 25th July 2013

3.2 MOSAIC Public Sector people classification system

'MOSAIC Public Sector' is a people classification system compiled by Experian that provides a detailed and accurate understanding of the demographics, lifestyle, and behaviours of the population in order to understand the needs for public services now and in the future. It uses over 440 data elements and classifies all UK citizens into 69 types and 15 groups in order to better understand the needs and target services to the local population.

The population groups are as follows:

Group	Description
A	Residents of isolated rural communities
B	Residents of small and mid-sized towns with strong local roots
C	Wealthy people living in the most sought after neighbourhoods
D	Successful professionals living in suburban or semi-rural homes
E	Middle income families living in moderate suburban semis
F	Couples with young children in comfortable modern housing
G	Young well-educated city dwellers
H	Couples and young singles in small modern starter homes
I	Lower income workers in urban terraces in often diverse areas
J	Owner occupiers in older-style housing ex-industrial areas
K	Residents with sufficient incomes in right-to-buy social housing
L	Active elderly people living in pleasant retirement locations
M	Elderly people reliant on state support
N	Young people renting flats in high density social housing
O	Families in low-rise social housing with high levels of benefit need

The following figures show a comparison of the MOSAIC groups in Maybury and Sheerwater with Woking, Surrey, and England.

Figure 22: MOSAIC groups in Maybury and Sheerwater compared with Woking and Surrey⁴⁹

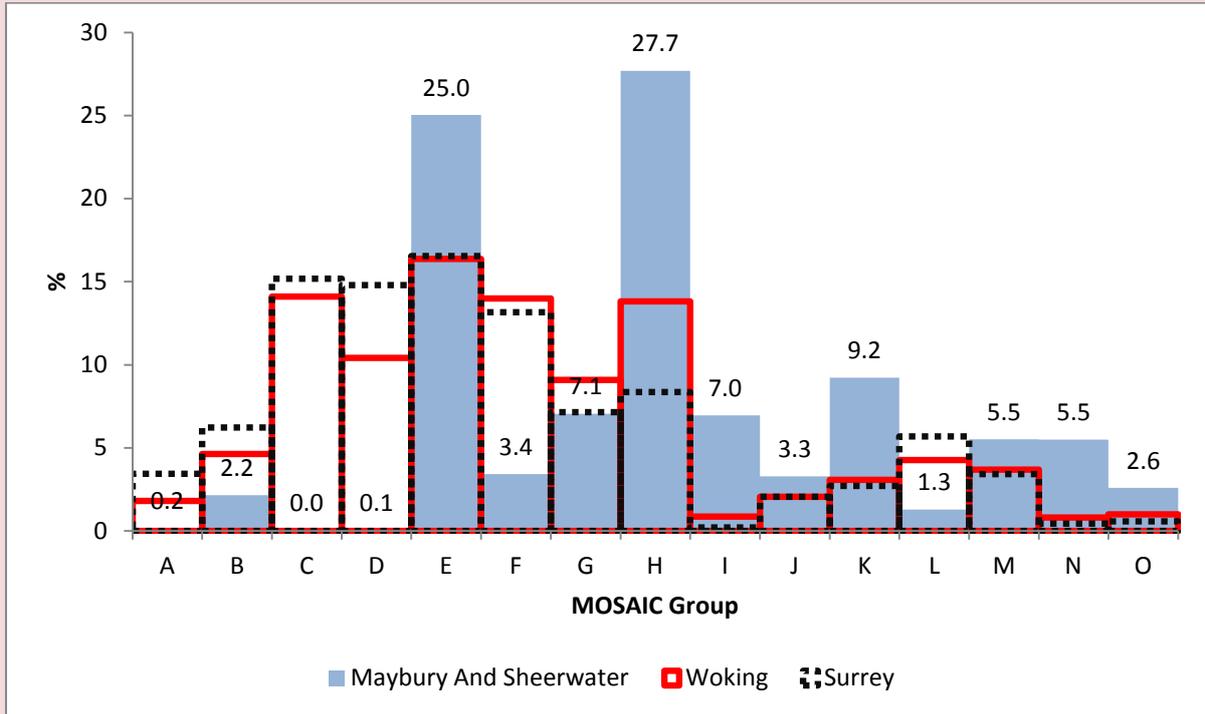
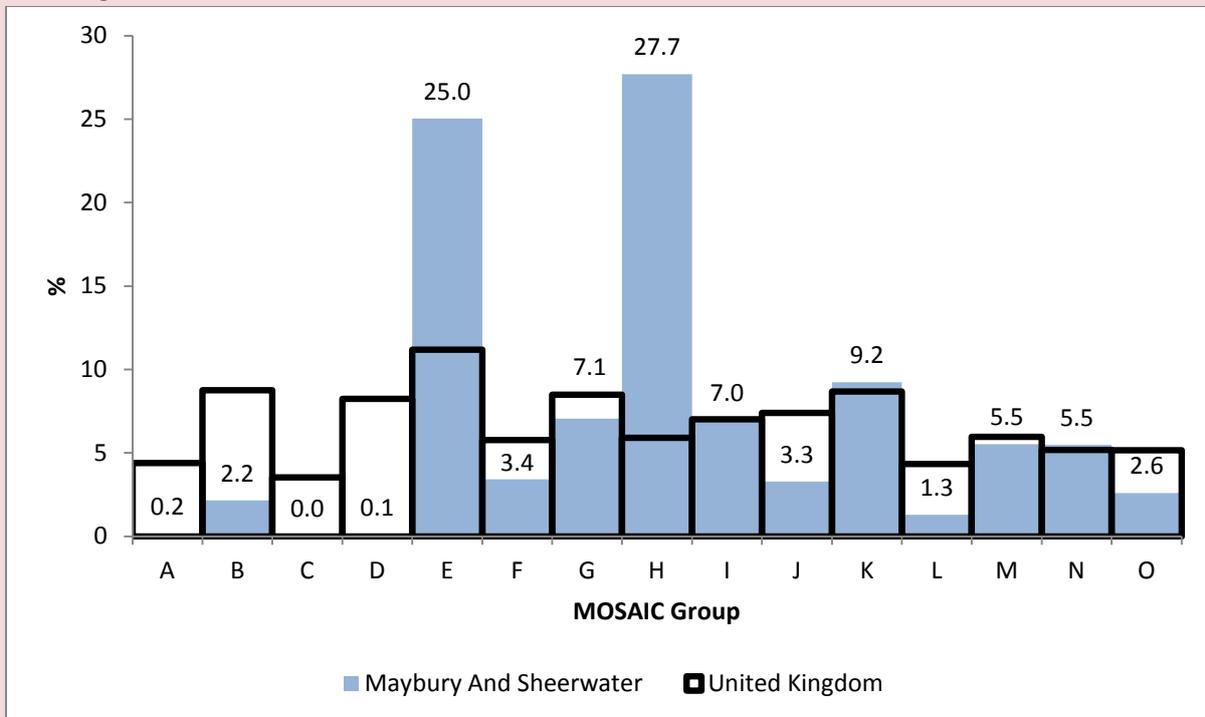


Figure 23: MOSAIC groups in Maybury and Sheerwater compared with UK average



⁴⁹ Source: Surrey-i MOSAIC profile, available at <http://www.surreyi.gov.uk/Viewdata.aspx?P=Data&referer=%2fViewpage.aspx%3fc%3dbasket%26BasketID%3d156> accessed 25th July 2013

These charts clearly illustrate that the MOSAIC group profile of Maybury and Sheerwater varies markedly not only from the UK average profile, but also from the Surrey and Woking profiles. This indicates that the needs of the population in Maybury and Sheerwater are different to the average needs of those in Woking borough, and focused attention should be given to ensuring the delivery of appropriate services locally.

The two largest MOSAIC groups in Maybury and Sheerwater are Group H (couples and young singles in small modern starter homes, 27.69%) and Group E (middle income families living in moderate suburban semis, 25.04%), with significant numbers of people in Group K (residents with sufficient incomes in right-to-buy social housing, 9.23%), Group G (young, well educated city dwellers, 7.06%), and Group I (lower income workers in urban terraces in often diverse areas, 6.95%).

Notably absent/low from the Maybury and Sheerwater profile are 3 high income/education groups that are major groups in the Surrey profile: Group C (wealthy people living in the most sought after neighbourhoods), Group D (successful professionals living in suburban or semi-rural homes) and Group F (couples with young children in comfortable modern housing).

In summary, this profile is consistent with the IMD 2010 profile for Maybury and Sheerwater, indicating that it is one of the most deprived areas of Surrey. The MOSAIC Group profiles are available on Surrey-i, and provide full breakdowns of the demographics, character, use of services, access, green behaviour, health status, education status, and many other aspects of each group type. Groups H, E, K, G, and I form the bulk of the Maybury and Sheerwater population.⁵⁰ The MOSAIC profile is significantly different to both the Woking and the Surrey profile, indicating a need for specially targeted interventions.

The recommendation is:

- Planners and commissioners should refer to the MOSAIC profiles for Maybury and Sheerwater to better understand the local population when designing services and allocating funding to tackle deprivation to improve health.

⁵⁰ Available at <http://www.surreyi.gov.uk/Resource.aspx?ResourceID=802> accessed 25th July 2013

3.3 Specific indicators of deprivation

3.3.1 Indicators of deprivation in children

5 indicators are used on Surrey-i to monitor deprivation in children at ward level:

- The Child Wellbeing Index (CWI)
 - The first index of child wellbeing at small area level for England, using a weighted analysis of administrative data on children covering seven domains of wellbeing: income, health, education, housing, environment, crime, and children in need.
- Percentage of children living in poverty.
- Number of young people not in education employment, or training (NEET).
- Percentage of pupils achieving 5+ A*-C (including English and Maths) GCSE or equivalent.
- Percentage of lone parent households with dependent children.

The performance of Maybury and Sheerwater relative to the rest of Surrey can be seen on the Surrey-i Maybury and Sheerwater Local Area Profile, and is reproduced below:

Figure 24: Maybury and Sheerwater performance on indicators of deprivation in children⁵¹

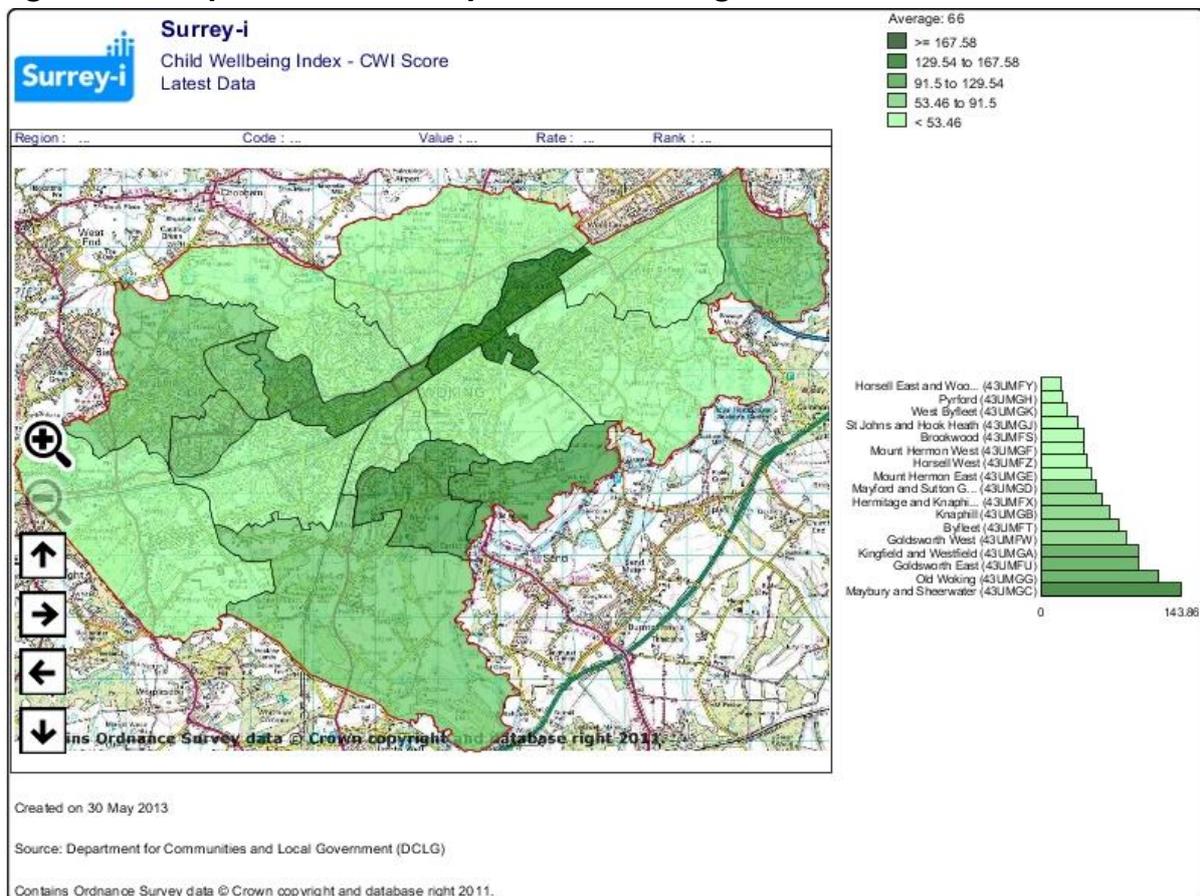
Click on an indicator to see more details	Local value	Rank	Wards Average	Wards Worst	Wards Range	Wards Best
7. Child well-being index Indices of Deprivation (3 years), 2009 CWI	143.86	196 (206)	71.79 †	205.62		15.42
8. % of children living in poverty - All Children Calendar Year, 2010	25.3%	203 (206)	10.2% †	27.5%		1.1%
9. No of Young people Not in Education, Employment or Training (NEET) Month, Mar 2013	16	100 (107)	7	22		0
10. % of pupils achieving 5+ A*-C (inc Eng & Maths), GCSE or equivalent 3 Year Pooled Data, 2009-2011	44.3%	190 (204)	61.4% †	32.7%		90.4%
11. % of lone parent households with dependent children Census (10 years), 2011 Census	5.72%	164 (206)	4.66% †	11.99%		1.38%

⁵¹ Source: Surrey-i Maybury and Sheerwater Local Area Profile, available at <http://www.surreyi.gov.uk/DrillDownProfile.aspx?rt=37&rid=296722&pid=31> accessed 25th July 2013

These data show that Maybury and Sheerwater performs significantly below average in Surrey on indicators relating to deprivation in children, ranking 10th worst in Surrey on the composite CWI index, and 4th worst in Surrey on percentage of children living in poverty. This should be read together with the IMD 2010 supplementary indicator of income deprivation affecting children, on which Maybury and Sheerwater ranked 4th worst in Surrey.

With regard to the CWI, Maybury and Sheerwater performs significantly worse than the rest of Woking, as illustrated in figure 25.

Figure 25: Map of CWI score by ward in Woking⁵²



Taken together, these findings demonstrate that deprivation affecting children is a significant problem in Maybury and Sheerwater, and should form a priority area of focus for service planners and commissioners. This should particularly be seen in the context of the 'life course approach' proposed by the Marmot Review (see section 1.2.2). Children living in relative deprivation are more likely to experience poor health, which in turn will lead to poorer

⁵² Source: Surrey-i Maybury and Sheerwater Local Area Profile, available at <http://www.surreyi.gov.uk/DrillDownProfile.aspx?rt=37&rid=296722&pid=31> accessed 25th July 2013

education outcomes and further deprivation into adulthood. Interrupting this vicious cycle must be a priority.

A complementary picture is provided by the Public Health England Local Health Profile for Maybury and Sheerwater ward, as illustrated below:

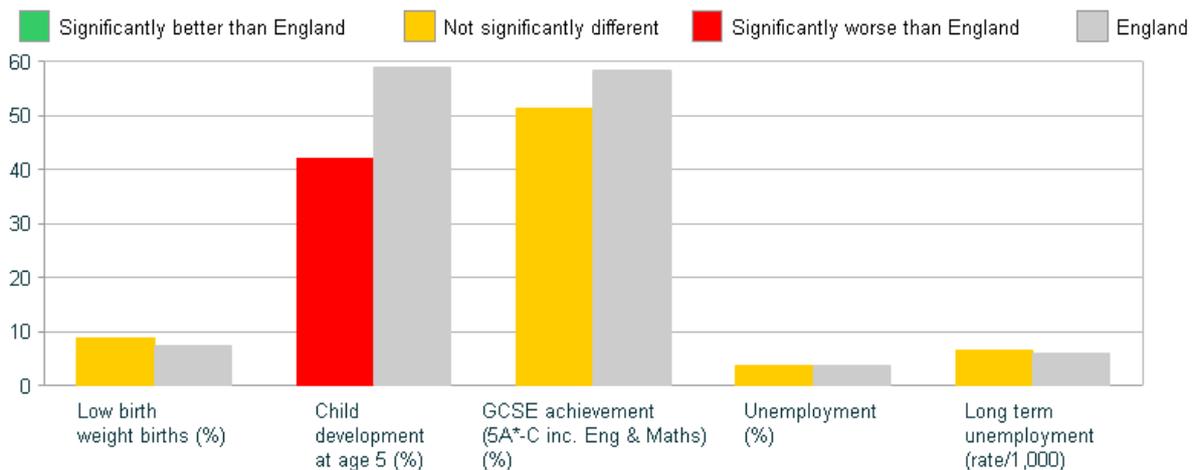
Figure 26: Child development, education, and employment indicators⁵³

Child development, education and employment indicators, values

Indicator	Selection	Local Authority Lower Tier (Woking)	Local Authority Upper Tier (Surrey)	England
Low birth weight births (%)	8.9	6.6	6.4	7.4
Child development at age 5 (%)	42.1	56.3	65.7	58.8
GCSE achievement (5A*-C inc. Eng & Maths) (%)	51.2	66.6	64.5	58.2
Unemployment (%)	3.7	2	1.7	3.6
Long term unemployment (rate/1,000)	6.5	3	2.7	6

Source: PHOs (now part of Public Health England), ONS, NOMIS, DfE

Child development, education and employment indicators, Selection (comparing to England average)



Source: PHOs (now part of Public Health England), ONS, NOMIS, DfE

This clearly shows that child development at age 5 is statistically significantly lower than the national average, and markedly so when compared with the Surrey and Woking average. When looking at the other indicators, the differences are not statistically significant when comparing with the England average, but again when comparing with the Surrey and Woking averages, they are all likely to be significantly worse.

⁵³ Source: PHE Local Health Profile for Maybury and Sheerwater, available at http://www.localhealth.org.uk/GC_prepport.php?lang=en&s=106&view=map4&id_rep=r03&sellid0=6469&nivgeo=ward_2011 accessed 25th July 2013; some values may differ between datasets due to different time periods being used, but it is the relative performance to the regional and national average that is the most informative statistic, which remains constant.

3.3.2 Indicators of deprivation in adults and older people

3 indicator areas have been used to monitor specific areas of deprivation in adults and older people at ward level:

- Indicators relating to education, employment, and income:
 - Percentage of population claiming job seekers allowance.
 - Percentage of adults with no or low qualifications.
 - Percentage of population aged 16-64 claiming working age benefits.
 - Percentage economically active people unemployed.
 - Percentage economically inactive people.
 - Income: model-based estimates at MSOA level, 2007/8.⁵⁴

- Indicators relating to housing:
 - Percentage social rented housing.
 - Percentage owner occupied housing.
 - Percentage overcrowded households.
 - Percentage households with no central heating.
 - Percentage single person households aged 65+.

- Indicators relating to transport:
 - Percentage households with no car or van.
 - Average number of cars per household.

3.3.2.1 Indicators relating to education, employment, and income

The performance of Maybury and Sheerwater in relation to indicators relating to education, employment, and income can be seen on the Surrey-i Maybury and Sheerwater Local Area Profile, and is reproduced below:

⁵⁴ MSOA stands for middle super output area. MSOAs are build from groups of contiguous LSOAs, and have a minimum population of 5,000 and a mean population of 7,200. MSOA Woking 004 is contiguous with the boundary of Maybury and Sheerwater ward.

Figure 27: Maybury and Sheerwater performance on indicators relating to education and employment⁵⁵

Click on an indicator to see more details	Local value	Rank	Wards Average	Wards Worst	Wards Range	Wards Best
Economy						
1. % of population claiming job seekers allowance Month, Apr 2013	3.2%	203 (206)	1.52% †	4.52%		0.24%
2. % of adults with no or low qualifications Census (10 years), 2011 Census	48.4%	202 (206)	31.1% †	52.9%		14%
3. % of population aged 16-64 claiming working age benefits Calendar Quarter, 2012/Q4 (Oct-Dec)	14.29%	203 (206)	7.31% †	16.01%		1.26%
1. Economically active: Total Census (10 years), 2011 Census	72.04%	148 (206)	73.63% †	44.98%		82.56%
2. Economically active: Employed part-time Census (10 years), 2011 Census	12.07%	160 (206)	13% †	4.96%		17.19%
3. Economically active: Employed full-time Census (10 years), 2011 Census	38.75%	146 (206)	42.2% †	18.04%		57.12%
4. Economically active: Self employed Census (10 years), 2011 Census	10.39%	170 (206)	12.54% †	4.66%		22.97%
5. Economically active: Unemployed Census (10 years), 2011 Census	5.57%	2 (206)	2.79% †	0.85%		5.96%
6. Economically active: Full-time student Census (10 years), 2011 Census	5.25%	10 (206)	3.1% †	1.2%		17.33%
7. Economically inactive: Total Census (10 years), 2011 Census	27.96%	59 (206)	26.37% †	17.44%		55.02%
8. Economically inactive: Retired Census (10 years), 2011 Census	5.95%	204 (206)	12.92% †	5.16%		24.5%
9. Economically inactive: Student (including full-time students) Census (10 years), 2011 Census	4.73%	48 (206)	5% †	2.04%		45.61%
10. Economically inactive: Looking after home or family Census (10 years), 2011 Census	8.7%	4 (206)	4.67% †	1.78%		10.42%
11. Economically inactive: Long-term sick or disabled Census (10 years), 2011 Census	4.56%	4 (206)	2.05% †	0.4%		5.37%
12. Economically inactive: Other Census (10 years), 2011 Census	4.02%	4 (206)	1.72% †	0.68%		12.89%

These data show that Maybury and Sheerwater is in the 5 worst performing wards in Surrey (out of 206) for the percentage of people claiming jobseekers allowance and working age benefits, and the percentage of adults with no or low qualifications. Out of 206 wards in Surrey, Maybury and Sheerwater also has the 2nd highest proportion of unemployed people (5.57%) and a high proportion of economically inactive people (27.96%), including the 4th highest proportion of long-term sick/disabled (4.56%) and looking after home/family (8.7%) in the county.

Modelled estimates are also available for average weekly household income in 2007-08.⁵⁶ This shows that the average weekly household total income in Maybury and Sheerwater was £640, significantly below the South East

⁵⁵ Source: Reproduced from Surrey-i Maybury and Sheerwater Local Area Profile, available at <http://www.surreyi.gov.uk/DrillDownProfile.aspx?rt=37&rid=296722&pid=31> accessed 25th July 2013

⁵⁶ Source: ONS Neighbourhood Statistics, available at <http://neighbourhood.statistics.gov.uk/dissemination/LeadTableView.do?a=3&b=6503995&c=Maybury+and+Sheerwater&d=14&e=14&q=6471034&i=1001x1003x1004&m=0&r=1&s=1370003833996&enc=1&dsFamilyId=266> accessed 25th July 2013

average of £800, and the average weekly household net income after housing costs was £360, significantly below the South East average of £490.

Taken together, these data show provide a more detailed view of why on the IMD 2010 measure Maybury and Sheerwater is the most deprived ward for income and employment deprivation, and the 5th most deprived ward for education, skills, and training deprivation. Unemployment and low-income are significant social determinants of health, and the high levels seen in Maybury and Sheerwater are significant contributory factors to poor health in the area.

3.3.2.2 Indicators relating to housing

The performance of Maybury and Sheerwater in relation to indicators relating to housing can be seen on the Surrey-i Maybury and Sheerwater Local Area Profile, and is reproduced below:

Figure 28: Maybury and Sheerwater performance on indicators relating to housing (2011)⁵⁷

Click on an indicator to see more details	Local value	Rank	Wards Average	Wards Lowest	Wards Range	Wards Highest
8. Overcrowded households (with occupancy rating of -1 or less) Census (10 years), 2011 Census	21.28%	1 (206)	6.75% †	0.98%		21.28%
9. Households with no central heating Census (10 years), 2011 Census	2.49%	27 (206)	1.63% †	0.24%		5.03%
16. Owner occupied Census (10 years), 2011 Census	47.15%	205 (206)	72.88% †	42.59%		95.33%
17. Shared ownership (part owned and part rented) Census (10 years), 2011 Census	1.11%	60 (206)	1.02% †	0%		5.72%
18. Social rented Census (10 years), 2011 Census	28.99%	7 (206)	11.43% †	0.62%		42.68%
7. One person household: Aged 65+ Census (10 years), 2011 Census	8.46%	198 (206)	12.62% †	5.36%		28.11%

These data show that relative to the rest of Surrey, Maybury and Sheerwater has the highest proportion of overcrowded households (21.28% vs. Surrey average of 6.75%) and a high proportion of households with no central heating (2.49% vs. Surrey average of 1.63%). Out of 206 wards, it also has the 2nd lowest rate of owner occupied housing (47.15% vs. Surrey average of 72.88%), and the 7th highest rate of socially rented housing (28.99% vs. Surrey average of 11.43%).

The final indicator shows that out of 206 wards in Surrey, Maybury and Sheerwater has the 8th smallest percentage of people over 65 living alone, in

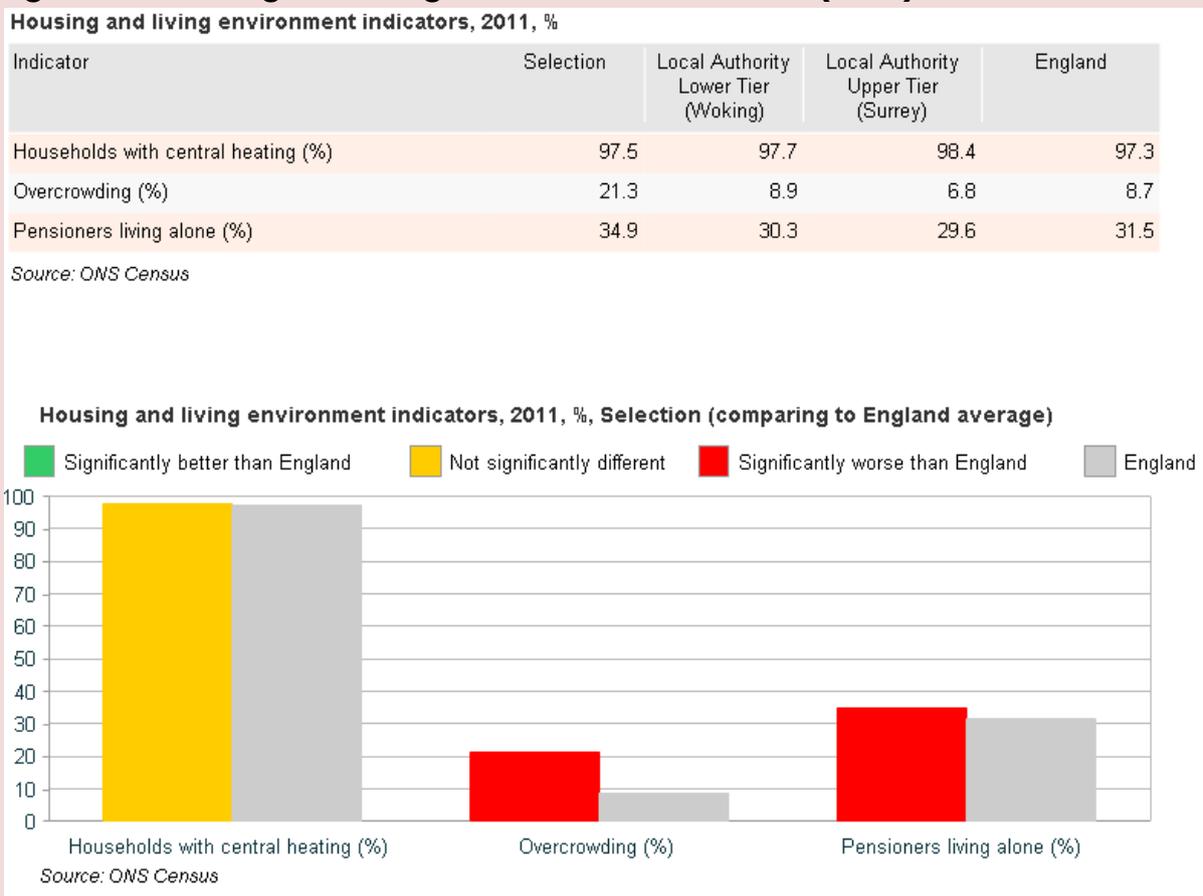
⁵⁷ Source: Reproduced from Surrey-i Maybury and Sheerwater Local Area Profile, available at <http://www.surreyi.gov.uk/DrillDownProfile.aspx?rt=37&rid=296722&pid=35> accessed 25th July 2013

line with the much smaller over 65 population than the Surrey average. However, this 8.46% of the local population still require additional surveillance, as they are the group most vulnerable from, for example: falls, hip fractures and consequent morbidity and mortality, and excess winter morbidity and mortality.

Taken together, these data show that the housing status of residents in Maybury and Sheerwater is significantly below that enjoyed by the average resident in Surrey, particularly with regard to overcrowded households which will impact on the health of children, adults, and older people alike.

A complementary picture is provided by the Public Health England Local Health Profile for Maybury and Sheerwater ward, as illustrated below:

Figure 29: Housing and living environment indicators (2011)⁵⁸



⁵⁸ Source: PHE Local Health Profile for Maybury and Sheerwater, available at http://www.localhealth.org.uk/GC_preporf.php?lang=en&s=106&view=map4&id_rep=r03&selld0=6469&nivgeo=ward_2011 accessed 25th July 2013; some values may differ between datasets due to different time periods being used, but it is the relative performance to the regional and national average that is the most informative statistic, which remains constant.

This clearly shows that with regard to overcrowding and pensioners living alone, Maybury and Sheerwater is statistically significantly worse than the national average, and the Surrey and Woking average.

3.3.2.3 Indicators relating to transport

The performance of Maybury and Sheerwater in relation to indicators relating to transport can be seen on the Surrey-i Maybury and Sheerwater Local Area Profile, and is reproduced below:

Figure 30: Maybury and Sheerwater performance on indicators relating to transport⁵⁹

Click on an indicator to see more details	Local value	Rank	Wards Average	Wards Lowest	Wards Range	Wards Highest
21. Households with no car Census (10 years), 2011 Census	26.87%	3 (206)	13.13% †	2.93%		29.3%
22. One car or van in household Census (10 years), 2011 Census	43.73%	50 (206)	40.42% †	24.84%		53.34%
23. Two cars or vans in household Census (10 years), 2011 Census	22.91%	203 (206)	34.21% †	16.17%		48.99%
24. Three cars or vans in household Census (10 years), 2011 Census	4.92%	191 (206)	8.69% †	3.06%		16.23%
25. Four or more cars or vans in household Census (10 years), 2011 Census	1.58%	196 (206)	3.54% †	0.6%		9.84%
26. Average number of cars per household Census (10 years), 2011 Census	1.11	203 (206)	1.51 †	0.95		2.06

These data show that out of 206 wards in Surrey, Maybury and Sheerwater has the 3rd highest proportion of households with no car (26.87% vs. Surrey average of 13.13%), and the 4th lowest average number of cars per household (1.11 vs. Surrey average of 1.51).

Transport is a key aspect of ability to access healthcare in addition to education and employment, and taken together these data indicate that transport may be a barrier for many residents in Maybury and Sheerwater being able to lead full and healthy lives.

The performance of Maybury and Sheerwater in relation to this indicator can be seen on the Surrey-i Maybury and Sheerwater Local Area Profile, and is reproduced below:

⁵⁹ Source: Reproduced from Surrey-i Maybury and Sheerwater Local Area Profile, available at <http://www.surreyi.gov.uk/DrillDownProfile.aspx?rt=37&rid=296722&pid=35> accessed 25th July 2013

In summary, these indicators provide a more detailed understanding of deprivation in Maybury and Sheerwater, but broadly speaking reflect the findings of the IMD analysis. Deprivation in children is a major problem, with poor childhood development and poor educational attainment. The major problems for adults are high unemployment, low incomes, and overcrowded housing, which are markedly worse than the rest of Woking and Surrey.

The recommendations are:

1. Planners and commissioners should focus particularly on child poverty and deprivation in Maybury and Sheerwater. Poor development and educational attainment in childhood is likely to result in unemployment/underemployment, low incomes, and poor mental and physical health in adulthood. In turn, children that grow up in these families are more likely to suffer the same problem. Breaking this vicious cycle must be a priority.
2. With regard to local development plans, planners and commissioners should pay particular regard to issues relating to housing, particularly overcrowding, which can have a detrimental effect on health and wellbeing.

3.4 Life expectancy at birth

Life expectancy at birth is included in the deprivation chapter because the difference in life expectancy between the most affluent areas and the least affluent areas is an indicator of relative deprivation. Figure 31 is reproduced from the Woking 2012 Health Profile developed by the English Public Health Observatories working in partnership. It shows the 'Slope Index of Inequality', which is a modelled estimate of the range in life-expectancy at birth across the whole population of Woking. Based on the death rates in 2006-10, this range is 7.3 years for males and 2 years for females. Each point on the chart shows the average life expectancy in each tenth of the population of Woking.

Figure 31: Slope Index of Inequality for Woking (2006-2010) ⁶⁰



More recently, the Surrey Public Health Analyst team has looked at the change in life expectancy at birth by ward for every ward in Surrey from 1999-2003 to 2007-2011. This gives a more detailed breakdown of the comparison of Maybury and Sheerwater to the rest of Woking and Surrey, and the change in life expectancy over the last 10 years in the ward.

⁶⁰ Source: APHO Health Profile for Woking 2012, available at http://www.apho.org.uk/default.aspx?QN=HP_METADATA&ArealD=50594 accessed 25th July 2013

Figure 32: Life expectancy at birth in Woking by ward and time period⁶¹

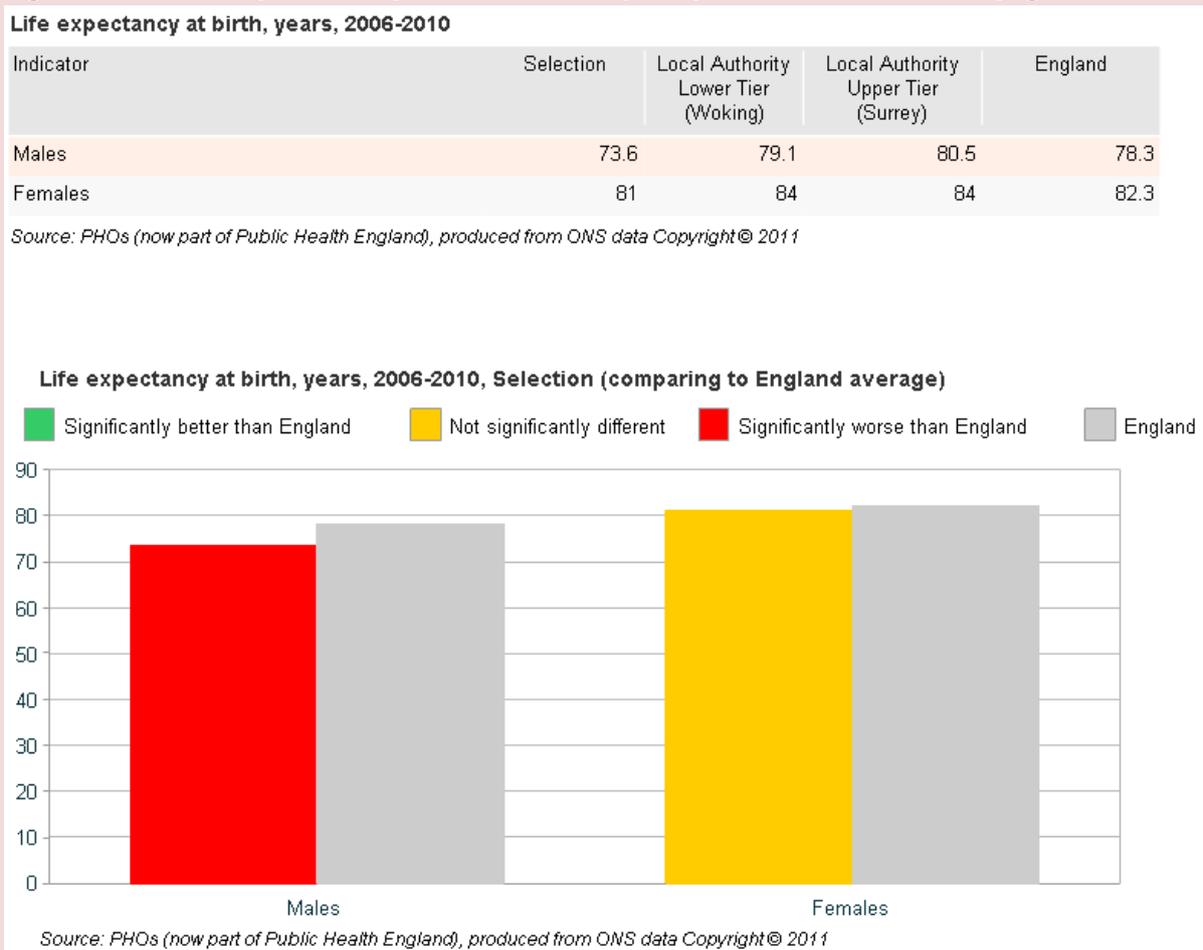
Ward Name	Life Expectancy At Birth (2007-11)					Life Expectancy At Birth (1999 - 2003)				
	Life Expectancy	Standard Error	95% Confidence Limits			Life Expectancy	95% Confidence Limits			Increase in Life Expectancy
			Lower	-	Upper		Lower	-	Upper	
Surrey	82.6	0.06	82.50	-	82.73	80.4	80.3	-	80.5	
Brookwood	85.1	1.88	81.37	-	88.74	81.2	79.0	-	83.3	3.9
Byfleet	82.6	0.78	81.09	-	84.16	80.3	78.8	-	81.8	2.3
Goldsworth East	82.5	0.99	80.61	-	84.48	81.0	79.5	-	82.5	1.5
Goldsworth West	80.6	1.05	78.55	-	82.65	83.0	80.7	-	85.2	-2.4
Hermitage and Knaphill South	83.6	1.14	81.36	-	85.82	81.3	79.5	-	83.0	2.3
Horsell East and Woodham	84.1	0.74	82.68	-	85.58	81.3	79.8	-	82.8	2.8
Horsell West	83.2	0.70	81.78	-	84.54	81.7	80.3	-	83.1	1.5
Kingfield and Westfield	80.4	0.74	78.93	-	81.84	78.6	76.9	-	80.3	1.8
Knaphill	83.1	0.78	81.53	-	84.60	80.5	79.1	-	82.0	2.6
Maybury and Sheerwater	76.9	0.75	75.46	-	78.39	76.2	74.7	-	77.7	0.7
Mayford and Sutton Green	80.9	1.56	77.83	-	83.95	81.5	78.4	-	84.7	-0.6
Mount Hermon East	82.1	0.82	80.46	-	83.68	80.2	78.6	-	81.8	1.9
Mount Hermon West	81.7	1.12	79.47	-	83.84	80.9	78.8	-	82.9	0.8
Old Woking	82.8	1.64	79.60	-	86.03	78.6	76.2	-	80.9	4.2
Pyrford	81.3	0.76	79.78	-	82.77	80.6	79.3	-	81.9	0.7
St John's and Hook Heath	84.1	0.77	82.57	-	85.57	83.4	82.1	-	84.8	0.7
West Byfleet	83.5	0.81	81.89	-	85.04	80.0	78.4	-	81.7	3.5

This shows that Maybury and Sheerwater has the lowest life expectancy in Woking, at 76.9 years, which has improved marginally from 1999-2003 by 0.7 years (not statistically significant). Life expectancy at birth is significantly below the Surrey average of 82.6 years, and 9.2 years below the life expectancy at birth in Brookwood (highest in Woking).

A complementary picture showing the difference in life expectancy between men and women in Maybury and Sheerwater is provided by the Public Health England Local Health Profile, and reproduced below:

⁶¹ Source: Reproduced from the Surrey Public Health Annual Report 2012-2013: Hidden Disadvantages in Surrey, available at <http://www.surreyi.gov.uk/Resource.aspx?ResourceID=1076> accessed 25th July 2013

Figure 33: Life expectancy at birth in Maybury and Sheerwater by gender⁶²



This shows that the life expectancy at birth for males is statistically significantly worse than the national average, and markedly so compared with the Surrey and Woking average. Whilst the life expectancy at birth for females is not statistically significantly different from the national average, it is likely to be significantly different from the Surrey and Woking average.

In summary, Maybury and Sheerwater has the lowest life expectancy of any ward in Woking, with residents dying on average 5 years younger than the average Surrey resident, and 9 years younger than the most affluent in Woking. This difference is most marked in males, though is also true in females.

The recommendation is:

- Planners and commissioners use these harsh statistics to add weight to proposals to address the root causes of lower life expectancy.

⁶² Source: PHE Local Area Profile for Maybury and Sheerwater, available at http://www.localhealth.org.uk/GC_preporf.php?lang=en&s=106&view=map4&id_rep=r03&selld0=6469&nivgeo=ward_2011 accessed 25th July 2013; some values may differ between datasets due to different time periods being used, but it is the relative performance to the regional and national average that is the most informative statistic, which remains constant.

4. Behavioural risk factors

In the Dahlgren and Whitehead (1991)⁶³ model of the relationship between the individual, their environment, and their health (see section 1.2.2), the core of 'fixed' risk factors has already been considered in the demography section. The second layer of 'behavioural' or 'modifiable' risk factors is considered in this chapter, comprising: (1) the 'traditional' major risk factors of smoking, alcohol, diet, and exercise; and (2) the additional indicators of substance misuse, immunisations, screening, and teenage pregnancy.

It has also been noted that behavioural risk factors considered in this chapter are the 'causes' of ill health, and indicators of deprivation and the wider determinants of health considered in the previous chapter are the 'causes behind the causes of ill health'. Using that paradigm foreshadows the finding that areas of relative deprivation, e.g. Maybury and Sheerwater ward, have a higher prevalence of behavioural risk factors like smoking and obesity, and consequently higher levels of chronic disease and poorer health outcomes.

This chapter considers data at both ward/MSOA (Maybury and Sheerwater) level, and local authority (Woking level). Please note the following:

1. The most recent model based estimates for smoking at ward/MSOA level are for the period 2003-2005, and for healthy eating and binge drinking are for the period 2006-2008. This HNA has been published in 2013, and therefore these data are now out of date, but can still provide a picture of relative prevalence.
2. Small area data (e.g. at the MSOA and ward level) require large sample sizes to deliver a useful level of accuracy, which is expensive to do across all wards/MSOAs. Accordingly, the point estimates at ward level tend to be less accurate than at local authority level.
3. Strategies to tackle behavioural risk factors are not typically developed at ward level, though an indication of the relative burden by ward can be helpful in allocating resources, and also in identifying 'problem areas' where more locally tailored solutions may be required.
4. Good quality recent data is available at the local authority (Woking) level for behavioural risk factors. Accordingly, this is presented alongside the model-based estimates from 2003-2005/2006-2008 for Maybury and Sheerwater to provide an indication of relative prevalence in Maybury and Sheerwater. Clearly this is a crude estimate, however, and should be interpreted with that in mind.

⁶³ Whitehead M, Dahlgren G 'What can be done about inequalities in health?' The Lancet 1991; 338:1059-63

4.1 Smoking

Why is smoking an important health issue?⁶⁴

Tobacco use is the single greatest cause of preventable deaths in England – killing over 80,000 people per year. This is greater than the **combined** total of preventable deaths caused by obesity, alcohol, traffic accidents, illegal drugs and HIV infections.

One in every two regular smokers is killed by tobacco, and half of them will die before age 70, losing an average of 10 years of life.

Two thirds of smokers say they began smoking before age 18, and 9 out of 10 started before the age of 19.

Local authorities have a responsibility to address health inequalities, and smoking is the primary reason for the gap in healthy life-expectancy between rich and poor.

Why is smoking an important economic issue?⁶⁵

The cost to society in the UK from smoking is nearly £14bn per year.

Each year in Woking, the estimated 9,869 smokers cost society is £16.2m, including:

- £4.8m through lost productivity due to early deaths
- £3.4m in smoking breaks
- £3.2m in NHS care
- £2.9m in sick days
- £0.8m from the impact of passive smoking
- £0.6m from domestic fires
- £0.4m from clearing up smoking litter

This is compared with a spend of £17.4m on tobacco products, contributing roughly £13.3m in duty to the Exchequer, resulting in a funding shortfall of £2.9m.

⁶⁴ Source: NICE local government public health briefing on tobacco, available at <http://publications.nice.org.uk/phb1> accessed 25th July 2013

⁶⁵ Source: Costs of smoking to society for Woking LA taken from ASH Reckoner tool, available at <http://ash.org.uk/localtoolkit/docs/Reckoner.xls> accessed 25th July 2013

The following two tables are reproduced from the Local Tobacco Control Profile for Woking. The first table compares smoking and smoking related morbidity and mortality for Woking with England, and the second table provides a comparison with the South East Region, which generally has a lower prevalence of smoking than the national average. Values are given per 100,000 population aged over 35 (smoking attributable deaths and hospital admissions), or per 100,000 population (deaths and registrations).

Figure 34: Local Tobacco Control Profile for Woking (Benchmark: England)⁶⁶

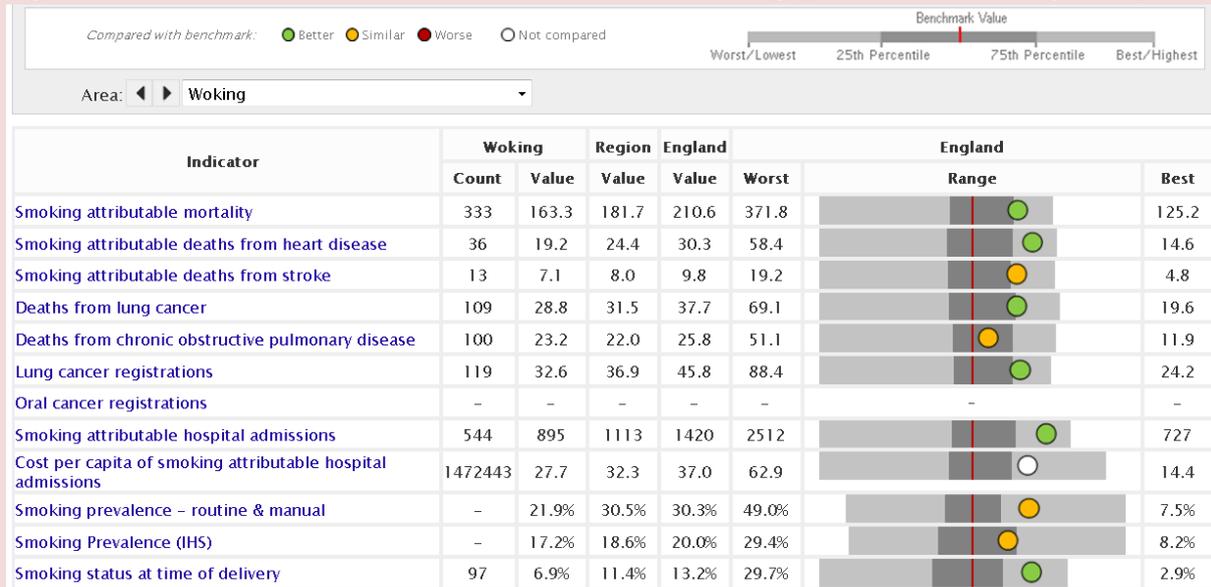
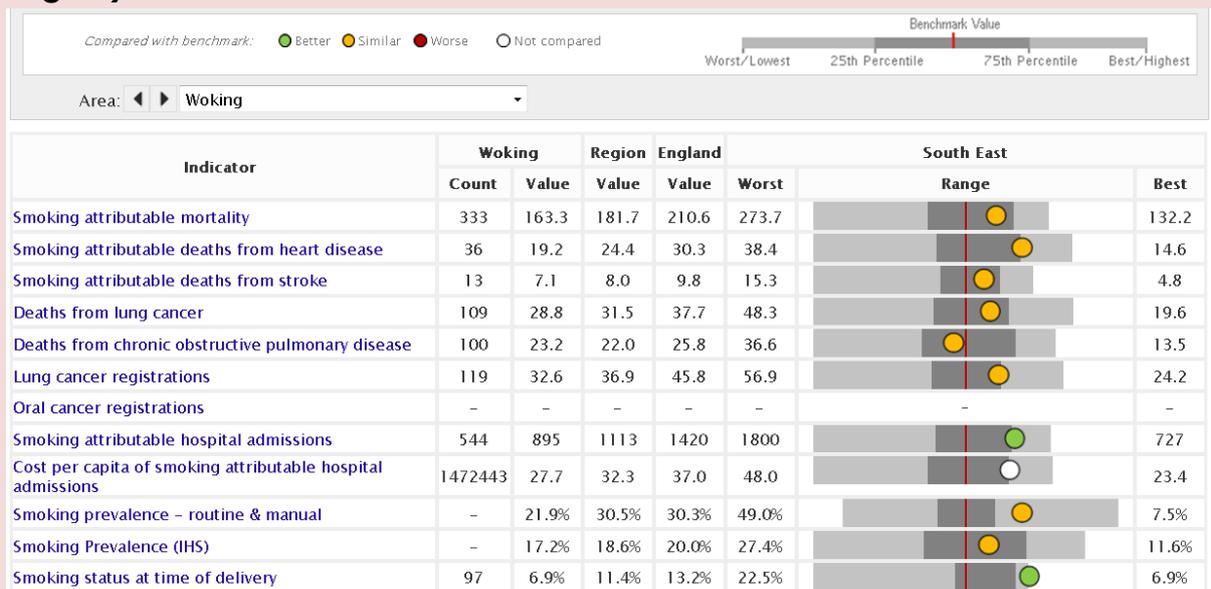


Figure 35: Local Tobacco Control Profile for Woking (Benchmark: South East Region)



⁶⁶ Source: Local Tobacco Control Profiles for England, produced by Public Health England, available at <http://www.tobaccoprofiles.info/tobacco-control#qjd/1000110/par/E12000008/ati/101/page/1/> accessed 25th July 2013

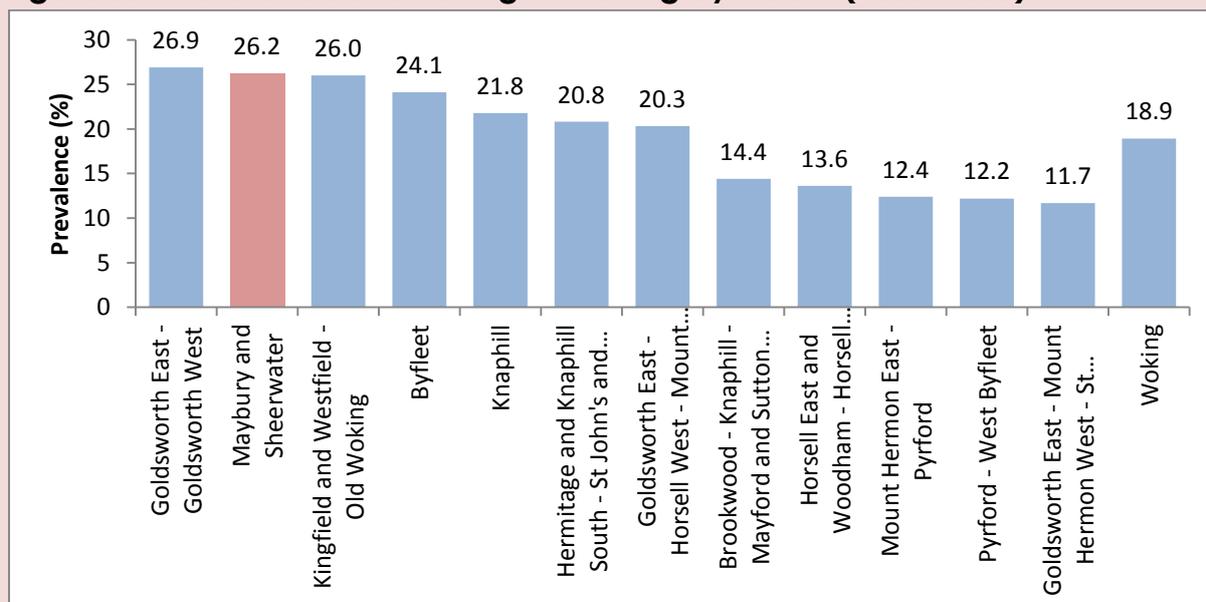
These data show that for all indicators, smoking prevalence, morbidity, and mortality are similar to or better than the regional and national average. However, it is still the case that smoking remains the biggest killer in Woking, and there is a significant gap between the performance of Woking and the best performance in the South East/England. For example:

- Smoking attributable mortality in Woking is 38.1/100,000 population over 35 higher than the national best.
- Deaths from COPD in Woking are almost double the national best, at 11.3/100,000 population higher.
- Hospital admissions from smoking in Woking are 168/100,000 over 35s higher than the national best.

It is also important to note that tobacco smoking is unique in that there is no safe level of consumption, and significant health and economic benefits can be gained from targeting a smoking prevalence of zero.

The following chart shows the relative prevalence of smoking in Maybury and Sheerwater compared with other MSOAs and the Woking average in 2003-2005 (synthetic estimates). As discussed above, these data are provided to show the relative burden of smoking in Maybury and Sheerwater relative to the Woking average, and not as an indicator of smoking prevalence in Maybury and Sheerwater today.

Figure 36: Prevalence of smoking in Woking by MSOA (2003-2005)⁶⁷



⁶⁷ Source: ONS model based estimates 2003-2005, available at <http://neighbourhood.statistics.gov.uk/dissemination/LeadTableView.do?a=3&b=6281668&c=Woking+004&d=140&e=6&q=6471050&i=1001x1003x1004&m=0&r=1&s=1370532812195&enc=1&dsFamilyId=969> accessed 25th July 2013

These data show that Maybury and Sheerwater (MSOA Woking 004) had the second highest prevalence of smoking in Woking, with a prevalence of 26.2% compared with the Woking average of 18.9%. The Woking prevalence has now fallen to 17.2%, and it is likely that Maybury and Sheerwater still has a smoking prevalence markedly above this.

The Stop Smoking Service in Maybury and Sheerwater

The NHS supports smokers to quit in a variety of ways, including Stop Smoking services, which GPs can refer patients to, postal 'Quit Kits', and other local initiatives. The Surrey NHS Stop Smoking Service has consistently generated the highest 4-week quit success rate in the South East, and been the most cost-effective.

However, despite this, engaging residents in Maybury and Sheerwater has historically been very difficult. With regard to GP practices, the Stop Smoking team have noted that despite consulting on the best time of day/week to hold clinics, attendance is generally very poor, and most clinics have had to close. One specific issue that was noted with regard to College Road Surgery was the high number of non-English speakers requiring service provision by a Punjabi speaking nurse, which was not available. A clinic at West Byfleet Health Centre is currently still running, albeit with small numbers.

With regard to community provision, recently a clinic that was trialled at the Children's Centre closed due to poor attendance, another clinic at Parkview Community Centre closed due to poor attendance, a well attended clinic at Woking Leisure Centre close due to changes in requirements for the storage of client sensitive data, and historical experience with the mosque showed that clinics there were poorly attended too.

The general picture is that when clinics have been set up, generally they have been very poorly attended, and this has historically been a very difficult community to engage with.

In summary, smoking remains the biggest cause of preventable deaths in Maybury and Sheerwater, and the prevalence in Maybury and Sheerwater is likely to be markedly above the Woking average. However, despite this the Stop Smoking service has historically found it very difficult to engage the local community in the service, and low numbers of attendees have meant that most clinics have had to close.

The recommendations are:

1. Reducing smoking prevalence and uptake must form a key part of any strategy aimed at improving health in Maybury and Sheerwater. A targeted approach to addressing smoking in the local population as part of a larger Woking-wide strategy to tackle the final 17.2% of the population that continue to smoke will be an effective use of resources.
2. However, alongside provision of a Stop Smoking service, engagement with residents to encourage and support them to use these services is a key component, and local stakeholders should consider how this might be done. One example might include increasing the delivery of health improvement messages in key community spaces e.g. shops, churches and mosques, and leisure facilities.
3. 9 out of 10 smokers start before their 19th birthday, so working together with schools will also be a key part of the strategy to reduce uptake. This may take the form of specific training for teachers, or a specific programme of health teaching delivered by health professionals.
4. Commissioners, planners, and providers should consider novel approaches where traditional approaches fail, as cigarette smoking carries such a huge burden of health and economic costs.

4.2 Alcohol

Why is alcohol an important health issue?⁶⁸

After tobacco and hypertension, alcohol is the third greatest overall contributor to ill health, accounting for over 1 million admissions to hospital per year for over 40 alcohol related conditions.

Those consuming at 'increasing risk' levels of more than 3-4 units (for men) or 2-3 units (for women) daily, have a significantly increased risk of developing head and neck cancer, cirrhosis, hypertension, coronary heart disease, and stroke. At 'higher risk' levels of more than 8 units per day/50 units per week (for men) or 6 units per day/35 units per week (for women) these risks rise markedly.

Local authorities have a responsibility to address health inequalities, and those in the most deprived quintile (including part of Maybury and Sheerwater) are 3-5 times more likely to die of an alcohol-specific cause and 2-5 times more likely to be admitted to hospital because of an alcohol-use disorder.

Why is alcohol an important economic issue?⁶⁹

The cost to society in the UK from alcohol is estimated to be nearly £21bn per year, including:

- £11bn in crime
- £7.3bn in lost productivity
- £3.5bn in NHS care

In Surrey, the estimated alcohol-related healthcare costs are £71.2m, or £78 per adult. This includes:

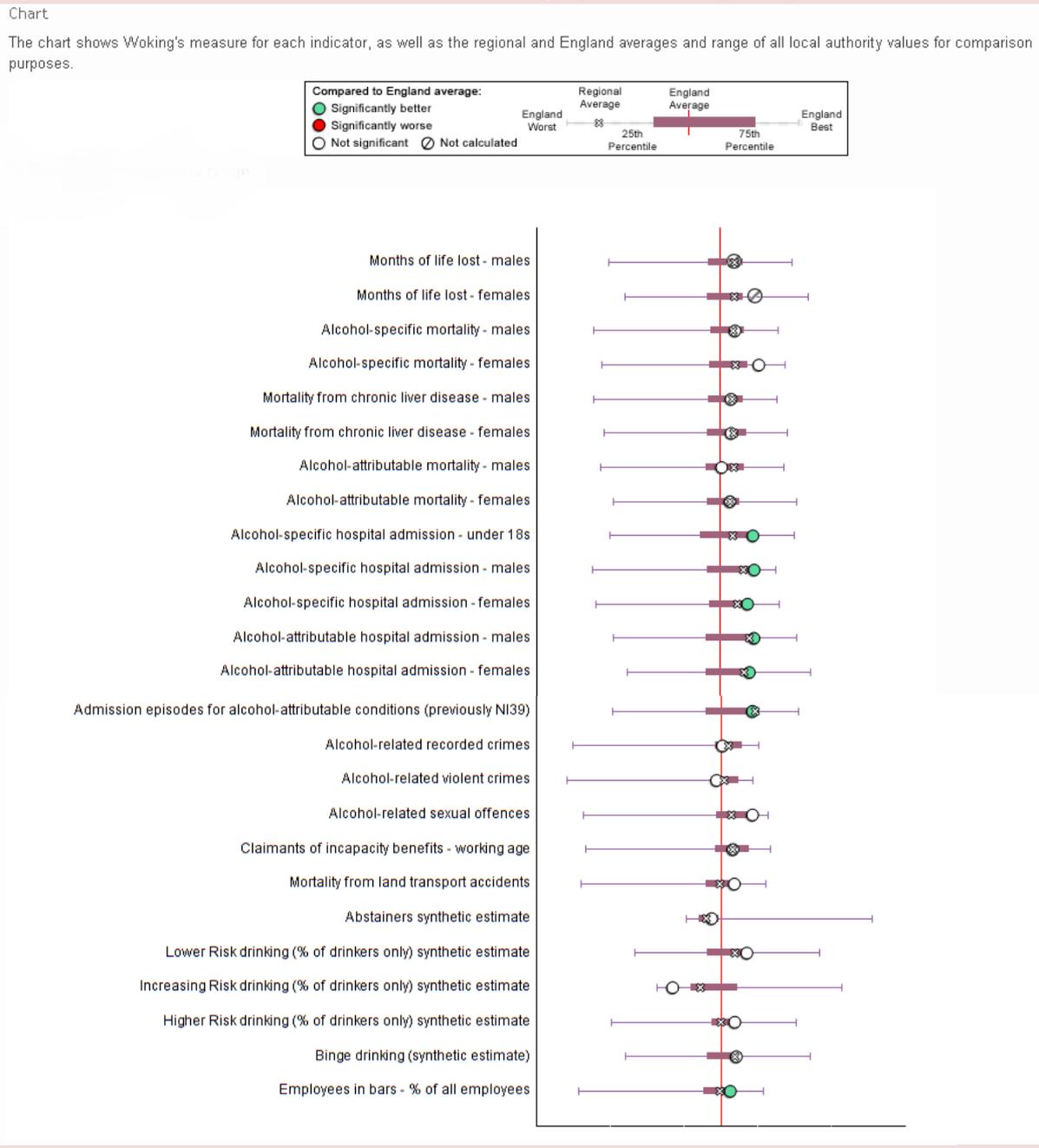
- £12m in A&E attendances
- £43.4m in inpatient admissions
- £15.8m in outpatient attendances

⁶⁸ Source: NICE local government public health briefing on alcohol, available at <http://publications.nice.org.uk/alcohol-phb6> accessed 25th July 2013, and NHS Choices Alcohol Pages, available at <http://www.nhs.uk/Livewell/alcohol/Pages/Effectsofalcohol.aspx> accessed 25th July 2013

⁶⁹ Source: Costs to society in the UK from alcohol taken from NICE local government public health briefing on alcohol (link in preceding footnote), alcohol-related healthcare costs in Surrey taken from Alcohol Concern Alcohol Harm Map, available at <http://www.alcoholconcern.org.uk/campaign/alcohol-harm-map> accessed 25th July 2013

The following three figures are reproduced from the Local Alcohol Profile for Woking.⁷⁰ The first figure shows the performance of Woking against the regional and national average for a range of alcohol related indicators on a spine chart, and the second figure shows this data in table format. The final figure shows a range of trend charts for alcohol related indicators in Woking over the last few years.

Figure 37: Local Alcohol Profile for Woking spine chart(2012)

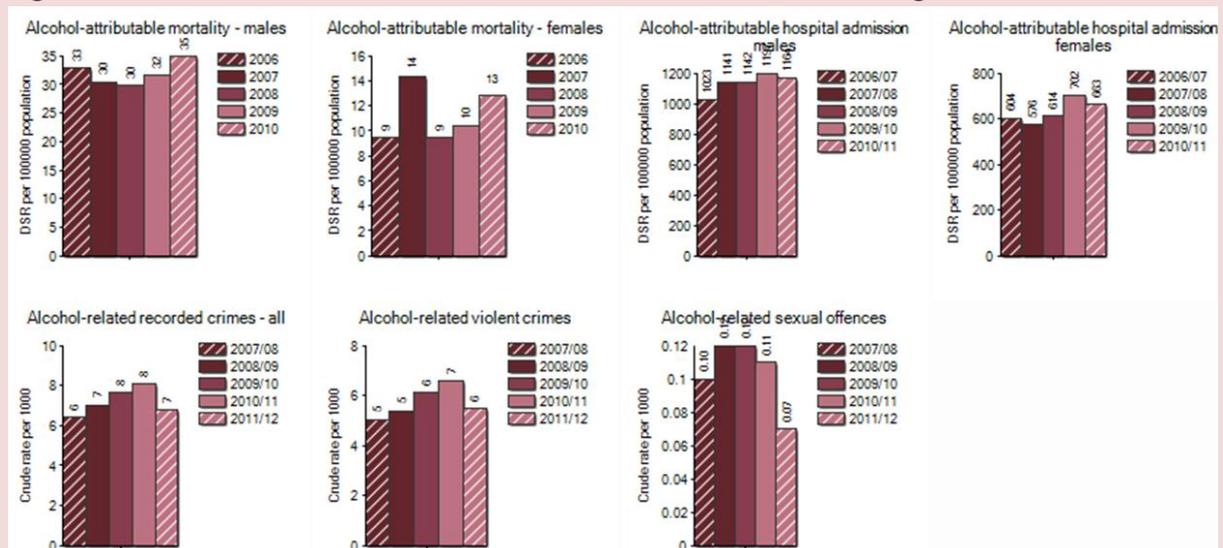


⁷⁰ Local Alcohol Profiles for England (LAPE) available at <http://www.lape.org.uk/LAProfile.aspx?reg=j> last accessed 7th June 2013

Figure 38: Local Alcohol Profile for Woking table

	Indicator	Measure	National Rank	Regional Average
1	Months of life lost - males	7.7	127	7.6
2	Months of life lost - females	2.6	30	3.5
3	Alcohol-specific mortality - males	9.7	122	10.1
4	Alcohol-specific mortality - females	2.4	33	4.6
5	Mortality from chronic liver disease - males	11.0	144	10.7
6	Mortality from chronic liver disease - females	5.8	136	5.5
7	Alcohol-attributable mortality - males	34.8	185	30.9
8	Alcohol-attributable mortality - females	12.8	131	12.8
9	Alcohol-specific hospital admission - under 18s	30.6	72	45.9
10	Alcohol-specific hospital admission - males	257.4	62	318.0
11	Alcohol-specific hospital admission - females	143.4	68	173.3
12	Alcohol-attributable hospital admission - males	1164.0	75	1207.9
13	Alcohol-attributable hospital admission - females	662.7	68	695.5
14	Admission episodes for alcohol-attributable conditions (previously NI39)	1489.7	90	1455.1
15	Alcohol-related recorded crimes	6.8	210	6.1
16	Alcohol-related violent crimes	5.5	239	4.7
17	Alcohol-related sexual offences	0.1	31	0.1
18	Claimants of incapacity benefits - working age	69.2	169	69.8
19	Mortality from land transport accidents	0.9	73	1.3
20	Abstainers synthetic estimate	15.4	109	14.7
21	Lower Risk drinking (% of drinkers only) synthetic estimate	72.3	60	72.7
22	Increasing Risk drinking (% of drinkers only) synthetic estimate	21.3	311	20.5
23	Higher Risk drinking (% of drinkers only) synthetic estimate	6.5	81	6.8
24	Binge drinking (synthetic estimate)	17.9	98	18.1
25	Employees in bars - % of all employees	1.6	82	2.0

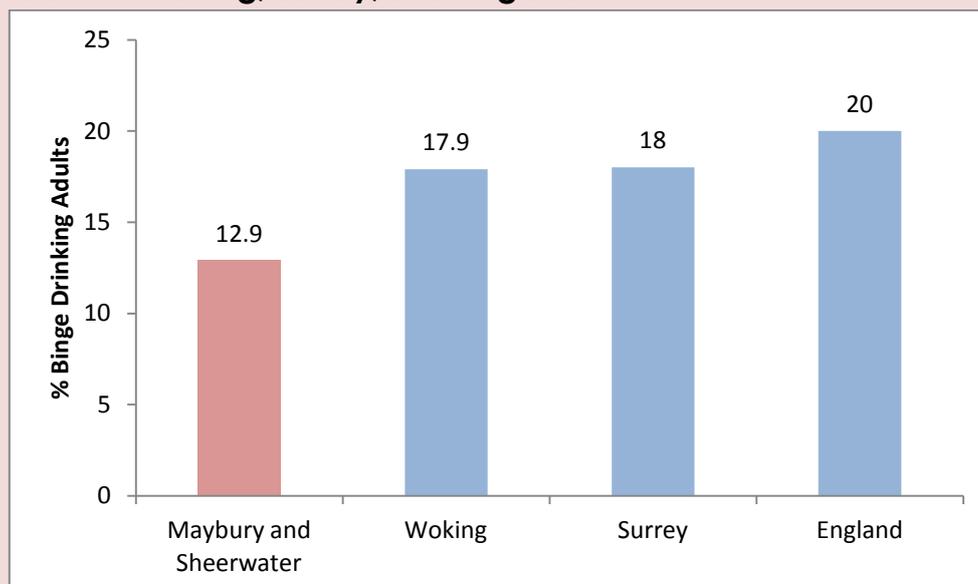
Figure 39: Trend charts from Local Alcohol Profile for Woking



These data show that Woking has the 16th highest prevalence of increasing risk drinkers of 326 local authorities in England (as a percentage of drinkers only) at 21.3%, compared with a regional average of 20.5%. Other important areas where Woking falls below the regional average include alcohol attributable mortality in males (34.8 vs. 30.9 per 100,000 population), alcohol related crimes (6.8 vs. 6.1 per 1,000 population) and alcohol related violent crimes (5.5 vs. 4.7 per 1,000 population). Please note, however, that in terms of statistical significance at the 95% confidence level, Woking performs better than or not statistically different to the national average on all alcohol related indicators. The trend charts show the performance on certain indicators between 2006 and 2012 (varies by indicator), and there is no clear trend established for any of the indicators.

The following chart shows the relative prevalence of binge drinking in Maybury and Sheerwater compared with the Woking, Surrey, and England average in 2006-2008 (modelled estimates based on individual-level data from the Health Survey for England). As discussed above, these data are provided to show the relative burden of binge drinking in Maybury and Sheerwater relative to the Woking average, and not as an indicator of binge drinking prevalence in Maybury and Sheerwater today. It should also be noted that binge drinking is only one indicator of harmful alcohol use, but is the only indicator that is modelled at ward/MSOA level so is included here.

Figure 40: Prevalence of binge drinking in Maybury and Sheerwater compared with Woking, Surrey, and England⁷¹



⁷¹ Source: Public Health England Local Health Profiles, available at <http://www.localhealth.org.uk/#z=488649,165613,24180,16132;y=map4;i=t2.bingedrinking;l=en> accessed 25th July 2013. Original data source for this data: PHOs (now part of PHE), NHS IC, based on HSE 2007-8 reported results.

These data show that Maybury and Sheerwater has a lower prevalence of binge drinking than the Woking, Surrey, and national average, with a prevalence of 12.9% compared with the Woking average of 17.9%, Surrey average of 18%, and national average of 20%.

In summary, whilst Woking has a major problem with harmful levels of drinking (in the worst 5% of local authorities), using the indicator of binge drinking Maybury and Sheerwater is likely to have much lower levels than the rest of Woking. This is consistent with the ethnic/religious make-up of the population. However, Sheerwater (as distinct from Maybury) is likely to have higher rates of alcohol related harm, and harmful alcohol use has multiple health and economic consequences, so is an important issue that needs tackling.

The recommendations are:

1. A targeted approach to alcohol harm reduction in Maybury and Sheerwater over and above a Woking-wide strategy is unlikely to be an effective use of resources.
2. However, any strategy to improve the health of the local population must take into account the harms associated with high levels of alcohol consumption, which remains one of the biggest risk factors for ill health. Accordingly, stakeholders should ensure the effective implementation of a Surrey and Woking wide alcohol harm reduction strategy, with Maybury and Sheerwater included in the delivery of that plan.

4.3 Diet and exercise

Why are diet and exercise important health issues?⁷²

Dietary factors are a significant cause of hypertension, cardiovascular disease, diabetes, and some cancers (e.g. colorectal cancer). Important dietary factors include being low in fruits, low in nuts and seeds, high in sodium, low in vegetables, high in processed meat, low in fibre, low in whole grains, and low in polyunsaturated fatty acids.

Likewise, physical activity is essential for good health. Physically active adults have a 20-30% reduced risk of premature death, and up to 50% reduced risk of developing major chronic diseases.

Local authorities have a responsibility to tackle health inequalities, and children and adults from lower socioeconomic groups and some black and minority ethnic groups do less sport and exercise, and are less likely to have a healthy diet than those in higher socioeconomic groups.

Why are diet and exercise important economic issues?⁷³

In England the costs of lost productivity from sickness absence and premature death have been estimated at £6.5bn. Physical activity programmes at work have been found to reduce absenteeism by up to 20%, and physically active workers take 27% fewer sick days.

Inactivity costs the NHS an estimated £1.06bn per year in direct costs. Also, walking or cycling instead of using motorised transport can help reduce the associated costs of poor air quality, congestion and collisions in urban areas of England. Each of these issues costs society around £10bn per year.

The cost to society in the UK from people being overweight or obese was estimated to be £16bn in 2007, including:

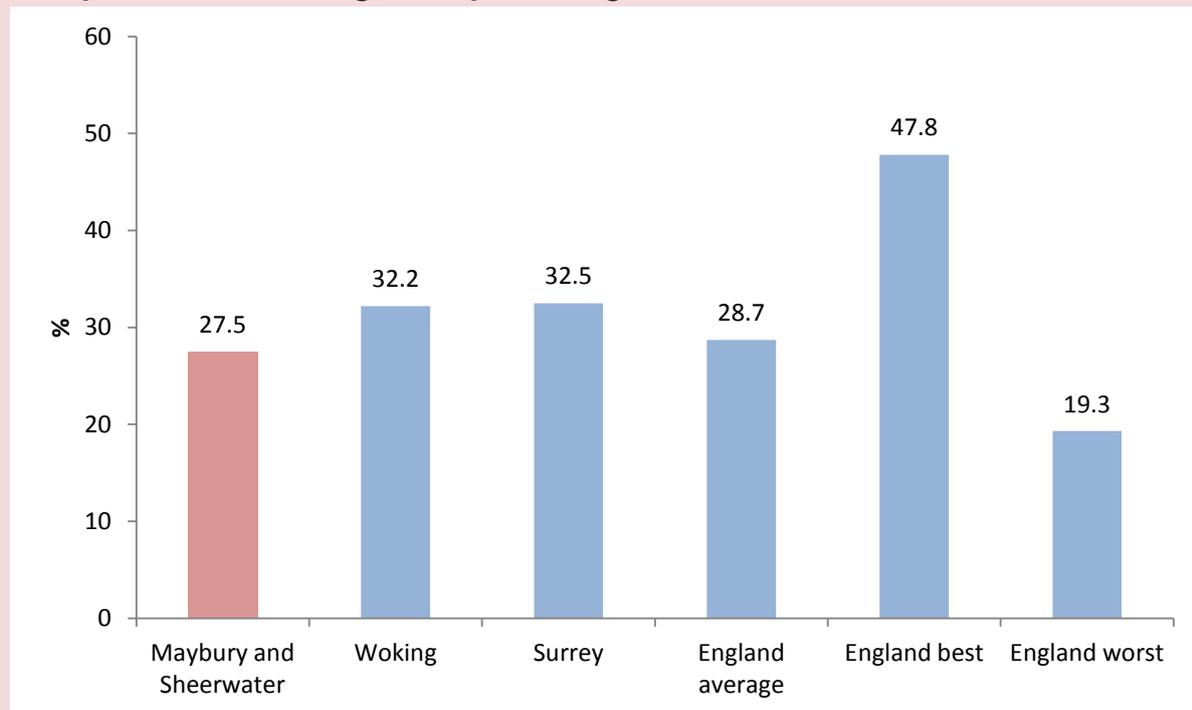
- £5.1bn in NHS care
- £11.6bn in unemployment, early retirement, and welfare benefits
- This is projected to increase from £16bn to £50bn in 2050, not including the provision of social care by local authorities

⁷² Source: NICE local government public health briefings on preventing obesity and helping people to manage their weight, available at <http://publications.nice.org.uk/phb9> and physical activity, available at <http://publications.nice.org.uk/phb3/> accessed 25th July 2013

⁷³ Source: as previous reference

Figure 41 shows the percentage of healthy eating adults in Maybury and Sheerwater, compared with Woking, Surrey, and the England average, best, and worst. These data are modelled estimates from the Health Survey for England Surveys 2006-2008, as recorded by the Public Health England Local Health Profiles.

Figure 41: Percentage healthy eating adults in Maybury and Sheerwater, compared with Woking, Surrey and England⁷⁴



This shows that a lower proportion of adults in Maybury and Sheerwater eat healthily than the Woking average (27.5% vs. 32.2%), or the Surrey average (27.5% vs. 32.5%). The difference from the national average (28.7%) is not statistically significant. However, the England best is 47.8%, and indeed the ultimate goal is for the whole population to eat healthily, and so there is significant room for improvement.

⁷⁴ Source: PHE Local Health Profile for Maybury and Sheerwater (original data source HSE 2006-2008), available at http://www.localhealth.org.uk/#z=489104,169418,26090,18934;sid=6469;v=map4;l=en;sly=wards_eng_2011_sorted_sn_ap_DR accessed 25th July 2013

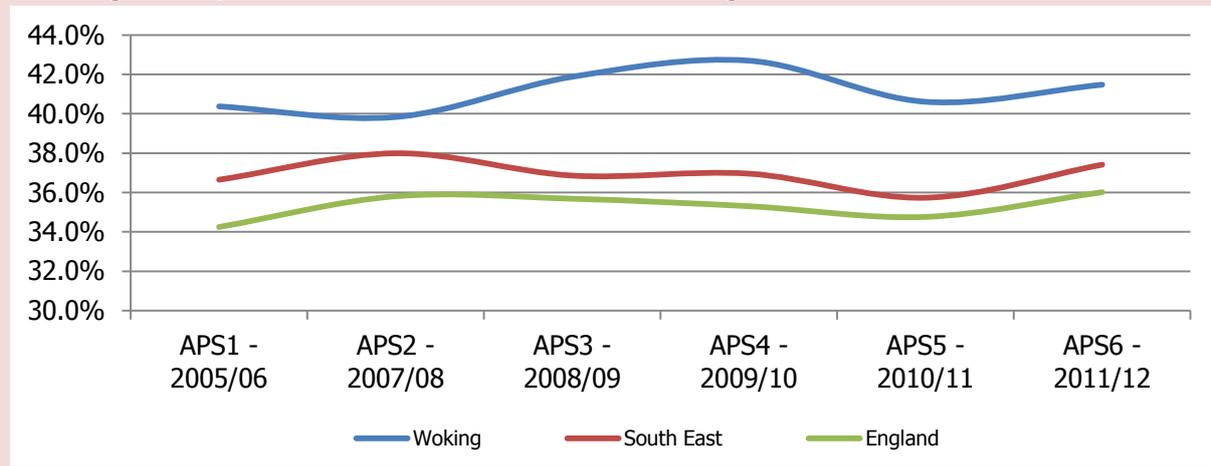
With regard to exercise, Sport England produce Local Sport Profile for each lower tier local authority, and the data for Woking is presented below.⁷⁵

Figure 42: Health costs of physical inactivity in Woking, compared with the South East and England

Geography	The Health Costs of Physical Inactivity by disease category					The Health Costs of Physical Inactivity	
	Cancer lower GI e.g. bowel cancer	Breast Cancer	Diabetes	Coronary heart disease	Cerebrovascular disease e.g. stroke	Total Cost	Cost per 100,000 pop
Woking	£121,587	£106,192	£268,274	£690,587	£306,780	£1,493,420	£1,625,625
South East	£9,709,321	£9,106,531	£27,701,104	£65,517,904	£21,137,006	£133,171,867	£1,580,313
England	£67,816,189	£60,357,887	£190,660,420	£491,095,943	£134,359,285	£944,289,723	£1,817,285

Source: Sport England commissioned data from British Heart Foundation Health Promotion Research Group for PCTs and reworked into estimates for LAs by TBR
Year: 2009/10, Measure: Health costs of physical inactivity, split by disease type

Figure 43: Adult (16+) participation in sport (at least once a week*) by year in Woking, compared with the South East and England



*1 session a week (at least 4 sessions of at least moderate intensity for at least 30 minutes in the previous 28 days)
Source: Active People Survey, Year: 2005/06 (APS1), to 2011/12 (APS6), Measure: Adult participation

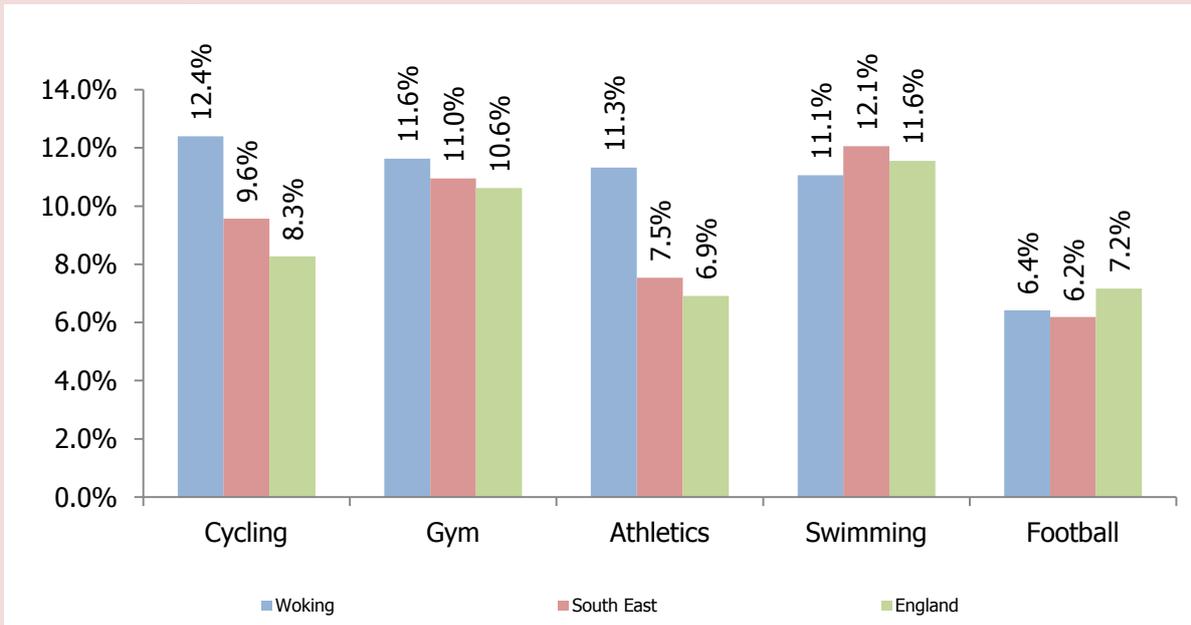
⁷⁵ Sport England Local Sport Profile tool available at <http://www.sportengland.org/our-work/local-work/local-government/local-sport-profile/> accessed 25th July 2013

Figure 44: Adult (16+) participation in sport and active recreation at least 3 times per week by year and gender in Woking, compared with the South East and England



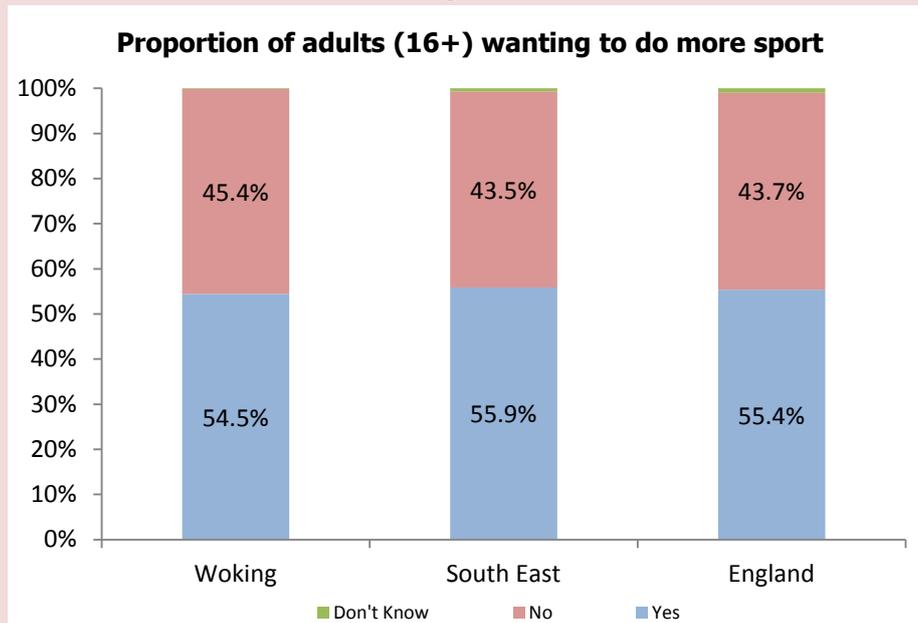
Source: Active People Survey 2005/6 to 2011/12. Measure: Adult participation

Figure 45: Participation in top 5 sports in Woking, compared with the South East and England



Source: Active People Survey 6, Population data: ONS Annual Population Survey 2012. Measure: Participation rate of the top 5 sports and the number of adults (16+) that participate at least once per month.

Figure 46: Proportion of adults (16+) wanting to do more sport in Woking, compared with the South East and England



Source: Active People Survey 6. Population data: ONS Annual Population Survey 2012. Measure: Top sports in latent demand by adults (16+) based on proportion.

These data show that in Woking, the estimated cost of physical inactivity in 2009/10 was almost £1.5m, and that cost will be higher today. Additionally, whilst the rates of adult participation in sport at least once a week is higher in Woking (40-42%) than the South East average (36-38%) or England average (34-36%), the rates for exercising 3 times per week are now lower than the South East average (22.5% vs. 24.7%). This is predominantly due to lower rates in men, and reflects that rates increased in the South East from 2005/6 to 2010/12 whilst the Woking rates remained static. Also instructive from the perspective of planners and commissioners, the top 5 sports in Woking are cycling, gym, athletics, swimming, and football, and over 50% of the local population would like to do more sport. Addressing the barriers to increased levels of exercise will increase health gains and reduce the economic costs due to physical inactivity.

At the ward level, data is available from the Sport England Market Segmentation Tool,⁷⁶ which divides the population into 19 'segments', each with different attitudes to sport, participation rates, motivations for taking part, and barriers to increased uptake. The overview for Maybury and Sheerwater is illustrated in figure 47, and a description of the 5 dominant 'sectors' follows in figure 48.

⁷⁶ Sport England Market Segmentation Web Tool, available at <http://segments.sportengland.org/index.aspx#segment=dominant&focusType=PC&focusName=GU215PB&catchmentParam=1000>, accessed 25th July 2013

Figure 47: Sport England Segments for Maybury and Sheerwater

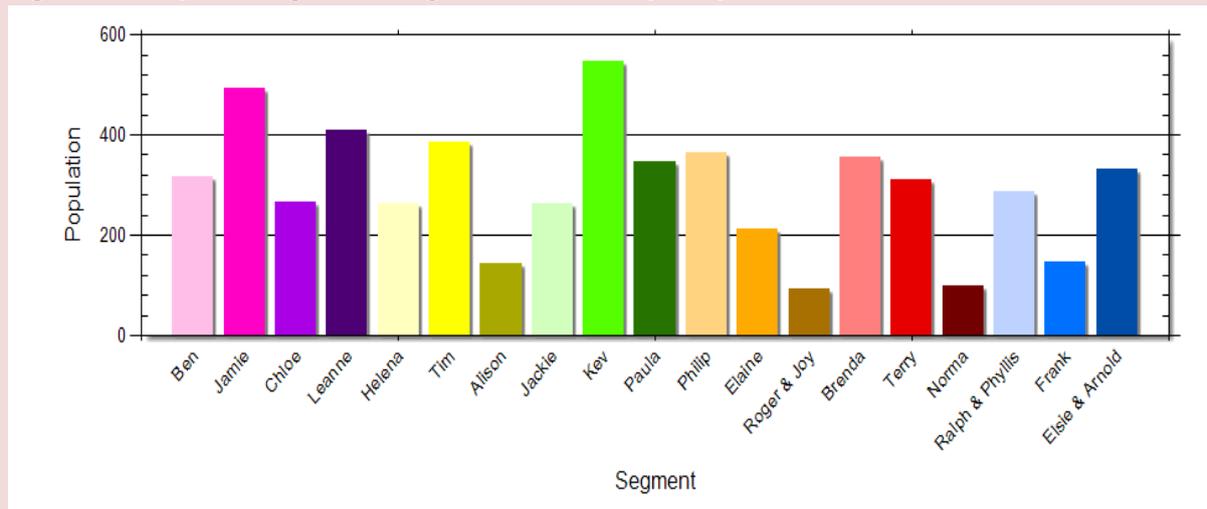


Figure 48: Profile of top 5 Sport England Segments

Segment	Key characteristics	Current sport activities	Motivators	Barriers
Kev	<p>“Blokes who enjoy pub league fames and watching live sport”</p> <p>Aged 36-45 Married or single May have children Vocational job</p>	<p>Keep fit/gym (14%) Football (12%) Cycling (11%) Swimming (10%)</p> <p>30 minutes of moderate intensity exercise: ≥ 1/wk 42% ≥ 2/wk 29% ≥ 3/wk 17%</p>	<p>Enjoyment (43%) Keeping fit (30%) Socialising (14%) Take children (9%) Lose weight (5%)</p> <p>Would do more sport if: Less busy (48%) Cheaper (21%) People to go with (12%) Better facilities (9%)</p>	<p>62% would like to do more sport, barriers include:</p> <p>Work (32%) Other* (26%) Health/injury/disability (22%) Lack of time (15%)</p>
Jamie	<p>“Young blokes enjoying football, pints and pool”</p> <p>Aged 18-25 Single Vocational student</p>	<p>Football (28%) Keep fit/gym (22%) Athletics (12%) Cycling (12%) Swimming (10%)</p> <p>30 minutes of moderate intensity exercise: ≥ 1/wk 59% ≥ 2/wk 42% ≥ 3/wk 31%</p>	<p>Enjoyment (54%) Keeping fit (37%) Socialising (22%) Improve performance (9%) Lose weight (7%)</p> <p>Would do more sport if: Less busy (40%) Company (23%) Cheaper (20%) Better facilities (13%)</p>	<p>40% would like to do more sport, barriers include:</p> <p>Other* (33%) Work (27%) Lack of time (22%) Health/injury/disability (13%)</p>

Segment	Key characteristics	Current sport activities	Motivators	Barriers
Leanne	<p>"Young busy mums and their supportive college mates"</p> <p>Aged 18-25 Likely to have children Student/part time vocational</p>	<p>Keep fit/gym (23%) Swimming (18%) Athletics (9%) Cycling (6%) Football (4%)</p> <p>30 minutes of moderate intensity exercise: ≥ 1/wk 42% ≥ 2/wk 25% ≥ 3/wk 17%</p>	<p>Enjoyment (44%) Keep fit (34%) Socialising (15%) Lose weight (13%) Take children (7%)</p> <p>Would do more sport if: Less busy (42%) Cheaper (26%) Company (21%) Better opening hours (12%) Better facilities (8%)</p>	<p>42% would like to do more sport, barriers include:</p> <p>Work (35%) Other * (25%) Lack of time (17%) Family (17%) Health/injury/disability (5%)</p>
Tim	<p>"Sporty male professionals, buying a house, and settling down with a partner"</p> <p>Aged 26-45 Married or single May have children Professional</p>	<p>Cycling (21%) Keep fit/gym (20%) Swimming (15%) Football (15%) Athletics (13%)</p> <p>30 minutes of moderate intensity exercise: ≥ 1/wk 62% ≥ 2/wk 38% ≥ 3/wk 27%</p>	<p>Enjoyment (52%) Keep fit (42%) Socialising (17%) Take children (12%) Improve performance (9%)</p> <p>Would do more sport if: Less busy (59%) Cheaper (11%) More free time (11%) Company (10%) Better facilities (6%)</p>	<p>59% would like to do more sport, barriers include:</p> <p>Work (36%) Other * (23%) Lack of time (16%) Health/injury/disability (16%)</p>
Phillip	<p>"Mid-life professional, sporty males with older children and more time for themselves"</p> <p>Aged 46-55 Married with children Full time employment and owner-occupier</p>	<p>Cycling (16%) Keep fit/gym (15%) Swimming (12%) Football (9%) Golf (8%)</p> <p>30 minutes of moderate intensity exercise: ≥ 1/wk 51% ≥ 2/wk 29% ≥ 3/wk 19%</p>	<p>Enjoyment (48%) Keep fit (34%) Socialising (17%) Take children (13%) Lose weight (6%)</p> <p>Would do more sport if: Less busy (59%) Cheaper (12%) More free time (10%) Company (9%) Better facilities (5%)</p>	<p>59% would like to do more sport, barriers include:</p> <p>Work (31%) Health/injury/disability (30%) Other* (21%) Lack of time (14%) Family (4%)</p>

*Other barriers include: 'left school', 'no opportunity' and 'economic/work factors'

These data give an indication as to the most common sport and exercise behaviours of the population of Maybury and Sheerwater. Common themes include the finding that most people that engage in sport/exercise do so because they enjoy it, followed by to keep fit, followed by to socialise. Importantly, at least 40% of these groups would like to do more exercise, and examining the barriers and motivations are an important component of maximising this and increasing rates of exercise in the local population.

In summary, the levels of healthy eating in Maybury and Sheerwater are lower than the Woking and Surrey average, and markedly lower than the England best levels. There is no survey data to indicate the level of physical activity in Maybury and Sheerwater, but it is generally the case that people want to do more sport and exercise, and the Sport England Segments in Maybury and Sheerwater describe motivators and barriers to assist with this.

The recommendations are:

1. For planners and commissioners to carefully consider how to increase the proportion of residents that eat healthily. This merits a specific targeted approach for Maybury and Sheerwater, both with regard to the lower levels of healthy eating and poor health, and with regard to the ethnic make-up and specific dietary preferences.
2. With regard to increasing levels of sport and exercise, decision-makers should have regard to the motivators and barriers described above when planning strategies and interventions.

4.4 Illicit drug use

Why is illicit drug use an important health issue?⁷⁷

Whilst the number of people with a serious drug dependency is relatively small, drug misuse and dependency affects the user, their family, friends, communities, and society at large. Many communities across England have experienced the debilitating effects of people using the most destructive substances, heroin and crack:

- Crime
- Drug litter
- The spread of blood-borne viruses
- Drug related deaths

Effective treatment is the best way of tackling the harm that drug dependency can cause, helping users overcome their addiction, reducing involvement in crime, sustaining their recovery, and enabling them to make a positive contribution to their family and community.

Whilst illicit drug use is falling, on the horizon the problems of new and prescription drugs, and the need to help former drug users find the jobs and houses that will sustain their recovery will require dedicated attention from all partners in local health and community bodies.

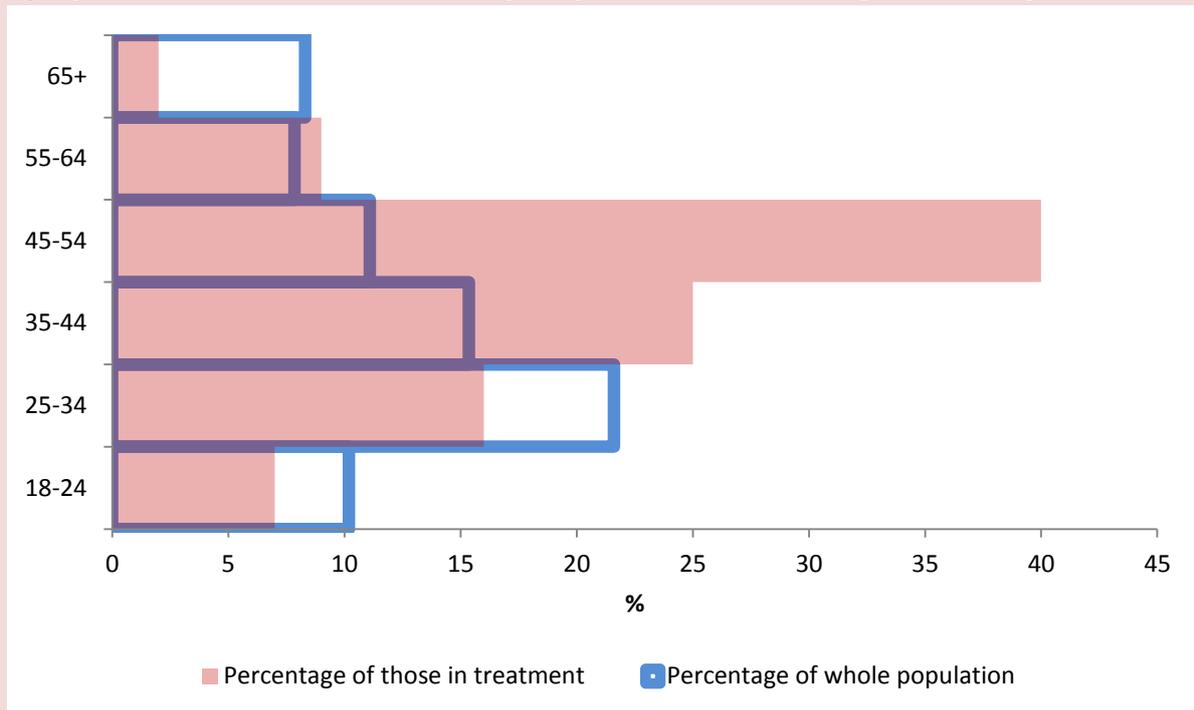
Due to the need to protect the confidentiality of service users in Maybury and Sheerwater, the precise numbers of clients of the Surrey Drug and Alcohol Team (DAAT) in Maybury and Sheerwater cannot be published.

However, in terms of highlighting the relative scale of substance misuse, the percentage of the 18-69 population in Maybury and Sheerwater who are 'in treatment' is over double the average rate in Surrey, and over 1.5 times the average rate in Woking.

Furthermore, the age profile of clients differs markedly from the age structure of Maybury and Sheerwater, as can be seen from figure 49.

⁷⁷ Source: National Treatment Agency for Substance Misuse (NTA), available at <http://www.nta.nhs.uk/> accessed 25th July 2013

Figure 49: Age profile of Maybury and Sheerwater population compared with age profile of DAAT clients in Maybury and Sheerwater (2012-2013)⁷⁸

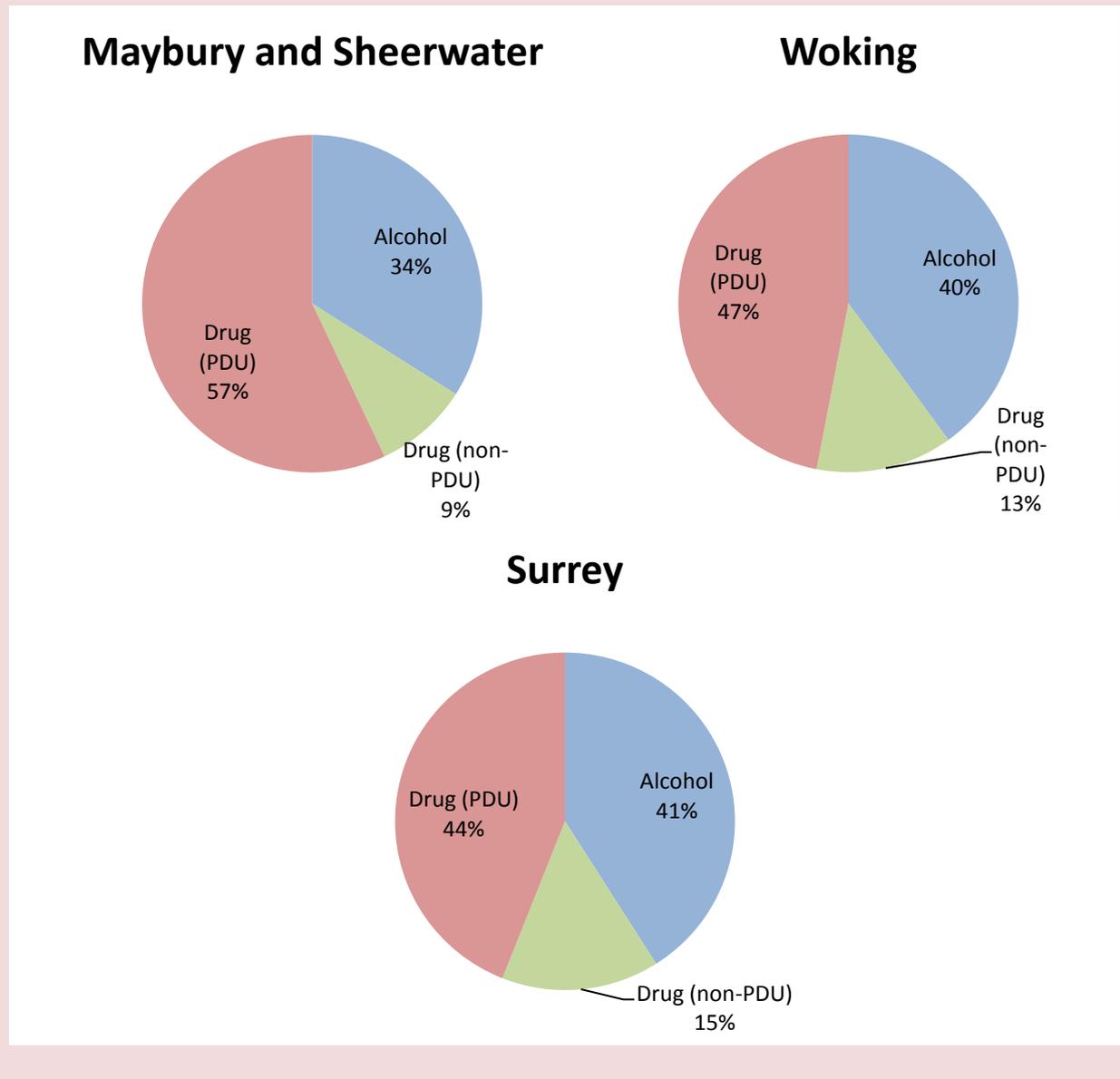


This chart clearly shows that despite the age distribution being weighted towards the younger age groups, a much greater proportion of clients are in the older age groups. This is an interesting finding, and one that merits further investigation in order to plan prevention and support services appropriately.

One further piece of data that should be highlighted is the split of service users between alcohol, 'problematic drug users' (opiates/crack cocaine), and 'non-problematic drug users' (all other drugs). The charts below show this for Maybury and Sheerwater, Woking, and Surrey to allow comparison.

⁷⁸ Source: DAAT/Surrey County Council confidential data set on clients in treatment with a care plan (2012/13). The presentation of this data in this report does not allow specific numbers to be identified, and is therefore permitted. The 18-24 age group in this chart is an estimate, as ward populations are only available by 5 year age group.

Figure 50: Comparison of distribution of DAAT service users between alcohol, problematic drug users (PDU), and non-problematic drug users (non-PDU) in Maybury and Sheerwater compared with Woking and Surrey (2012-2013)⁷⁹



These charts clearly show that the proportion of clients in treatment for alcohol in Maybury and Sheerwater (34%) is significantly lower than the Woking average (40%) or Surrey average (41%). Importantly, it is the problematic drug user percentage that is higher in Maybury and Sheerwater (57% vs. 47% in Woking and 44% in Surrey). Together with the previous data, this indicates that not only are a higher proportion of residents in treatment for substance misuse in Maybury and Sheerwater, but a larger proportion of

⁷⁹ Source: DAAT/Surrey County Council confidential data set on clients in treatment with a care plan (2012/13)

these were using opiates or crack cocaine. These data indicate that supporting local provision of services for substance misuse should be a priority area for commissioners.

In summary, the proportion of the resident adult population who are in treatment with the Drug and Alcohol Services (DAAT) in Maybury and Sheerwater is over double the Surrey average, and over 1.5 times the Woking average. There is a higher proportion of clients in older age groups (45-54), despite the population being much younger than the Woking or Surrey average. The proportion of those in treatment for alcohol is relatively low, as would be expected from the ethnic/religious makeup of the ward, but worryingly there is a markedly higher proportion of clients in treatment for problematic drug use, which include opiates and crack cocaine.

The recommendations are:

1. Stakeholders should support the Drug and Alcohol Team (DAAT) to develop a local strategy around both prevention and treatment, taking into account the root causes of drug and alcohol addiction, and working together to tackle these root causes.
2. Stakeholders should work together to support former drug users with employment, housing, and ongoing support in the community to support and sustain their recovery.

4.5 Immunisations

Why are immunisations important?

Immunisation programmes are one of the most significant public health interventions globally, estimated to have saved more lives than any other intervention.⁸⁰ The two periods in life where they are routinely given are childhood, to protect us from illnesses with serious morbidity and mortality e.g. measles, mumps, rubella, diphtheria, polio, and pertussis (whooping cough), and in old age to protect against excess winter morbidity and mortality from influenza and pneumonia. They are also given in the context of travel and lifestyle (e.g. Yellow Fever), and occupational protection (e.g. Hepatitis B in health workers), though these are not covered here.

Unfortunately, despite well-established national childhood immunisation programmes uptake has fallen over recent years, particularly for MMR, which has resulted in well-publicised measles outbreaks.⁸¹ A large reason for this was the unfortunate publication of a poor quality study purporting a link between the MMR jab and autism, a finding that could not be replicated in several much larger studies, leading to a full retraction of the article by the Lancet and the lead author being struck off the GMC.^{82,83,84} A 95% uptake of MMR immunisation is required for 'herd immunity' for measles, and so this is the target. Below this level of uptake, the disease is able to persist in the population allowing the possibility of outbreaks.

The data below, broken down by GP practice in Maybury and Sheerwater, show the uptake of primary (childhood) immunisations and seasonal flu and pneumonia vaccinations in adults. The data is charted, followed by tables showing the raw data to allow the numbers of individuals involved to be clearly understood.

⁸⁰ Bedford H, Elliman D. Concerns about immunisation. British Medical Journal. 2000; 320:240-243

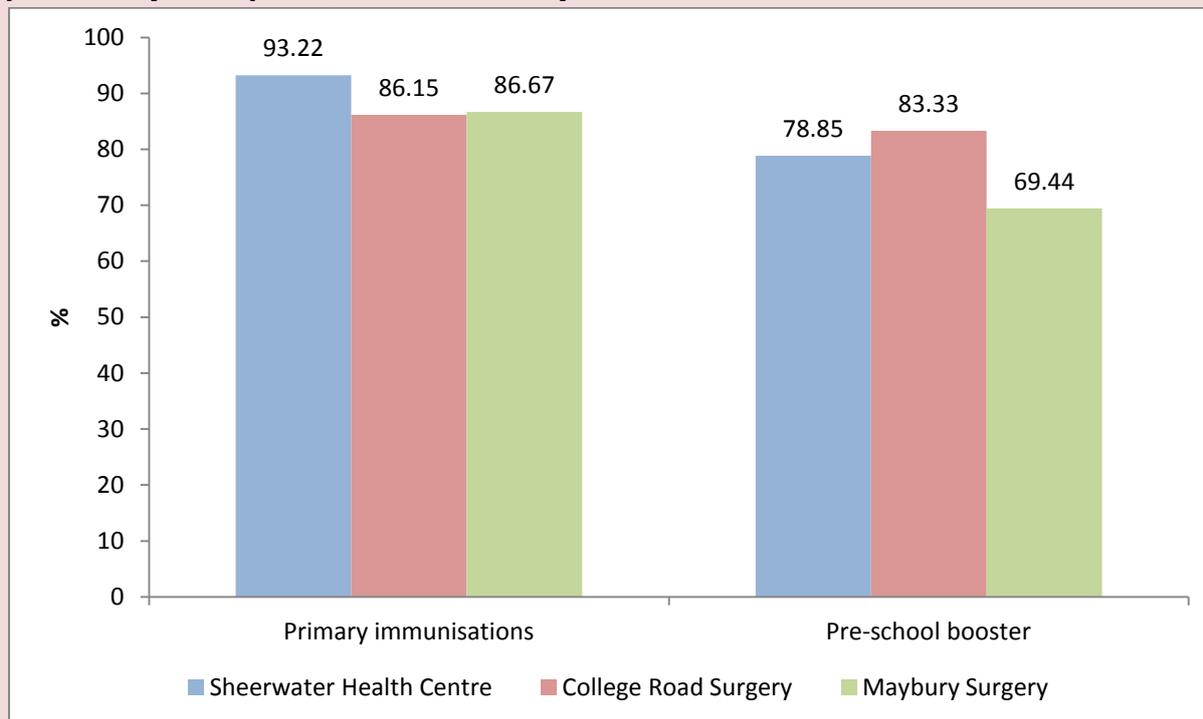
⁸¹ See, for example <http://www.independent.co.uk/life-style/health-and-families/health-news/50000-mmr-vaccinations-so-far-in-battle-to-halt-welsh-measles-epidemic-8619312.html> accessed 25th July 2013

⁸² Wakefield AJ et al. RETRACTED: Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children. The Lancet 1998; 351:637-641

⁸³ Dyer C. Lancet retracts Wakefield's MMR paper. BMJ 2010; 340:c696

⁸⁴ See www.gmc-uk.org where the registration status for the lead author 'Andrew Wakefield' is 'Not Registered – Erased after Fitness to Practise panel hearing', accessed 25th July 2013

Figure 51: Percentage of children aged 2-5 vaccinated with primary immunisations and pre-school boosters in Maybury and Sheerwater by GP practice (last 2 years, as of Q1 2013) ⁸⁵



Primary immunisations include: MMR, meningitis C, and Pediacel (diphtheria, tetanus, pertussis, Haemophilus influenza type b, and polio, (DTaP/Hib/IPV)). Pre-school booster includes: diphtheria, tetanus, pertussis, and polio (DTaP/IPV).

Figure 52: Uptake of primary immunisations and pre-school boosters in 2-5 year olds in Maybury and Sheerwater by GP practice (last 2 years, as of Q1 2013)

GP Practice	% had primary immunisations	% had pre-school booster
Sheerwater Health Centre	93.22	78.85
College Road Surgery	86.15	83.33
Maybury Surgery	86.67	69.44

The Open Exeter dataset is the most accurate dataset for primary immunisations in GP practices, as it is the dataset on which payments are based (as childhood immunisations are a Directed Enhanced Service, DES). However, the dataset does not separate the rates of MMR from Meningitis C or DTaP/Hib/IPV. Therefore, it is not possible to say which practices are

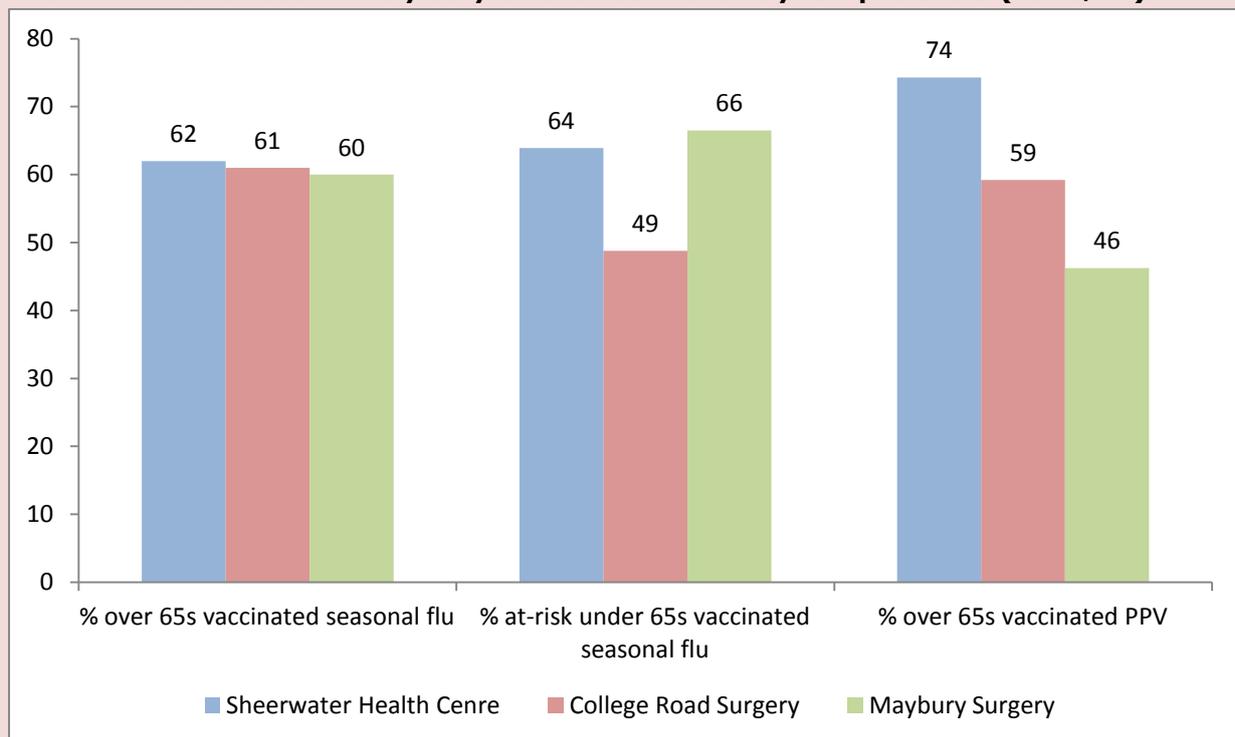
⁸⁵ Source: Open Exeter, Q1 2013

meeting the 95% herd immunity threshold for MMR and which practices are not.

The UK COVER (Cover of Vaccination Evaluated Rapidly) dataset which is collected by the HPA Health Protection Services (HPS) does separate the different immunisations to allow the specific rates to be identified. However, this data is not accurate for many practices, including those in Maybury and Sheerwater, as the appropriate data is not routinely uploaded. This dataset allows for a more sophisticated analysis and GP practices in Maybury and Sheerwater should strongly consider uploading this data routinely in order to better target quality improvement.

What can be said from the available data is that variation exists between practices, and the rates of uptake for the pre-school booster show that there is a significant drop-off from the primary immunisations. This is an area for practices to work on.

Figure 53: Uptake of seasonal flu vaccine in over 65s and at-risk under 65s, and PPV in over 65s in Maybury and Sheerwater by GP practice (2010/11)⁸⁶



⁸⁶ Source: QoF data available at <https://indicators.ic.nhs.uk/webview/> accessed 19th August 2013

Figure 54: Uptake of seasonal flu vaccine and PPV in over 65s in Maybury and Sheerwater by GP practice (2010/11)

GP Practice	Total no. of >65s	Over 65s vaccinated against seasonal flu (no.)	Over 65s vaccinated against seasonal flu (%)	Over 65s vaccinated with PPV (no.)	Over 65s vaccinated with PPV (%)
Sheerwater Health Centre	383	238	62	286	74
College Road Surgery	179	110	61	106	59
Maybury Surgery	91	55	60	43	46
Total	653	403	61.7	435	66.6

These data show that the average uptake of seasonal flu in over 65s is 61.7% (highest uptake in the country was 100% in one practice in Dudley) and the average uptake of PPV in over 65s in Maybury and Sheerwater was 66.6% (highest uptake in the country is was 100% in two practices in Newham). This indicates that there is significant room for improvement, whilst taking into account that there are many factors that influence the uptake of immunisations in older people.

Figure 55: Uptake of seasonal flu vaccine in at-risk groups⁸⁷ aged 6 months to 65 years in Maybury and Sheerwater by GP practice (2010/11)

GP Practice	Total at-risk population	At-risk population vaccinated against seasonal flu (no.)	At-risk population vaccinated against seasonal flu (%)
Sheerwater Health Centre	327	209	64
College Road Surgery	365	178	49
Maybury Surgery	185	123	66
Total	877	510	58.2

These data show that the average uptake of seasonal flu vaccine in at-risk groups in Maybury and Sheerwater is 58.2% (highest uptake in the country was 100% in three practices in Rotherham, North East Lincolnshire, and Ealing). This indicates again that there is significant room for improvement, taking into account that there are multiple factors that influence the uptake of seasonal flu vaccine in at-risk groups.

⁸⁷ At-risk groups include: chronic respiratory disease, chronic heart disease, chronic kidney disease, chronic liver disease, chronic neurological disease, diabetes, immunosuppression, and pregnancy. For further definitions please see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/152138/dh_129856.pdf.pdf accessed 25th July 2013

In summary, uptake of childhood vaccinations in Maybury and Sheerwater drops off between age 2 and the pre-school booster. Furthermore, vaccination uptake differs significantly between practices. Due to the limitations of the Open Exeter dataset, it is not possible to draw more specific conclusions from this data.

The recommendations are:

1. NHS Surrey and Sussex Area Team should continue to work together with the CCG and individual practices to increase uptake of immunisations through evidence based methods.
2. Other partners, including council officers, elected members, nurseries, schools, and community groups and centres should support these efforts to increase immunisation uptake in the young and elderly in order to improve health and reduce avoidable morbidity and mortality.
3. GP practices in Maybury and Sheerwater should upload accurate data routinely to the UK COVER database to allow a more robust analysis and better directed quality improvement.

4.6 Screening

Why is screening important?

Screening is the systematic testing of a particular population group at risk of a disease, which if detected and treated early, has a much better outcome. For example, the cervical screening programme can detect pre-cancerous lesions of the cervix, allowing removal of these lesions before cancer has developed. Without the screening programme in place, patients would only be picked up at a more advanced stage of disease, making treatment more difficult, and in some cases impossible. Likewise, the breast screening programme can detect early cancers before the woman has noticed them, and when they are much easier to treat.

The current national screening programmes for young persons and adults include:⁸⁸

- Breast screening programme (women 50-70 every three years)
- Cervical screening programme (women 25-50 every three years; women 50-64 every five years)
- Bowel cancer screening programme (all persons in their sixties every two years)
- Abdominal Aortic Aneurysm screening programme (men in the year they turn 65, or over 65s by appointment)
- Diabetic eye screening programme (diabetics aged 12 or over yearly)

The following data is reproduced from the Health and Social Care Information Centre (HSCIC) Indicator Portal for the breast screening, cervical screening, and bowel cancer screening programmes. The abdominal aortic aneurysm screening programme is currently being rolled out across the country.

⁸⁸ Antenatal and newborn screening programmes include: foetal anomalies, infectious diseases in pregnancy, antenatal and newborn sickle cell and thalassaemia, newborn and infant physical examination, newborn blood spot, and newborn hearing. For more information see <http://www.screening.nhs.uk/england> accessed 25th July 2013

Figure 56: Uptake of cervical screening, bowel screening, and breast screening in eligible patients in Maybury and Sheerwater by GP practice (cervical screening: 2010/11, bowel and breast screening 2012)⁸⁹

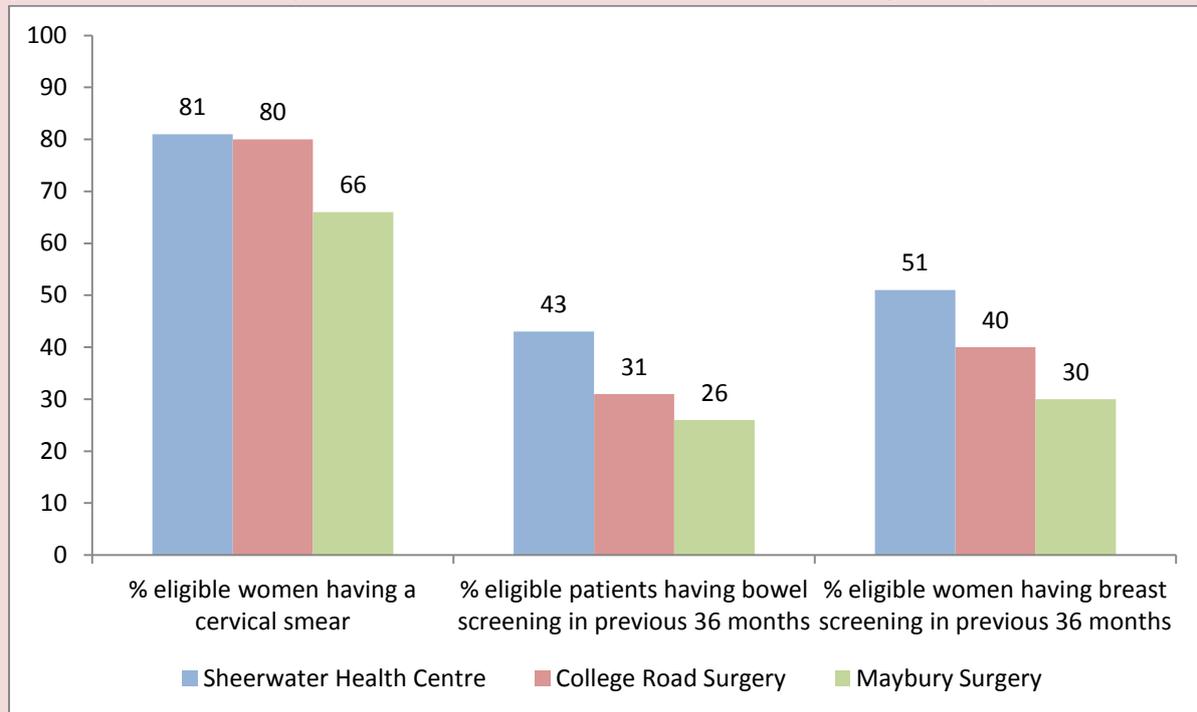


Figure 57: Uptake of cervical screening in eligible women in Maybury and Sheerwater by GP practice (2010/11)⁹⁰

GP Practice	Total number of eligible women	Eligible women who had a cervical smear (no.)	Eligible women who had a cervical smear (%)
Sheerwater Health Centre	626	504	80.5
College Road Surgery	639	512	80.1
Maybury Surgery	477	314	65.8
Total	1,742	1,330	76.4

These data show that 76.4% of eligible women in Maybury and Sheerwater had a cervical smear in 2010/11 (national target 80%, highest uptake in the country was 100% achieved in 8 practices across the country), indicating room for partnership working to improve uptake. The national standard for 5 year coverage is 80%, at which point the evidence suggests that a reduction in mortality of 65-70% is possible in the long term.⁹¹

⁸⁹ Source: QMAS 2010/11 data as at end of July 2011 and National Cancer Intelligence Network March 2012

⁹⁰ Source: QMAS 2010/11 data as at end of July 2011

⁹¹ Source: West Midlands Public Health Observatory, at

http://www.wmpho.org.uk/localprofiles/metadata.aspx?id=META_CERVICAL accessed 25th July 2013

Figure 58: Uptake of bowel screening in eligible patients aged 60-74 in Maybury and Sheerwater by GP practice (2012)⁹²

GP Practice	Total number of eligible patients	Number invited for screening in previous 12 months	Number screened within 6 months of invitation	Uptake % of those invited in previous 12 months	Number screened in previous 30 months	36 month coverage % all eligible patients
Sheerwater Health Centre	263	143	67	47	112	43
College Road Surgery	182	97	29	30	56	31
Maybury Surgery	98	51	16	31	25	26
Total	543	291	112	38.5	193	35.6

These data show that the 36 month coverage of bowel screening in eligible patients in Maybury and Sheerwater was 35.6% (national target 60%, highest 36 month coverage was 75% in 2 practices in Devon and Norfolk), and the percentage uptake of those invited in the previous year was 38.5% (highest uptake of those invited for screening in the previous 12 months was 80% in 1 practice in Norfolk). There is therefore room for co-ordinated partnership working to improve bowel screening uptake and coverage in Maybury and Sheerwater.

Figure 59: Uptake of breast screening in eligible women aged 60-74 in Maybury and Sheerwater by GP practice (2012)⁹³

GP Practice	Total number of eligible women	Number invited for screening in previous 12 months	Number screened within 6 months of invitation	Uptake % of those invited in previous 12 months	Number screened in previous 30 months	36 month coverage % all eligible patients
Sheerwater Health Centre	294	*	*	33	150	51
College Road Surgery	240	*	0	0	97	40
Maybury Surgery	145	8	*	13	44	30
Total	679	*	*	~15	291	42.9

*Data suppressed due to low numbers

⁹² Source: National Cancer Intelligence Network, March 2012

⁹³ Source: National Cancer Intelligence Network, March 2012

These data show that the 36 month coverage of breast cancer in eligible women in Maybury and Sheerwater was 42.9% (national target 80%, minimum standard 70%, highest 36 month coverage was 85% in 1 practice in Yorkshire), and the uptake of those invited for screening in the previous 12 months was approximately 15% (estimate due to suppression of low numbers, highest uptake of those invited for screening was 100% achieved in 118 practices across the country). There is therefore room for co-ordinated partnership working to improve breast screening uptake and coverage in Maybury and Sheerwater.

In summary, uptake of cervical screening is slightly below the national target, and uptake of bowel and breast screening is markedly below the national target. Uptake also varies significantly from practice to practice.

The recommendation is:

- For planners and commissioners to work together with GP practices to develop and support initiatives to improve uptake of screening in Maybury and Sheerwater. This will result in early detection of these cancers, allowing treatment and significantly improved prognosis.

4.7 Teenage pregnancy

Why is teenage pregnancy an important issue?

Teenage pregnancy is linked to deprivation and poverty, and babies born to teenage mothers have worse health outcomes than those born to older mothers. In particular, they are at risk of premature birth, death in the first year, and accidental harm. Teenage mothers themselves are at higher risk of poor mental health, more likely to smoke, less likely to breastfeed, more likely to be not in education, employment, or training (NEET), and more likely to live in poverty.⁹⁴

Addressing teenage pregnancy has a generational effect, not just through addressing health outcomes, but through addressing the issue of teenage pregnancy being viewed as culturally normal due to the numbers of young women having mothers who were teenage mothers themselves.

The following data is for 2008-2010 under 18 conceptions by ward in England and Wales, collected by the ONS. The raw rates per 1,000 cannot be published, but these have been converted into deciles to show (1) which decile, of all wards nationally, Maybury and Sheerwater falls into, (2) how this compares with the other wards in Woking, and (3) which decile, of all LAs nationally, Woking falls into.

The East Midlands Public Health Observatory has also produced a mapping tool showing whether the teenage pregnancy rates by ward are significantly different from the national average, and the map for Woking showing Maybury and Sheerwater is reproduced in figure 61.

⁹⁴ Source: Social Exclusion Unit. Teenage Pregnancy – Report by the Social Exclusion Unit. 1999 HM Stationary Office.

Figure 60: National deciles for under 18 conceptions per 1,000 population for wards in Woking, and for Woking LA (2008-10) (1 = lowest rate of under 18 conceptions, 10 = highest rate of under 18 conceptions)⁹⁵

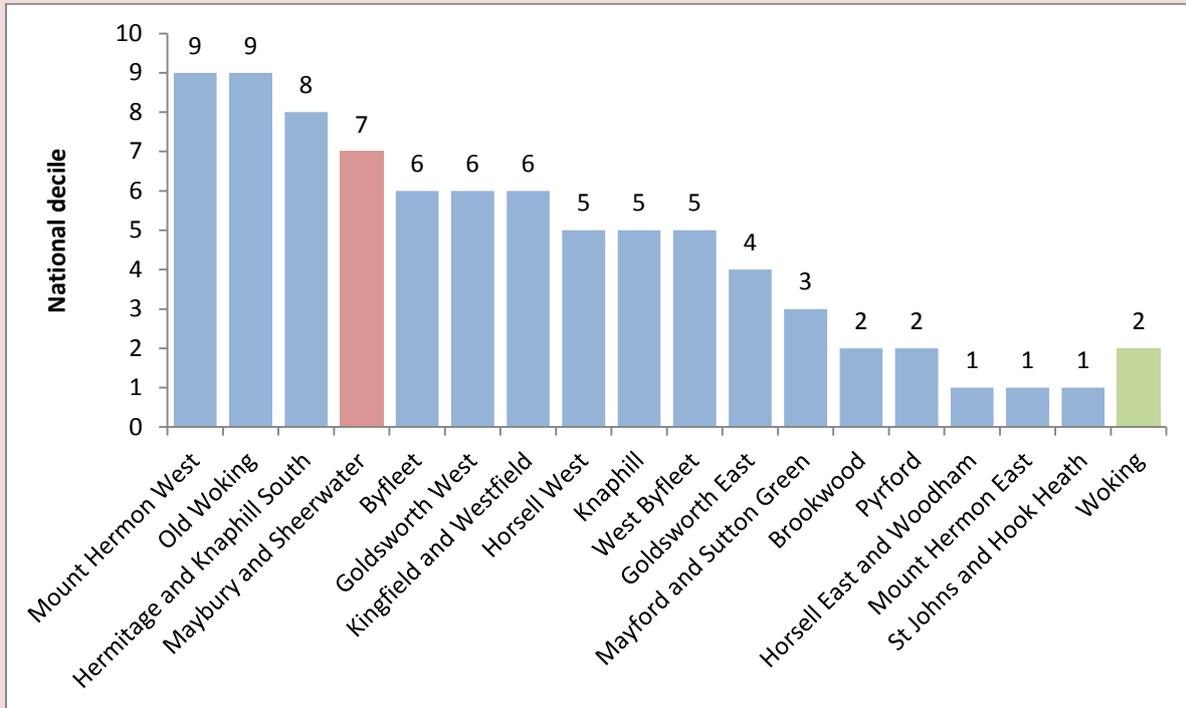
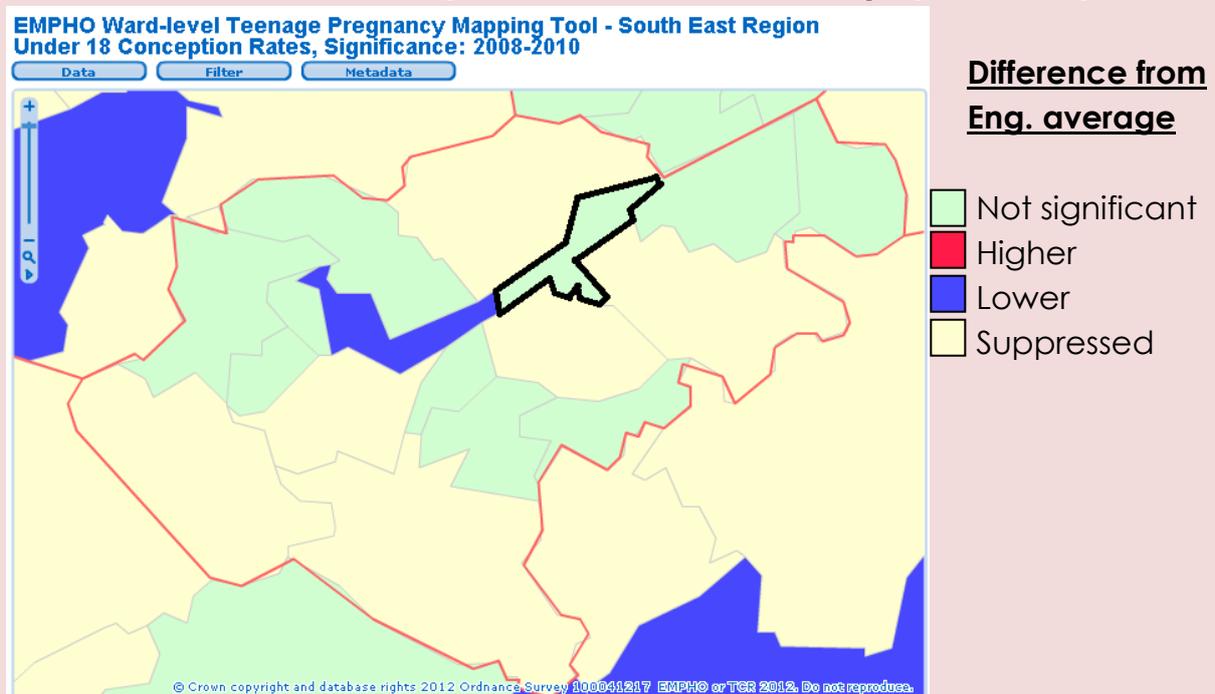


Figure 61: Ward level teenage pregnancy rates in Woking (Maybury and Sheerwater outlined in black) relative to national average (2008-2010)⁹⁶



⁹⁵ Source: EMPHO data on conceptions 2008-10 by ward

⁹⁶ Source: EMPHO ward level teenage pregnancy mapping tool for South East England, 2008-2010. Available at http://www.apho.org.uk/addons/_116223/atlas.html accessed 25th July 2013

These data show that the rate of under 18 conceptions in Maybury and Sheerwater is in the 4th highest decile of wards nationally, compared with a Woking average of the 2nd lowest decile of local authorities nationally. This is consistent with the deprivation maps of Maybury and Sheerwater as teenage pregnancy is strongly linked with deprivation. Accordingly, whilst the rate of teenage conceptions is not statistically significantly different in Maybury and Sheerwater from the England average, there is clearly a local need to address the higher rates in Maybury and Sheerwater (together with Mount Hermon West, Old Woking, and Hermitage and Knaphill South) in order to tackle this problem.

In summary, Maybury and Sheerwater is in the 4th highest decile of all wards nationally for teenage pregnancies, which is particularly worrying in a local authority that is in the 2nd lowest decile of all local authorities nationally. However, the absolute numbers are low, and it should be noted that the rate is not statistically significantly different from the England average.

The recommendations are:

1. For planners and commissioners to consider teenage mothers and teenage pregnancies when planning service delivery, particularly with regard to education programmes targeted at schools and communities where this is a real issue.
2. For NHS Surrey and Sussex Area Team to strongly consider the commissioning of the Family Nurse Partnership in Surrey, targeting areas of deprivation where rates of teenage pregnancy are high alongside poor education, housing, and low income. This is a crucial, evidence-based programme in the fight to break the vicious inter-generational cycle of poverty and poor health.

5. Specific conditions

Specific conditions, which are synonymous with 'diseases' and 'illnesses' for the purposes of this chapter, are what we traditionally identify as the causes of hospital admission, or ultimately death. Traditional examples include coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD), diabetes, and cancer. More recently, specific conditions attracting attention include obesity as a condition in its own right, and hip fractures due to the associated serious morbidity and mortality in the ageing population.

Data available for specific conditions are split in this report into the following categories:

- 1. Prevalence (recorded and expected) by condition**
- 2. Prevalence of obesity (considered separately)**
- 3. Cancer incidence**
- 4. Emergency hospital admissions by condition**
- 5. All-age and premature mortality by condition**

Each of these will be considered in turn for the Maybury and Sheerwater population, either broken down by practice population or at ward level, and compared with the Surrey and England average.

5.1 Prevalence of specific conditions

Understanding prevalence

The prevalence of a condition within a population is the percentage of the population that has that condition. There are two main forms of prevalence data: recorded prevalence and expected prevalence. Recorded prevalence is the percentage of a practice population that has been diagnosed with a specific condition. It is recorded by GP practices for 20 conditions for the Quality Outcomes Framework (QoF).⁹⁷ Expected prevalence is the modelled 'true' prevalence of a specific condition in a population, based on the modelled practice population. For COPD, coronary heart disease, hypertension, and stroke, modelled estimates of expected prevalence have been devised by the Public Health Observatories.

Both these types of prevalence have strengths and shortcomings. For example, recorded prevalence gives us a good picture of the local population because it looks at patients that have actually been diagnosed with a condition. However, it relies on a diagnosis being made and recorded, which is much more likely for major events e.g. strokes, than it is for 'silent' diseases that can go unnoticed for many years e.g. hypertension and dementia. Therefore, the recorded prevalence for some conditions will be markedly lower than the 'true' prevalence due to underdiagnosis.

By contrast, modelled estimates aim to pick up those people who have a condition but are either unaware of it, or haven't been formally diagnosed, or recorded by their GPs as having the condition. However, because the estimate is based on a model, it may differ from the actual prevalence in the local population due to factors not taken into account by the model, or chance. Nonetheless, by putting recorded and modelled/expected prevalence together, we can get an idea of the rates of underdiagnosis.

Whilst we would expect the three GP practices in the area of Maybury and Sheerwater to have similar recorded prevalences, it is important to note that QoF data should not be used exclusively to undertake comparative analysis at practice level. This is because it does not take into account some factors that affect prevalence, or local circumstances around practice infrastructure e.g. staffing and IT issues that affect levels of underdiagnosis.⁹⁸

⁹⁷ QoF is a voluntary incentive scheme for GP practices in the UK. For more details see <http://www.nice.org.uk/aboutnice/gof/> accessed 25th July 2013

⁹⁸ For further details see: <http://www.gof.ic.nhs.uk/faqs/#gof21> accessed 25th July 2013

Figure 62 shows the recorded prevalence for 9 major conditions in Maybury and Sheerwater, compared with Surrey and England. Figure 63 shows how the prevalence for the 7 most common conditions varies by practice in Maybury and Sheerwater.

Figure 62: Recorded prevalence for major conditions in Maybury and Sheerwater compared with prevalence in Surrey and England (2010/11)⁹⁹

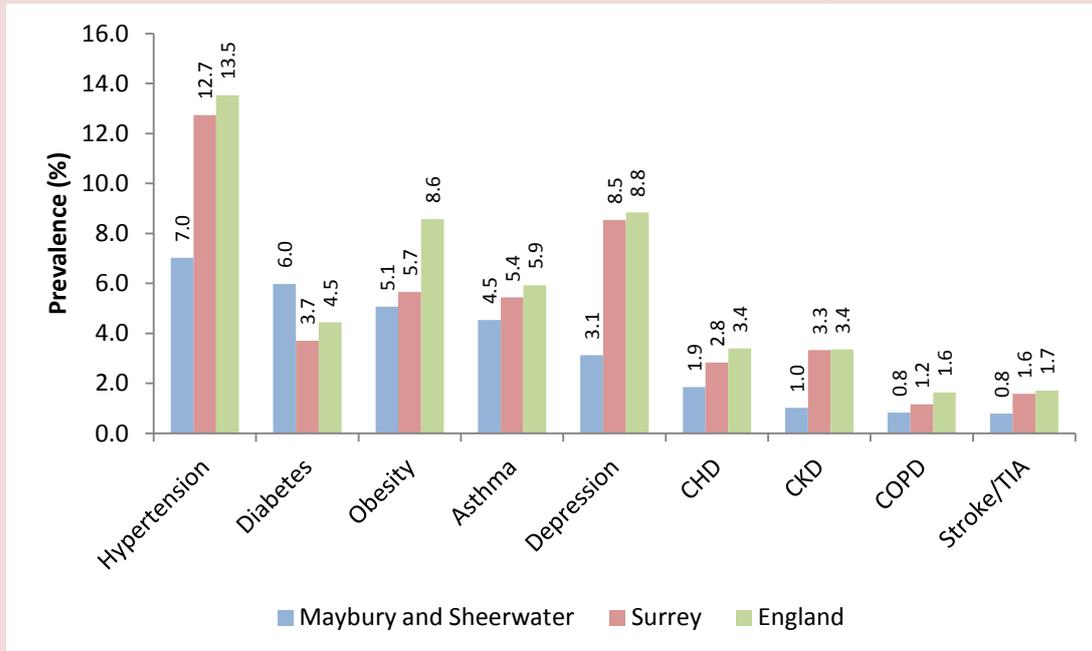
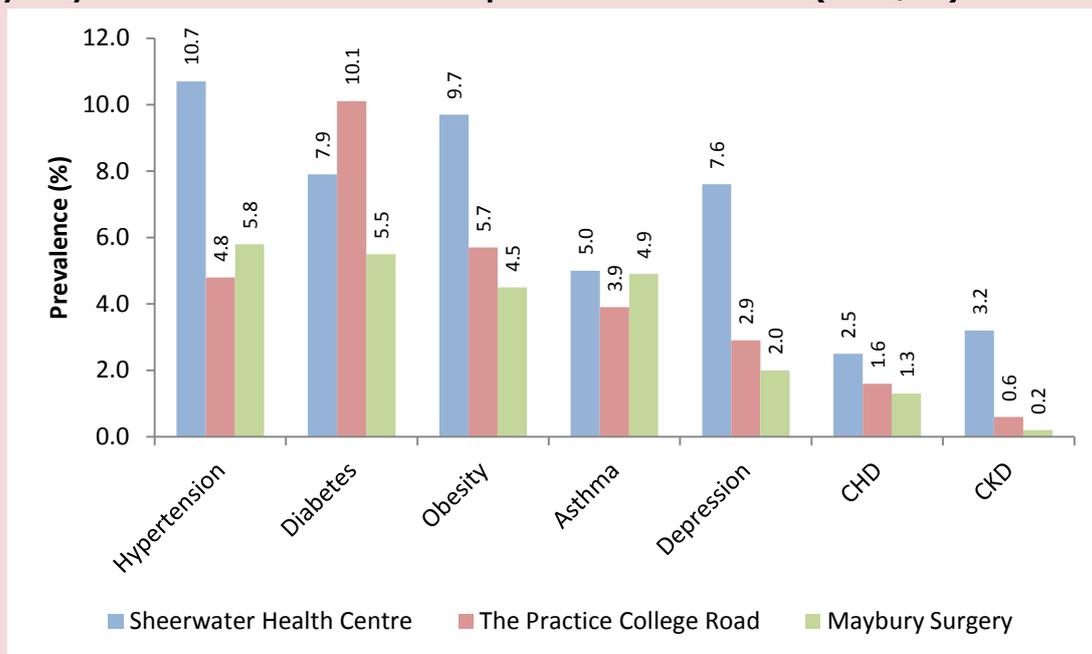


Figure 63: Variation of recorded prevalence between GP practices in Maybury and Sheerwater for most prevalent conditions (2010/11)



⁹⁹ Source: QMAS database 2010/11 as at end of July 2011, via the Health and Social Care Information Centre Indicator Portal, available at <https://indicators.ic.nhs.uk/webview/> accessed 25th July 2013

Figure 64: Recorded prevalence for all 20 conditions recorded for QoF for Maybury and Sheerwater by practice, compared with Surrey and England (2010/11)

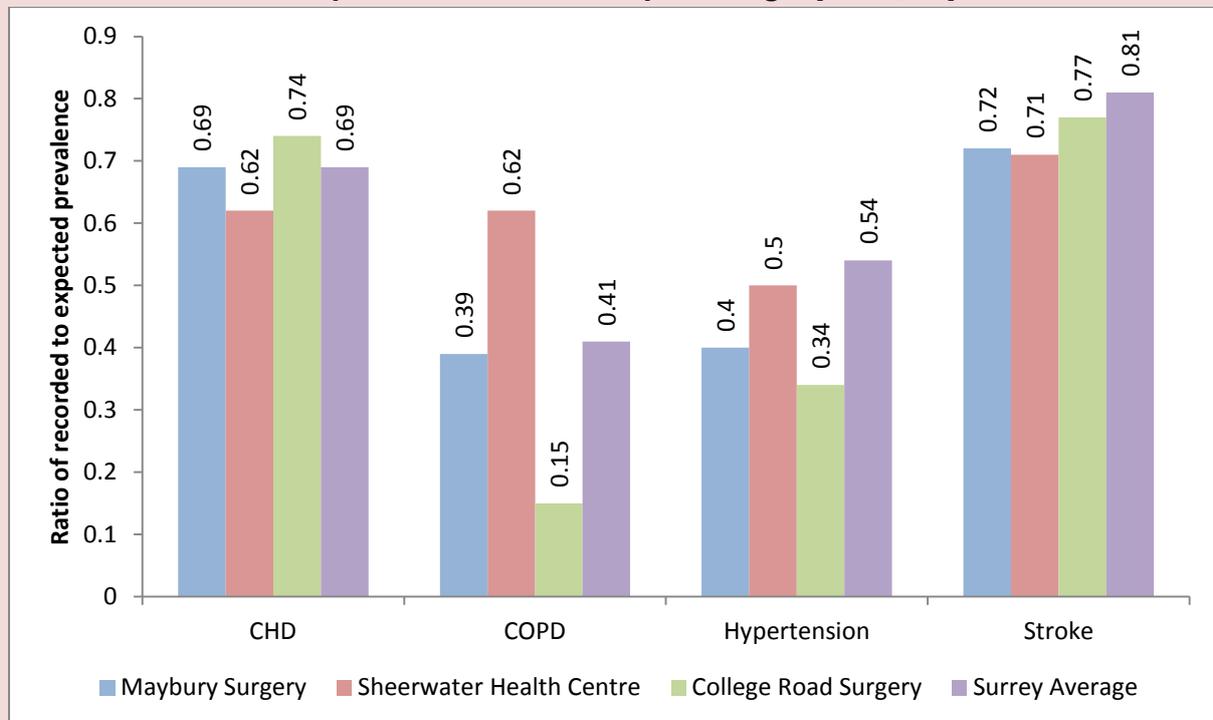
	Sheerwater Health Centre	College Road Surgery	Maybury Surgery	Maybury and Sheerwater	Surrey	England
Asthma	5.0	3.9	4.9	4.5	5.4	5.9
AF	1.3	0.2	0.4	0.6	1.5	1.4
Cancer	1.0	0.3	0.5	0.6	1.8	1.6
CDPP	0.7	0.8	1.2	0.9	1.1	1.2
CKD	3.2	0.6	0.2	1.0	3.3	3.4
CHD	2.5	1.6	1.3	1.9	2.8	3.4
Dementia	0.4	0.1	0.0	0.2	0.5	0.5
Depression	7.6	2.9	2.0	3.1	8.5	8.8
Diabetes	7.9	10.1	5.5	6.0	3.7	4.5
Epilepsy	0.5	0.2	0.4	0.3	0.5	0.6
Heart Failure	0.3	0.3	0.3	0.3	0.5	0.7
Heart Failure due to LVD	0.1	0.1	0.2	0.1	0.2	0.4
Hypertension	10.7	4.8	5.8	7.0	12.7	13.5
Hypo-thyroidism	3.2	2.2	2.5	2.6	3.4	3.0
Learning disabilities	1.0	0.2	0.7	0.4	0.3	0.3
Mental health	1.0	0.5	0.3	0.6	0.7	0.8
Obesity	9.7	5.7	4.5	5.1	5.7	8.6
Palliative Care	0.3	0.1	0.0	0.2	0.1	0.2
COPD	1.7	0.2	0.6	0.8	1.2	1.6
Stroke/TIA	1.2	0.6	0.5	0.8	1.6	1.7

These data show that the recorded prevalence for the major conditions (except diabetes) recorded by QoF are lower in Maybury and Sheerwater overall than in Surrey and England. The higher prevalence of diabetes in Maybury and Sheerwater is an important finding (6% vs. 3.7% in Surrey and 4.5% in England), and highlights a specific area of need for further work.

Looking more closely at the two charts, it can be seen that the recorded prevalence for Sheerwater Health Centre is markedly higher than the other two practices for some of these conditions, and much closer to the Surrey average. One possible explanation for this is underdiagnosis in the other two practices, though the LSOA adjacent to Sheerwater Health Centre is the most deprived in Maybury and Sheerwater and so the prevalence of chronic disease is likely to be higher. For the four conditions COPD, CHD,

hypertension, and stroke, modelled estimates are available together with ratios for recorded:expected prevalence, providing a picture of the levels of underdiagnosis. Lower ratios indicate higher rates of underdiagnosis.

Figure 65: Ratio of recorded to expected prevalence for practices in Maybury and Sheerwater compared with the Surrey average (2010/11)¹⁰⁰



These data show that for some conditions there is a marked variation in ratios, e.g. COPD (range 0.15 – 0.62), and for others the ratios are more tightly grouped e.g. stroke (range 0.71 – 0.77). For chronic diseases which can remain undiagnosed in the community for long periods, e.g. COPD and hypertension, the levels of underdiagnosis appear to be significant, and this is a cause for concern. Picking up these individuals and diagnosing them appropriately will allow them to be treated in line with an evidence-based pathway, thereby reducing complications, unplanned hospital admissions, and mortality from these conditions.

Even though obesity prevalence is included in QoF, it is not fully understood as a condition in its own right. Therefore, GPs tend not to record all of their patients who are obese, and so reported prevalence from QoF is markedly lower than reported prevalence from other sources. Obesity is therefore considered separately in the next section.

¹⁰⁰ Source: APHO/PHE National General Practice Profiles available at <http://www.apho.org.uk/PracProf/Profile.aspx> accessed 25th July 2013

In summary, the commonest conditions (by recorded prevalence) in Maybury and Sheerwater are: hypertension, diabetes, obesity, asthma, and depression. The major condition where prevalence is higher than average is diabetes. Additionally, there is marked variation in recorded prevalence between practices, and the modelled data for four major conditions indicate that there is significant underdiagnosis for some conditions in the community. This is particularly the case for COPD and hypertension, but is likely to apply to other conditions too.

The recommendations are:

1. For all partners within the local health system to work together to identify the root causes for under-diagnosis and address these to ensure that all patients with chronic conditions are managed appropriately to avoid complications and serious events.
2. For health professionals and community support groups to focus on diabetes prevention and management, as prevalence in Maybury and Sheerwater is higher than in Surrey or England, likely due to a mix of ethnicity factors and diet/exercise factors.
3. For all commissioners and planners to ensure that services are available to support the health needs of the local community with regard to the prevalence of the commonest conditions, e.g. patient education and support programmes for long-term conditions.

5.2 Prevalence of obesity

Why is obesity an important health issue?¹⁰¹

Obesity is a factor in developing type 2 diabetes, heart disease, and certain cancers. In fact, obese women who are obese are 12.7 times more likely to develop diabetes, and obese men are 5.2 times more likely to develop diabetes than the general population.

44% of diabetes and 23% of heart disease, as well as between 7-41% of certain cancers are attributable to excess body fat. Furthermore, over the past decade an increasing number of children have developed type 2 diabetes.

Local authorities have a responsibility to reduce inequalities, and both childhood and adult obesity is linked to deprivation, and have a higher prevalence in deprived communities and some minority ethnic groups. Women in the highest income group have a prevalence of obesity of 17%, rising to 28% in the lowest income group.

Why is obesity an important economic issue?

The cost to society in the UK from people being overweight and obese is estimated to be nearly £16bn per year, projected to rise to £50bn per year by 2050 if conditions are left unchecked. This includes:

- £5.1bn in NHS care
- £11.6bn in unemployment, early retirement, and associated welfare benefits (including an estimated 16 million days of sickness absence a year)

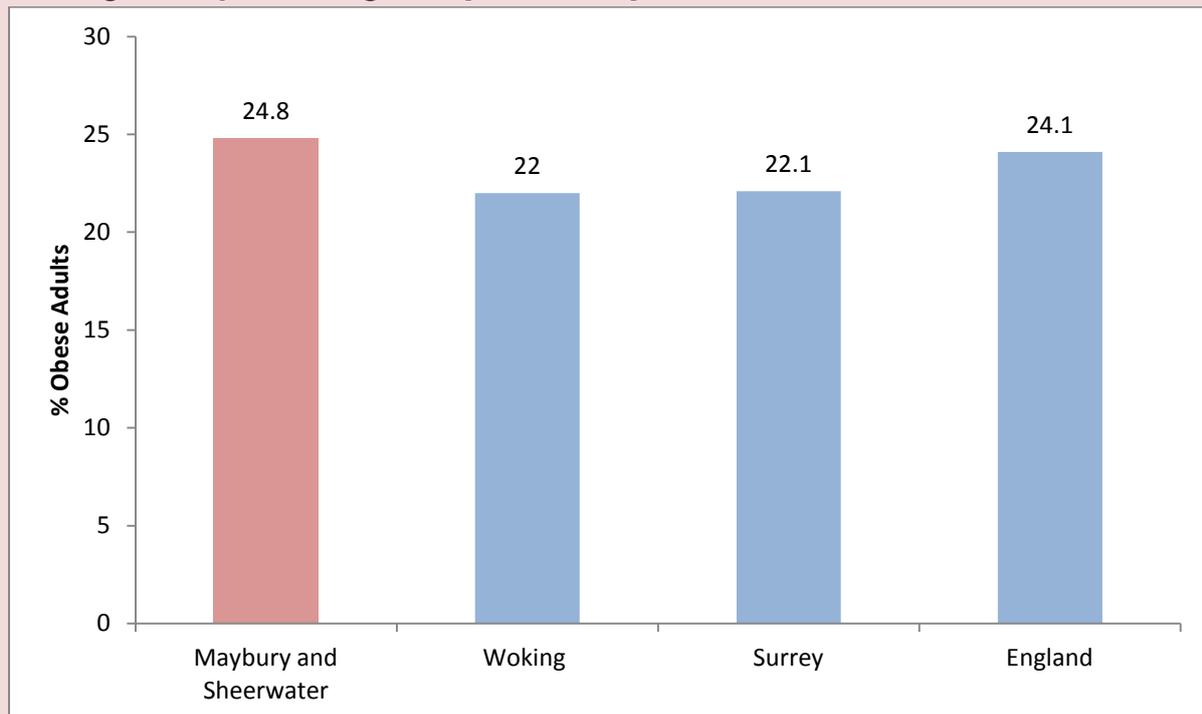
Diabetes alone costs 10% of the NHS budget, which equates to £25,000 per minute, or £286 per second.

NICE notes that generally, the upfront costs of most preventative interventions will not be repaid for a number of years. However, these costs will usually be small in comparison with the future health benefits and the long-term cost savings from reductions in type 2 diabetes, cardiovascular disease and some cancers (as well as the wider savings in benefits and social care).

¹⁰¹ Source: NICE local government public health briefing on obesity, available at <http://publications.nice.org.uk/preventing-obesity-and-helping-people-to-manage-their-weight-phb9> accessed 25th July 2013

The major source of data on obesity in adults at ward level comes from the Health Survey for England data from 2006-2008, and is reported on the PHE Local Health Profiles. The major source of data on obesity in children at MSOA level comes from the National Child Measurement Programme (NCMP) data, and is reported on the National Obesity Observatory (NOO) website. Both are reproduced below.

Figure 66: % Obese adults in Maybury and Sheerwater compared with Woking, Surrey, and England (2006-2008)¹⁰²



This chart shows that the prevalence of adult obesity is higher than both the Woking and Surrey average (24.8% in Maybury and Sheerwater vs. 22% in Woking and 22.1% in Surrey), but broadly similar to the national average (24.8% in Maybury and Sheerwater vs. 24.1% in England). This is in keeping with the deprivation profile of Maybury and Sheerwater, and is in part caused by the lower rates of healthy eating and exercise. Interventions aimed at encouraging healthy eating, cooking, and exercise are, amongst other benefits, likely to be most successful at reducing obesity rates.

¹⁰² Source: HSE 2006-2008, via PHE Local Health Profiles, available at http://www.localhealth.org.uk/GC_preport.php?lang=en&s=106&view=map4&id_rep=r03&sellid0=6469&nivgeo=ward_2011 accessed 25th July 2013

Figure 67: % Obese children aged 4-5 (reception year) in Maybury and Sheerwater (bar chart highlighted in black), reproduced from the NOO NCMP MSOA e-atlas (2009/10 – 2011/12)¹⁰³

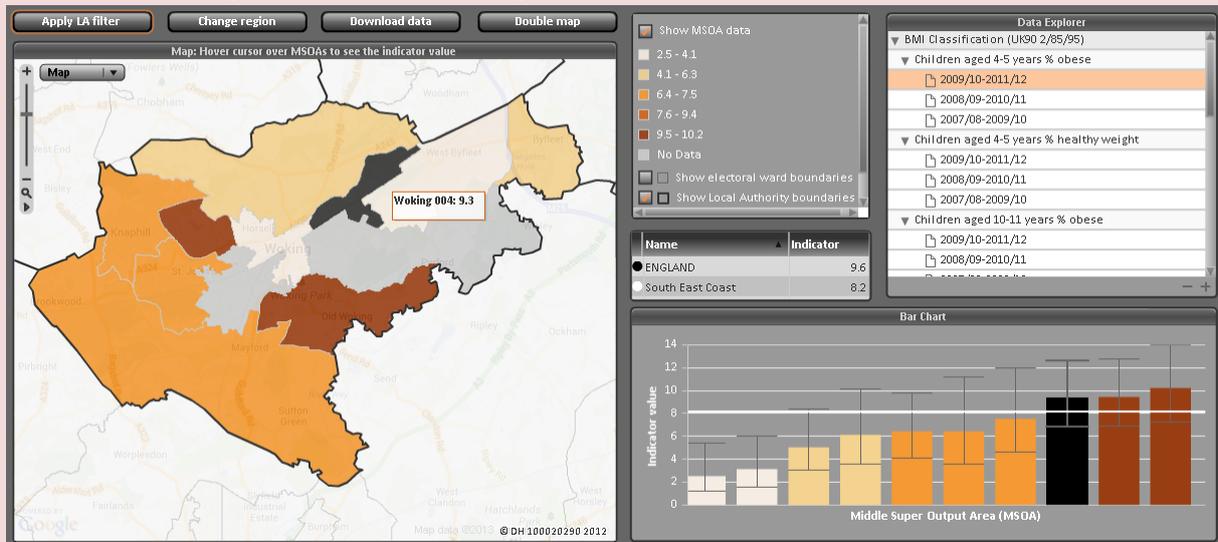
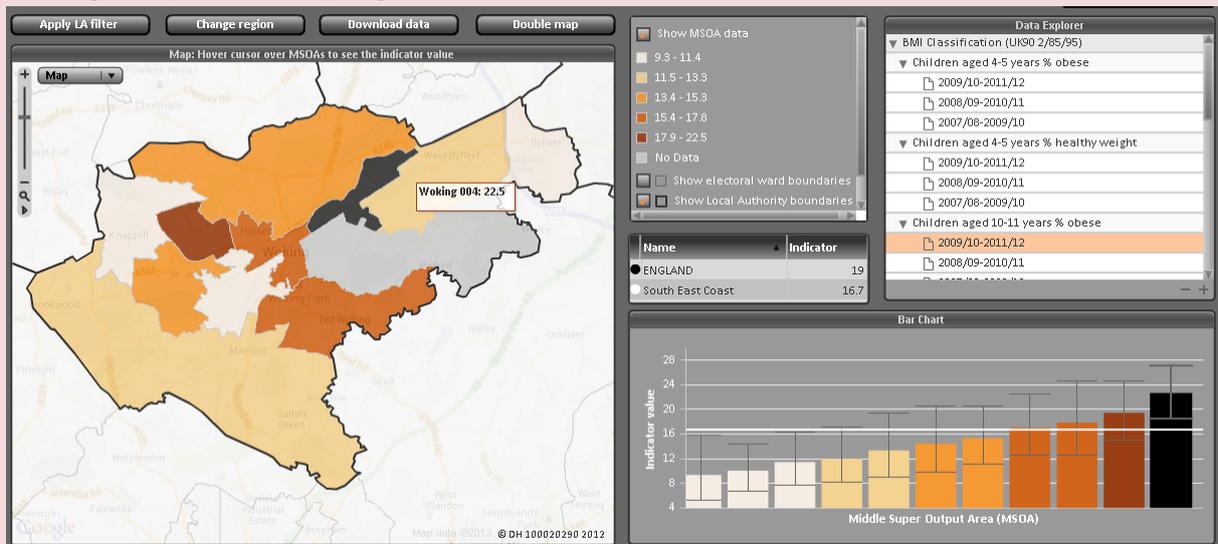


Figure 68: % Obese children aged 10-11 (year 6) in Maybury and Sheerwater (bar chart highlighted in black) reproduced from the NOO NCMP MSOA e-atlas (2009/10 – 2011/12)¹⁰⁴



The second of these maps show that Maybury and Sheerwater has the highest rate of obesity in Year 6 children in Woking, at 22.5%, which is statistically significantly higher than the Woking average of 15.4% and the Surrey average of 14%. Similarly, the first of these maps show that Maybury and Sheerwater has the third highest rate of obesity in Reception year children in Woking, at 9.3%, which is statistically significantly higher than the

¹⁰³ Source: National Obesity Observatory, using National Child Measurement Programme data, available at <http://www.noo.org.uk/visualisation/eatlas> accessed 25th July 2013

¹⁰⁴ Source: As previous reference

Woking average of 6.7% and the Surrey average of 6.8%. This indicates that childhood obesity is a problem that starts early in Maybury and Sheerwater, and almost 1 in 4 10-11 year olds being obese is clearly a cause for concern.

In summary, adult obesity rates are higher in Maybury and Sheerwater than the Woking and Surrey average, and not significantly different from the England average. Most worryingly, childhood obesity in Maybury and Sheerwater is the highest in Woking with 22.5% of year 6 children obese compared with 15.4% in Woking.

The recommendations are:

1. For decision makers to prioritise action on childhood obesity in Maybury and Sheerwater, as these children are at significantly higher risk of poor physical health in adulthood, including diabetes, cardiovascular disease, and complications from these conditions.
2. For commissioners and planners to support assets in the community that work with children and young people, including nurseries, schools, and the Woking SureStart Centre, to further develop healthy behaviour promotion programmes, centred around diet, exercise, and parent health education programmes.

5.3 Cancer incidence

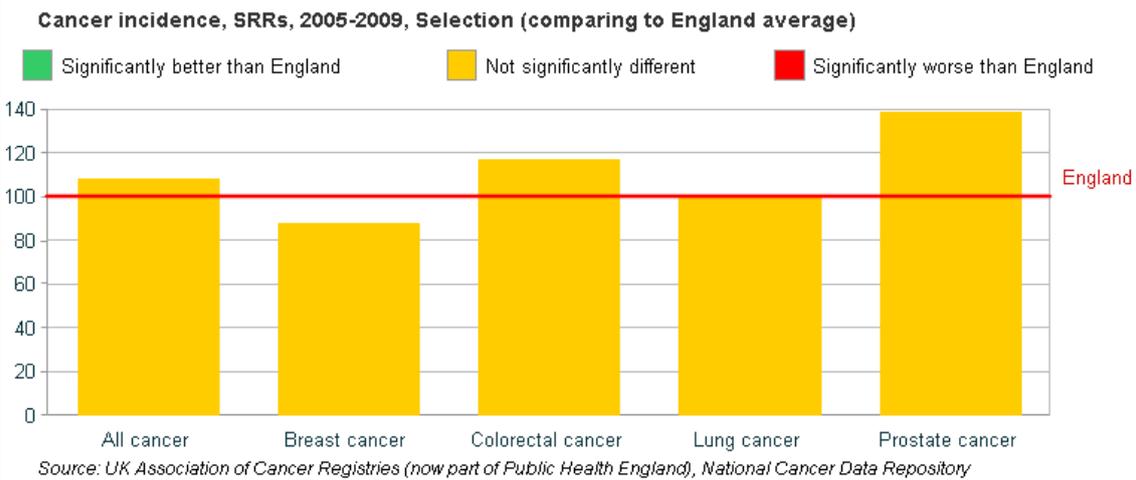
The UK Association of Cancer Registries (now part of PHE) logged the incidence (number of new cases per year) of cancers between 2005-2009, and these are now available on the PHE Local Health Profiles. The data for Maybury and Sheerwater ward is reproduced in Figure 69.

Figure 69: Cancer incidence in Maybury and Sheerwater (2005-2009)

Cancer incidence, Standardised Registration Ratios (SRRs), 2005-2009

Indicator	Selection	Local Authority Lower Tier (Woking)	Local Authority Upper Tier (Surrey)	England
All cancer	108.1	94.5	92	100
Breast cancer	87.3	84	100.4	100
Colorectal cancer	116.5	103.9	97.1	100
Lung cancer	99	79.7	72.3	100
Prostate cancer	138.6	109.5	97.4	100

Source: UK Association of Cancer Registries (now part of Public Health England), National Cancer Data Repository



In summary, cancer incidence in Maybury and Sheerwater for breast, colorectal, lung, and prostate cancer is not significantly different from the national average. However, when compared with the Surrey average, the incidences of colorectal cancer (linked to diet, exercise, weight, and smoking) and prostate cancer are significantly higher.

The recommendation is:

- For stakeholders to work together on the diet, exercise, smoking, and alcohol prevention agenda, which will translate into lower cancer incidences over time, in addition to the multitude of other health benefits.

5.4 Emergency hospital admissions

Emergency hospital admissions are an indication that there is room for improved management in the community (which can involve both elements of self-management and health professional led management). They are also expensive for the health service, disruptive for patients and their families (and their employers), and can lead to an increased burden on social care services if the patient leaves hospital requiring more support at home, e.g. after a stroke or fall.

Comprehensive practice-level data on secondary care use is available on the PHE National General Practice Profiles,¹⁰⁵ however these are not included here in order to focus on the important areas. Key areas are highlighted in the PHE Local Health Profiles, and are reproduced for Maybury and Sheerwater in Figure 70.

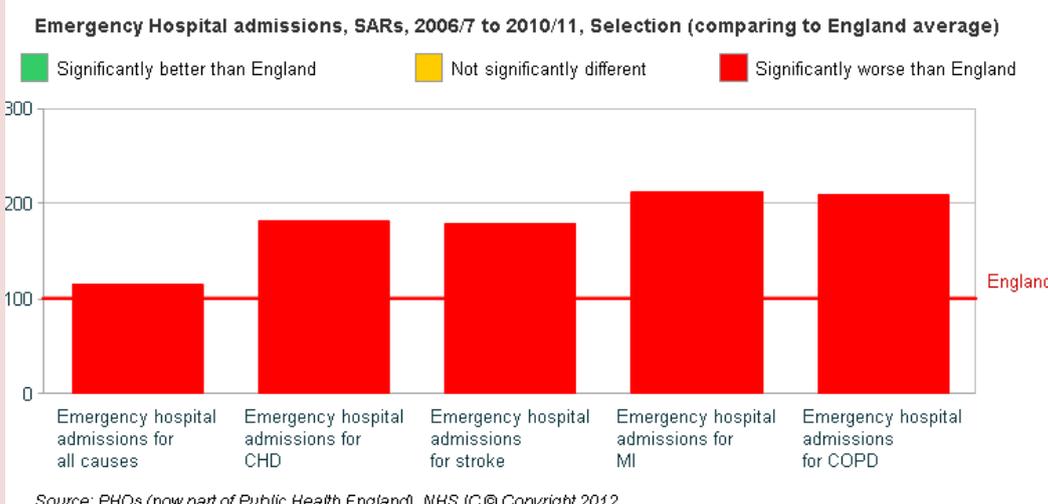
Figure 70: Emergency hospital admissions by condition for Maybury and Sheerwater, compared with the England average (2006/7 to 2010/11)¹⁰⁶

* CHD: Coronary Heart Disease; MI: Myocardial Infarction (heart attack); COPD: Chronic Obstructive Pulmonary Disease

Emergency Hospital Admissions, Standardised Admission Ratios (SARs), 2006/7 to 2010/11

Indicator	Selection	Local Authority Lower Tier (Woking)	Local Authority Upper Tier (Surrey)	England
Emergency hospital admissions for all causes	114.4	82	80.8	100
Emergency hospital admissions for CHD	181.1	84.6	77.4	100
Emergency hospital admissions for stroke	178.8	108.9	94.1	100
Emergency hospital admissions for MI	212	97.4	88.3	100
Emergency hospital admissions for COPD	209	73.7	63.9	100

Source: PHOs (now part of Public Health England), NHS IC © Copyright 2012



¹⁰⁵ Available at <http://www.apho.org.uk/PracProf/Profile.aspx> accessed 25th July 2013

¹⁰⁶ Source: PHE Local Health Profile for Maybury and Sheerwater, available at http://www.localhealth.org.uk/GC_preport.php?lang=en&s=106&view=map4&id_rep=r03&sellid0=6469&nivgeo=ward_2011 accessed 25th July 2013

These data show that the rate of emergency hospital admissions for the population of Maybury and Sheerwater are statistically significantly higher for the four major groups: CHD, stroke, MI, and COPD. In part this is due to the high relative prevalence of unhealthy behaviours (smoking, unhealthy diet, low uptake of exercise), and in part this is related to the levels of underdiagnosis in primary care (particularly for COPD and hypertension, a major risk factor for CHD/stroke/MI, which modelled estimates indicate are being underdiagnosed by over 50%).

In summary, emergency hospital admissions for chronic diseases and their complications are significantly worse in Maybury and Sheerwater than the national average, and even more so when compared with the Woking and Surrey averages. Emergency admission for heart attacks and COPD are over double the national rate, and the Woking and Surrey rates are lower than the national rate. This represents a huge failure of prevention and management in the community, both self-management by patients and professional led management in primary care.

The recommendations are:

1. For health planners and commissioners to work together to develop a strategy to identify, within each of the three categories (prevention, self-management, health professional led-management), what can be done to address this huge problem.
2. From a prevention perspective, this is likely to include further local work on Stop Smoking services, diet and exercise health promotion, and alcohol harm reduction.
3. From a self-management perspective, this is likely to include supporting local assets to develop work on community engagement and patient education programmes, and engaging community leaders in highlighting the importance of self-management of chronic conditions, e.g. diabetes, cardiovascular disease, and COPD.
4. From a health professional led management perspective, this is likely to include reviewing management pathways to ensure that patients are being logged on disease registers, managed in line with evidence-based guidance, and supported to manage their own conditions.

5.5 All-age and premature mortality

Two datasets for mortality are routinely collected in England: all-age mortality and premature (under 65/75) mortality. These two measures correlate well by area, but provide slightly different information.¹⁰⁷

All-age mortality rates are based upon numbers of deaths registered in an area by specific condition, e.g. COPD or CHD. Accordingly, it can be used as a proxy indicator for lifetime risk behaviours/risk factors. Where it is significantly higher than average, this indicates a need for universal interventions (e.g. in primary and secondary prevention, and improved self management) to tackle these.

Premature mortality rates are based on numbers of deaths under the age of 75/65 in an area by specific condition. Accordingly, it can be used as a proxy indicator for avoidable risk behaviours/risk factors and correlates well with the level of deprivation. Where it is significantly higher than average, it supports targeted interventions in these deprived areas to tackle these risk factors.

The PHE Local Health Profiles show the comparison of all-age and premature mortality by condition with the national average, and is reproduced for Maybury and Sheerwater in figure 71.

¹⁰⁷ The following guidance has been developed together with the Surrey Public Health Principal Analyst and the South East Public Health Observatory (SEPHO) Principal Analyst.

Figure 71: Causes of deaths (all ages) by condition for Maybury and Sheerwater, compared with the England average (2006 to 2010)¹⁰⁸

Causes of deaths - all ages, Standardised Mortality Ratios (SMRs), 2006-2010

Indicator	Selection	Local Authority Lower Tier (Woking)	Local Authority Upper Tier (Surrey)	England
All causes	125.3	92.4	87.5	100
All cancer	117.6	97.1	88	100
All circulatory disease	107.2	86.8	85.8	100
Coronary heart disease	114.2	82.2	79.7	100
Stroke	84.6	89.4	88.2	100
Respiratory diseases	161.4	98.2	90.7	100

Source: PHOs (now part of Public Health England), produced from ONS data Copyright© 2011

Causes of deaths - all ages, SMRs, 2006-2010, Selection (comparing to England average)

■ Significantly better than England
 ■ Not significantly different
 ■ Significantly worse than England



Source: PHOs (now part of Public Health England), produced from ONS data Copyright© 2011

This shows that all-age all-cause mortality is statistically significantly higher in Maybury and Sheerwater than the national average, driven primarily by a markedly high mortality rate from respiratory disease. However, deaths from cancer, heart disease and stroke are not significantly different from the national average.

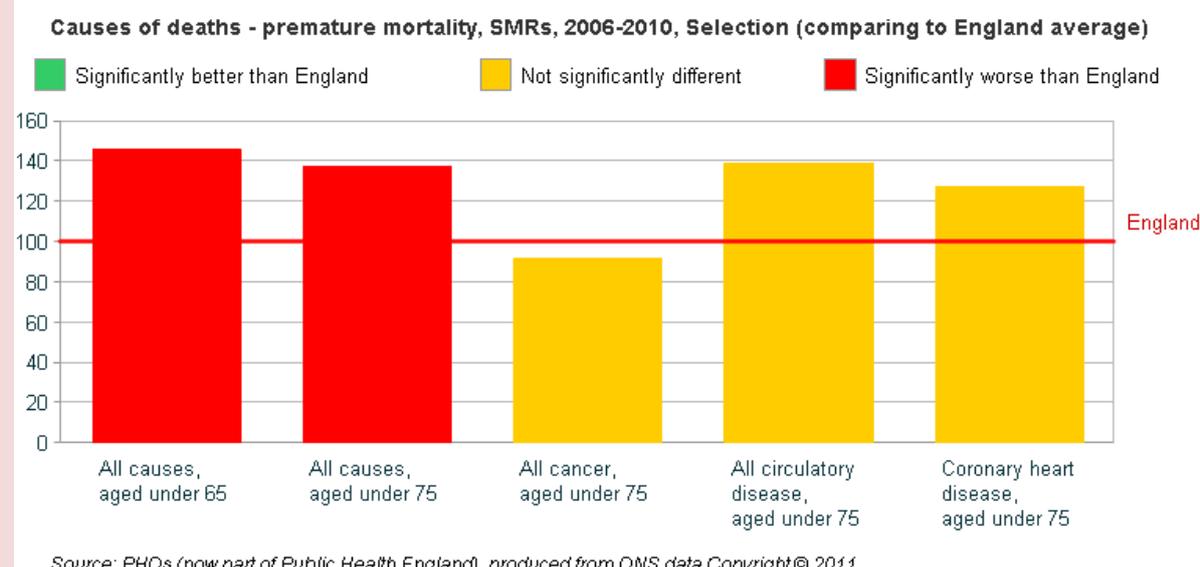
Notably, the rates in Maybury and Sheerwater are even worse when compared with the Woking and Surrey averages, which are generally much lower (better) than the national average. A worrying example is that all age mortality from respiratory disease is around 10% below the national average in Surrey, but around 60% above in Maybury and Sheerwater. Even for coronary heart disease, which is not significantly different from the England average, all age mortality is around 20% below the national average in Surrey, and 15% above in Maybury and Sheerwater.

¹⁰⁸ Source: PHE Local Health Profile for Maybury and Sheerwater, available at http://www.localhealth.org.uk/GC_preport.php?lang=en&s=106&view=map4&id_rep=r03&sellid0=6469&nivgeo=ward_2011 accessed 25th July 2013

Figure 72: Causes of deaths (premature) by condition for Maybury and Sheerwater, compared with the England average (2006 to 2010)¹⁰⁹

Causes of deaths - premature mortality, Standardised Mortality Ratios (SMRs), 2006-2010				
Indicator	Selection	Local Authority Lower Tier (Woking)	Local Authority Upper Tier (Surrey)	England
All causes, aged under 65	145.8	83.3	75.6	100
All causes, aged under 75	137.5	83.6	78.2	100
All cancer, aged under 75	91.5	92.4	86	100
All circulatory disease, aged under 75	138.9	74.4	71.8	100
Coronary heart disease, aged under 75	127.4	64.9	66.7	100

Source: PHOs (now part of Public Health England), produced from ONS data Copyright © 2011



This shows that whilst all cause premature mortality is markedly higher than the national average, it is not statistically significantly different for cancer, circulatory disease, and coronary heart disease. However, when compared with the Woking and Surrey average, premature mortality for circulatory disease and coronary heart disease are significantly worse.

A particularly worrying statistic that can be seen in the table is that all cause under 65 mortality is around 25% below the national average in Surrey, but around 45% above in Maybury and Sheerwater. More specifically, premature mortality from coronary heart disease is around 33% below the national average in Surrey, but around 27% above in Maybury and Sheerwater.

¹⁰⁹ Source: PHE Local Health Profile for Maybury and Sheerwater, available at http://www.localhealth.org.uk/GC_prepport.php?lang=en&s=106&view=map4&id_rep=r03&sellid0=6469&nivgeo=ward_2011 accessed 25th July 2013

In summary, all-age all-cause mortality in Maybury and Sheerwater is significantly higher than the Woking, Surrey, and national average (in line with the level of deprivation). All-age mortality from respiratory diseases and premature mortality from circulatory diseases are both much higher as well.

The recommendations are:

1. Strategic planners and healthcare commissioners should focus not just on the England comparison, but the Woking/Surrey comparison which is far more stark, and support local stakeholders to improve both prevention of long-term conditions, and community management of long-term conditions, particularly respiratory conditions.
2. With regard to respiratory conditions, developing a local strategy for increasing the uptake of NHS Stop Smoking services is likely to be the most cost-effective and clinically-effective approach.
3. As mentioned at the start of this report, this discrepancy in mortality is primarily the result of socio-economic deprivation, and so commissioners and planners should use this evidence to further bolster their goal of addressing deprivation to reduce health inequalities.

6. Community feedback

6.1 Introduction to the methodologies used

25 semi-structured interviews (see box below) were carried out with members of the community in Maybury and Sheerwater. These individuals were selected using convenience sampling (see box below), with the limitations of this approach to be borne in mind. The selection methodology, however, did seek to include:

- Men (n=15) and women (n=10)
- Asian/British Asian [all] (n=16) and White [all] (n=9)¹¹⁰

No children (aged <18) were included in the sample, but feedback with regard to children was gathered from services that work with children in the community.

Additionally, questionnaires were carried out with organisations or groups that provide services to the community or engage with the community in other ways. The responses from these bodies are grouped together to provide a 'service provider' perspective on the health needs of the community.

Semi-structured interviews¹¹¹

Semi-structured interviews are a technique used to collect qualitative data (the other commonly used qualitative methods include focus groups and questionnaires).

In a semi-structured interview, the researcher is looking to understand the respondent's point of view on a particular subject. However, the questions are not rigid and identical for each respondent. Instead, the researcher decides on the 'themes' to be discussed, and then explores the responses with further ad-hoc 'follow-up' questions before moving on to the next theme.

This 'two-way' conversation allows in-depth exploration of how the respondent feels about the issue, and clarification of any areas that are unclear to either the researcher or respondent.

¹¹⁰ The interviewees were not asked about their ethnic background, therefore ethnicity cannot be stated more specifically

¹¹¹ Source: Adapted from www.sociology.org.uk accessed 20th August 2013

Convenience sampling¹¹²

Convenience sampling is a common sampling method used in qualitative research. The selection method involves selecting study units that happen to be available at the time of data collection.

A drawback of this method is that the sample can be biased: some people may be over-selected, others under-selected or missed altogether. An obvious way in which this happens is that people working outside of local businesses in Maybury and Sheerwater will not be available to answer questions during working hours. Another way is that people who have language barriers will be unable to respond to questions.

6.2 Semi-structured interview with residents: framework of themes

1. **What do you think are the major health concerns in the local community?** *[respondents were advised to interpret health broadly, including: specific conditions like diabetes and heart disease; risk factors like smoking and alcohol; and social issues like poor housing and lack of access to green space]*
2. **What do you think the access to health services is like in Maybury and Sheerwater, and how could it be improved?** *[respondents were advised to include access to GP practices, dentists, hospital appointments, pharmacies, district nurses, and any other community based health service]*
3. **What additional services or projects do you think could be developed to tackle the health concerns in the local community?** *[if respondents asked for clarification, they were advised to consider the development of focused projects, provision of specialist clinics, provision of support workers, or provision of additional space]*
4. **What do you think would help the residents of Maybury and Sheerwater improve their own health?** *[if respondents asked for clarification, they were advised to consider cooking classes, sports and exercise opportunities, and better information]*

¹¹² Source: Adapted from <http://apps.who.int/medicinedocs/en/d/Js6169e/7.3.html#Js6169e.7.3> last accessed 20th August 2013

6.3 Semi-structured interview with residents: responses

The responses to each question were analysed by theme, and are presented here as a narrative to help build a picture of health needs from the perspective of the residents. They are not presented as 'percentage of respondents answering in a particular way', or bar charts, or any other data/charting method. This is so as not to give the impression that the responses can be held as a statistically robust reflection of the population in the same way as the health data in the preceding chapter, due to the small sample size and sampling method used. Instead, the purpose of should be seen as bringing out some of the issues that cannot be brought out using quantitative methods.

1. What do you think are the major health concerns in the local community?

The major 'specific condition' that was mentioned by respondents was diabetes, and most respondents knew several local people with the condition. Other specific conditions mentioned included heart disease, high blood pressure, and depression, the latter particularly mentioned by women.

With regard to 'risk factors', the commonest response was unhealthy diet, both in British/Asian respondents and White/any respondents. The lack of time to cook, ease of access to cheap takeaways, preference for 'traditional' Indian/Pakistani cooking with a high fat content, and a lack of understanding of how to cook healthily/quickly/cheaply were all cited as causative factors. Lack of exercise was also mentioned, primarily with regard to lack of time to exercise.

With regard to 'wider/social determinants of health', respondents felt that the major issue was low-paid employment and high costs of living resulting in needing to work up to 12 hours a day, 7 days a week just to make ends meet. This resulted in very little time to, for example, exercise, attend cooking classes, community groups, or even seek GP appointments for medical problems. The costs that were particular burdens were the cost of housing (including social housing) and the cost of food, and for taxi drivers the cost of fuel. Overcrowded housing was also mentioned, particularly in families with multiple generations living in the same house.

2. What do you think the access to health services is like in Maybury and Sheerwater, and how could it be improved?

Respondents were roughly evenly split between those who thought that access to services (GPs, pharmacists, St. Peter's hospital) was very good, and those who felt that it could be improved. Access to pharmacists was thought to be good, but respondents weren't clear on what illnesses and ailments were suitable for discussion and management by a pharmacist, preferring to access their GP for many of these.

With regard to ways in which access to health services could be improved, common themes included later opening hours in GP practices, and the need to improve the booking system for on-the-day appointments (several respondents mentioned that it was very difficult to get through to the receptionist at the appropriate time).

One specific area mentioned by many British/Asian respondents was the issue of privacy and confidentiality. They noted that from a cultural perspective they were uncomfortable with answering the question from the receptionist 'what is the problem that you want to see the GP about', as they might want to limit the number of people that know. Whilst some respondents immediately noted that they understood the need to triage on the basis of urgency, they felt that just asking a variation of 'is it urgent (e.g. ...) or can it wait a few days (e.g. ...)' would be more appropriate.

3. What additional services or projects do you think could be developed to tackle the health concerns in the local community?

Many respondents, as noted above, felt that there was generally a good level of service provision in Maybury and Sheerwater. Over and above what is available, many respondents in the Muslim community thought that provision of services either at the mosque, or advertised through the mosque would help uptake. This included suggestions of running a GP session at the mosque on a Friday, and more regular delivery of health promotion messages at the mosque after Friday prayers. Some respondents noted that in addition to the convenience aspect, this would have the additional advantage of leadership from within the community on focusing on health, and so was likely to be more effective.

Another more general area was 'something around diabetes care', whether that be setting up community support groups, or specialist clinics, or any other service tailored to helping reduce the burden of managing the condition for the relatively high number of people with it in Maybury and Sheerwater.

4. What do you think would help the residents of Maybury and Sheerwater improve their own health?

The major themes here were cooking classes (to address the issues of poor diet noted in question 1), and subsidised access to gyms/sports facilities.

With regard to cooking classes, there were two separate issues. In the British/Asian community, the major issue was not that they did not know how to cook, but that the cooking methods used large amounts of oil or other fats, and so were consequently very unhealthy. Accordingly, a very targeted intervention would be required to teach these families how to cook the same food more healthily. In the White/any community, and in younger males across ethnicities, the major issue was that they either didn't know how to cook, or how to cook healthy food, or how to cook quickly. Therefore, cooking classes for this group would be more basic 'how to cook', with simple recipes of quick, healthy meals, and the importance of healthy eating.

With regard to exercise, respondents were split between those that did not think that they would use sports/exercise facilities under any circumstances, and those that noted barriers to increased uptake. With regard to the former group, the main reasons given were: too busy with work and no time to think about that, and no segregated facilities for women-only groups. With regard to the latter group, the main barrier was cost – for adults it was noted to be prohibitively expensive, particularly with regard to average income in the area, to access e.g. the gym. Subsidised/free entry was universally suggested as a way to increase uptake amongst this group.

A core issue, as has been mentioned already, is summarised in the following quote from one of the residents in response to this question:

“I work from 8am until 8pm every day, just to afford my rent and food, and so do many people who live here. If you think that when I get off work, instead of spending a couple of hours with my family, eating food that I enjoy, I’m going to think about going to the gym or a cooking class ... Even if all of these things were free, I still wouldn’t think about it.”

In summary, from the perspective of the residents:

- The major health problems include diabetes, heart disease, hypertension, and depression, alongside poor diet and low levels of exercise.
- Access to health services could be improved by increasing the availability of information on what pharmacists can manage, and by increasing the availability of after-hours GP appointments, improving the GP appointment booking system, and addressing some barriers with regard to privacy and confidentiality when booking GP appointments.
- Additional services to address the health issues in the community might include increased health promotion and delivery through the mosques, particularly after Friday prayers, and an improved service for supporting diabetics.
- Approaches to helping residents improve their own health could include tailored cooking classes and subsidised exercise opportunities.

Crucially, some residents felt that their focus was on earning enough money just to pay for their rent and food, and preferred to spend their very limited free time with their family. Accordingly, questions of what the council, NHS, or other organisations could do to improve their health missed the point that they don’t feel as though they have the luxury of thinking about things like that. High rents, including in social housing, was their major concern.

The recommendations are:

1. GP practices should consider making changes to appointment booking/availability in line with community feedback.
2. Key stakeholders should work in partnership to further develop relationships with faith organisations and other non-health community groups to explore further ways in which health might be improved through these groups.
3. Commissioners and planners should consider the community feedback when planning local development and how health improvement might fit in with this. Key themes in this regard included the potential benefit of tailored cooking classes and subsidised access to exercise facilities.
4. Finally, the council should work together with housing partners when planning re-development of the area to consider whether any options are available to reduce the burden of cost of housing, particularly social housing, for residents on very low relative incomes.

6.4 Questionnaire with community assets: identification of 'assets'

The community assets were identified through the Woking Borough Council website, discussion with key individuals working with the community, and walking through Maybury and Sheerwater. They can be divided into:¹¹³

- Health services:
 - GP practices:
 - Sheerwater Health Centre
 - College Road Surgery
 - Maybury Surgery
 - District nurses and health visitors (based at West Byfleet)
 - Pharmacies
 - May and Thompson Pharmacy
 - Bridge Pharmacy
 - Dental surgeries:
 - Waterside Dental Centre
 - Macrocare Dental, Albert Drive

- Community, voluntary, and charity services:
 - Woking SureStart Children's Centre
 - CornerHouse Mental Health Resource Centre
 - Sheerwater Youth Centre
 - Community centres:
 - Maybury Centre
 - Parkview/Sheerwater Community Centre
 - Charities:
 - Linkable Learning Disability Charity

- Faith institutions:
 - St. Paul's Church
 - St. Michael's Church
 - Emmanuel Chapel
 - Shah Jahan Mosque
 - Al-Birr Mosque

¹¹³ Not all of these could be contacted to answer the questionnaire, but at least one from each grouping responded. As noted below, this

6.5 Questionnaire with community assets: structure of questionnaire and responses

The questionnaire was completed either via email, telephone, or in person with respondents from the groups listed above. Again, results are presented as a narrative rather than statistics/charts, as the purpose of the questionnaires was to bring out issues not clear from the routine data sources as opposed to be a statistically accurate representation of the health needs of the residents.

The questions were preceded by the following guidance:

"This set of questions relates to your views on the health of the local population, with regard to what you see in your work.

It will be used alongside health data that is routinely collected to build up a current picture of health needs in Maybury and Sheerwater, as well as a picture of community assets and resources. The overall aim is to create a resource for the community, the council, and health professionals to support partnership working to improve the health and wellbeing of local residents.

Health here is defined broadly, to include everything from conditions like diabetes, stroke, and mental health; to obesity and behaviours like poor diet, smoking, and alcohol; to lack of access to parks, social isolation, safety, or poor housing."

1. What do you think are the major health issues in the population/group that you work with?

With regard to adults, the main responses were again diabetes, heart disease, diet, poor exercise, and poverty. An additional issue that was mentioned was 'loneliness' and 'lack of things to do or people to do things with', which was not raised by the residents themselves.

With regard to children and young people, the main responses were poor diet/overweight and diabetes, lack of support/overcrowding at home, and smoking. Young people were a major concern for service providers in the area, with a high level of need identified.

2. What services are available in the community to address those issues that you're aware of?

This question was designed to understand to what extent these providers were aware of each other's presence, and the services available generally in the community. Whilst all providers were able to identify GP practices and community centres, there was generally a poor understanding of what services were available generally in the community. This was particularly with regard to what services were available at Woking Children's SureStart Centre, and what sports/exercise facilities were available locally.

3. What more do you think could be done to address these health issues, whether supporting existing services or developing new approaches?

A key theme that ran throughout the responses to this question was a need for more joined up working between service providers. Suggestions included a regular forum for all local providers to discuss services and work together, an information event providing the same function, and simply raising the profile of these organisations with GP practices.

With regard to new approaches, specific projects around young people and diet/diabetes/obesity/cardiovascular disease were suggested, as were tailored cooking classes for the different ethnic groups. Pilot projects for community provision of antenatal/postnatal services were also suggested, both to improve maternal/newborn outcomes, but also to engage new mothers to improve their own health and through them their family's health.

Another point that was raised, specifically in relation to the Muslim community, was an issue around providing services to young women. Culturally there is some resistance to this group accessing services where they may be in contact with men, and this is an area that merits further exploration as it may result in the exclusion of a large group of residents from access to services that may benefit their health.

It was also noted that there is a huge drop-off in services available once a child turns 16/18, and there is a need for follow on support for 16-25 year olds.

Finally, service providers also noted that increasing engagement with the mosques may be a useful route to try to engage with the local community, both from the perspective of accessibility, and from the perspective of engaging leadership from within the community on health issues.

4. What do you think would help the population/group that you work with improve their own health? [e.g. cooking classes, sports and exercise opportunities, community walks, information, more community groups]

The two main themes in the responses were: cooking classes, that need to be tailored to the specific needs of the local community; and increased provision of information to groups in the community where there was the greatest need. It was noted that this could be achieved through both making GP practices more aware of services available in the community, and using existing community networks including faith based networks.

5. Do you think this population/group have good access to health services? [e.g. GP practices, dentists, pharmacists]

The responses generally noted that there was good access to services in this area, though as noted above information about services could be better. Some responses noted that individuals that they worked with had trouble getting appointments with their GPs, or had expressed frustration with the GP appointment booking system.

6. What do you think could be done to improve access to services that would improve people's health? [e.g. improved location, opening hours, transport, information, childcare]

Those that answered this question (i.e. those that felt that improvements could be made) focused on later opening hours in general practice, or at least an increased number of appointments available at later hours, and better information on service provision as noted above.

The importance of privacy/confidentiality came up repeatedly in the responses, specifically when considering how to improve uptake of services by the British/Asian population. There were no specific suggestions, but respondents felt that if this issue could be addressed, and residents felt that it was a primary consideration of service providers, then they would use more services, e.g. with regard to mental health, GP services, and community groups.

One respondent noted that with the large number of one car households/taxi drivers that use the sole vehicle for work/mothers unable to drive, there was a transport issue related to women and mothers bringing children to access services. This had been a real issue for this provider.

7. Do you provide any health/health related services to the population/group that you work with?

These responses informed the overview of services in Maybury and Sheerwater section, considered next.

8. Any other thoughts on how the council, health professionals, and local groups can work together to improve the health of the population of Maybury and Sheerwater?

The responses from this answer fitted prior questions, and so have been incorporated into the relevant specific questions above based on theme.

In summary, the community assets that provide services related to health highlighted the same health issues as the residents, specifically: diabetes and heart disease, poor diet and exercise, and poverty. They additionally added the issue of loneliness and boredom, which may feed into the issue of depression noted by some of the residents and reflected in the QoF prevalence. The extent to which these groups/assets were aware of each other was mixed, and a common suggestion was the development of a forum or formal network in the area for groups to understand each other better and be able to signpost to each other more easily.

Suggestions for new projects/approaches included targeted interventions for young people around obesity/diet/diabetes/heart disease; more support for 16-25 year olds; and antenatal and postnatal support for new mothers in the community. The latter may tie in well to the potential roll-out of the Family Nurse Partnership in Surrey in the future. Cultural barriers were also identified, particularly around the difficulty in providing services to young women in the British/Asian community where men may be present, and the importance of privacy/confidentiality. Generally, it was widely noted that service provision was good, but improving the provision of information to residents would improve uptake of these services.

In common with the residents, service providers also noted the potential benefit of targeted cooking classes and dietary health promotion advice, highlighted the role of mosques in delivering health messages to the Muslim community, and referred to the potential benefits from examining the GP practice booking system and provision of late-hours appointments.

The recommendations are:

1. Community assets should be supported to develop a forum (or equivalent) for sharing information about services that are available in the community. This would allow appropriate signposting and easier identification of gaps in service provision.
2. A plan should be developed for improving the knowledge and understanding that residents have on what services are available and how to access them. This may include regular direct mailings, a well-publicised website specifically for residents in Maybury and Sheerwater, or other appropriate options.
3. Commissioners and planners should also work together to identify specific projects based around common themes that can be drawn from the quantitative and qualitative data. This could include work around diet, obesity, diabetes, or heart disease, particularly in young people. Using a targeted approach in this way would ensure that resources were used effectively, whilst potentially engaging the community more widely on the importance of healthy eating and having a healthy weight.
4. Commissioners and planners should take into account the cultural barriers to accessing services that have been identified here when developing services. These include issues around gender segregation and privacy/confidentiality. They should also consider the strength of community networks, and include key assets in discussions around developing services e.g. how to increase delivery of health messages through faith organisations and how to tailor messages and health education (e.g. cooking classes) for specific ethnic groups.
5. Finally, as recommended above, GP practices should consider changing the booking system/availability in line with feedback.

7. Community assets

This chapter will briefly outline the services provided by the assets identified in section 6.4. All efforts were made to identify the full range of services provided, but there may be omissions.

7.1 GP practices

There are 3 GP practices in Maybury and Sheerwater: Sheerwater Health Centre, Maybury Surgery, and College Road Surgery. They provide appointments for registered patients in the surgery and home visits if patients are unable to attend the practice in person. Additionally, they can provide the following services:

- Adult and children's immunisations
- Asthma, COPD, and diabetes clinics
- Antenatal/postnatal clinics
- Family planning and cervical smear testing
- Health screening clinics
- NHS Health checks

These three GP practices are members of North West Surrey Clinical Commissioning Group (NWS CCG), the largest CCG in Surrey covering 350,000 people, with a budget of £403.2m for 2013/14. CCGs have a legal duty to reduce inequalities as enacted in s.26 of the Health and Social Care Act 2012, and so Maybury and Sheerwater should be an important area of focus.

7.2 District nurses and health visitors

The district nurses for Maybury and Sheerwater are based at West Byfleet Health Centre, and are able to provide the following services:

- Wound care, including leg ulcers
- Continence care
- Palliative care
- Continuing care for chronic conditions, e.g. diabetes and heart disease
- Acute or short term care e.g. post-operative advice and support

The health visitors are able to provide the following services:

- Supporting parents from pregnancy through to the child reaching 5 years of age, through:
 - Offering parenting support and advice on family health and minor illnesses
 - New birth visits, with advice on feeding, weaning and dental health
 - Physical and development checks
 - Providing families with specific support on subjects such as post-natal depression
- Providing ongoing additional services for vulnerable children and families, through:
 - Referring families to specialists as needed, e.g. speech and language therapists
 - Arranging access to support groups, e.g. at the Sure Start children's centre
 - Organising practical support
- They also provide an important role in safeguarding children, and provide additional services in partnership with the Sure Start Centre.

7.3 Pharmacies

There are two pharmacies in Maybury and Sheerwater: May and Thompson pharmacy and Bridge pharmacy. Services provided by pharmacists include:

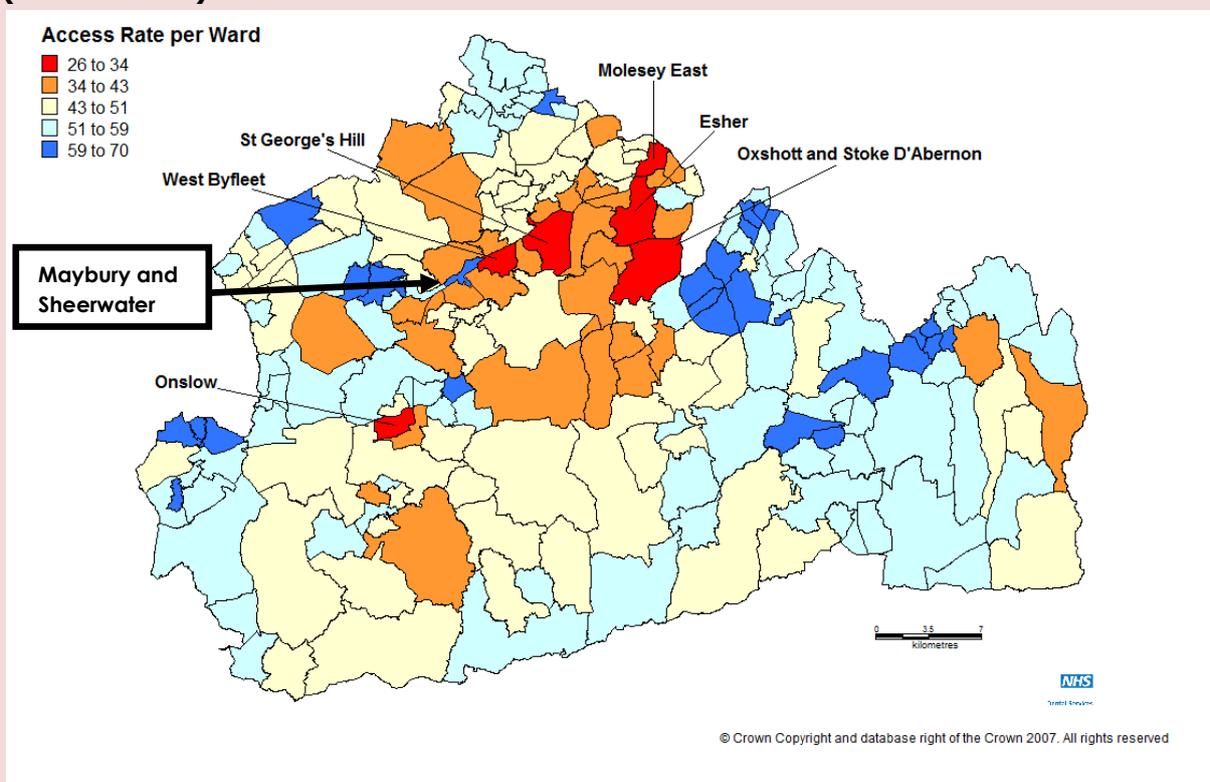
- Advice on minor ailments, including:
 - Viral illnesses, e.g. coughs and colds
 - Stomach/digestive problems
 - Minor injuries
 - Women's health
 - Skin conditions and allergies
 - Aches and pains
- Medicine usage review (MUR) service
- New medicine service (NMS) for long term conditions including asthma, COPD, type 2 diabetes, hypertension, or blood-thinning medications
- Supervised consumption
- Smoking cessation
- NHS Health Checks

7.4 Dental surgeries

There are two dental surgeries in Maybury and Sheerwater: the Waterside Dental Centre (where orthodontic treatment is additionally available), and Macrocare Dental (where dental anxiety management is additionally available). Both accept NHS patients, including children, charge-exempt adults, and fee-paying adults.

The provision of dental care in Maybury and Sheerwater is generally good, as can be seen from the 'Ward Level Access Rate' maps (figures 73 – 74).

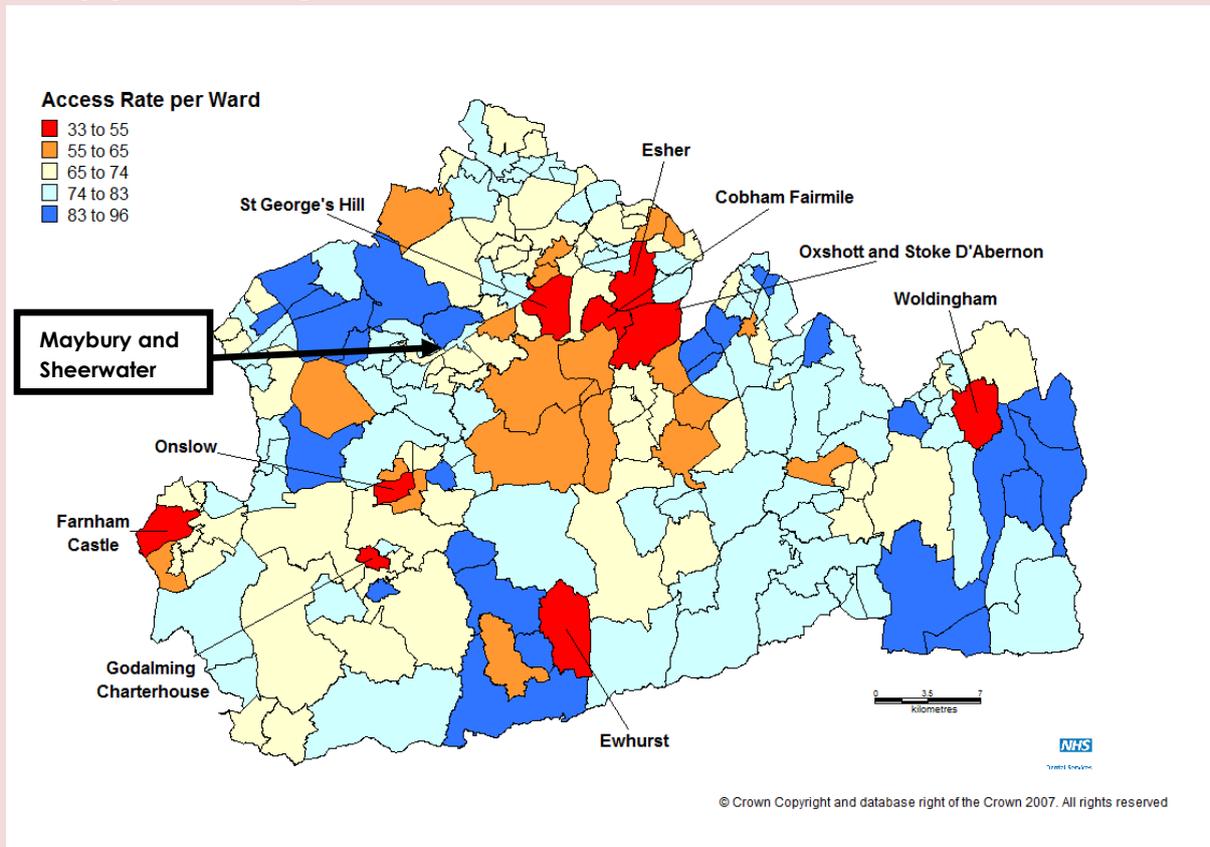
Figure 73: Ward level access rate (% of all patients) for dentistry in Surrey (March 2013)¹¹⁴



As can be seen in this map, the access rate for dentistry (all ages) in Maybury and Sheerwater is one of the highest in Surrey, at 59-70%.

¹¹⁴ Source: NHSBA Dental Services (March 2013)

Figure 74: Ward level access rate (% of patients under 19) for dentistry in Surrey (March 2013)¹¹⁵



As can be seen in this map, the access rate for dentistry in under 19s is also relatively high, at 74-83%.

7.5 Woking SureStart Children's Centre

Woking SureStart Children's Centre is a key asset located in Sheerwater, and runs activities, groups and special events throughout the year. It provides a comprehensive range of services to the local community, including: (further information available at www.wokingchildrenscentre.org.uk)

- Play and learn groups
- Baby club with the health visitor
- Water baby classes
- English, maths, and computer classes
- Toy library
- Job Club
- Antenatal and postnatal classes

¹¹⁵ Source: NHSBA Dental Services (March 2013)

- Maybury Health Clinic
 - Vaginal birth after caesarean (VBAC) clinic
 - Certificate in the Children and Young People's Workforce (CYPW)
 - Advice and support to young parents
 - Stop Smoking service
 - Daycare
- And many other services, including advice and information in several languages.

7.6 **CornerHouse Mental Health Resource Centre**

CornerHouse Mental Health Resource Centre is a provider of adult mental health services in Woking, and is located in Maybury and Sheerwater. It has a dual function in acting as a 'hub' for local voluntary sector mental health organisation, and providing services themselves. They are currently looking to expand services, but the services and groups that meet at CornerHouse include: (further information available at www.cornerhousewoking.org.uk/groups.html)

- Bipolar support group
- Depression support group
- Eating disorders self help group
- Lift Up Together – a social drop-in for anyone feeling down, alone, or simply wanting company
- Matrix Advocacy Service – a community advocacy service for anyone experiencing mental health difficulties
- Next Steps – a self-help support service for people with depression
- Release – a support group for those experiencing panic attacks, phobias, OCD, and anxiety disorder
- Rethink Carers support group
- Shifa Asian Women's Group – a support group specifically for Asian women with emotional health problems
- The Counselling Partnership – a charity offering a low-cost counselling service
- Woking Mind – affiliated with the national mental health charity 'Mind', offering social activities, an art group, a creative writing group, and a music group for people in Woking experiencing difficulty with their mental health

7.7 Sheerwater Youth Centre

Sheerwater Youth Centre operates as the hub for the Woking Youth Support Service during the day, as well as a Youth Centre for young people in the area two evenings a week, with a third evening given over to outreach. The Youth Support Service has taken on the joint roles of: the old Connexions service (employment education and training advice for young people aged 14-19); the Youth Justice Service (working with young people who offend or are involved in anti-social behaviour); and a youth engagement service.

Additionally, the Youth Centre has taken on a homelessness prevention role with 16-18 year olds, and Child in Need work with vulnerable teenagers aged 15-18.

7.8 Maybury Centre

The Maybury Centre is a multi-cultural community centre, providing facilities for social, business, education, health, welfare and general recreation events. The range of services provided by groups related to healthcare include:

- Arthritis Care
- Neighbourhood Advice Centre – advice on immigration, benefits, housing, Pakistani ID cards, translations, and similar services
- Citizens Advice Bureau – specialist surgery for those for whom English is a second language, with community language translators
- Carers Support Woking
- Child Health, baby weighing, and immunisation clinic
- Surrey Alcohol and Drug Advisory Service (SADAS) – counselling and group sessions
- New Buddha Way – weekly meditation group
- GLORIA – latin dance group
- GKR Karate – children's and adults karate class
- Yoga for all – yoga classes
- SAFA Tots – mother and toddler group for Muslim mums
- Woking PHAB – weekly meeting for physically handicapped and able bodied people

Besides these services there are other educational and community services offered at the Maybury Centre, which are well attended.

7.9 Parkview/Sheerwater Community Centre

Parkview is a community centre in Sheerwater, which was opened in 2009, with rooms and halls available for hire and a large drop-in cafe area. Activities focus on health and well-being, education and personal development, and include:

- Yoga, Pilates, podiatry, and massage therapy
- Fitness training, dance classes, and nutrition and cookery classes
- English language classes
- Depression support group meetings

7.10 Other halls for hire

Other halls for hire by community groups in Maybury and Sheerwater include: Alpha Road Community Hall (ARCH), St. Columba's House, St. Paul's Church Community Hall, Woking Homes residential care home, and Bishop David Brown School Hall. The residents themselves are the biggest asset in Maybury and Sheerwater, and developing and nurturing community groups will increase social capital, social cohesion, and social networks leading to improved health and wellbeing.

7.11 Linkable learning disability charity

Linkable is a charity based in Woking offering social activities and support to children, teenagers, and adults with learning disabilities. Their goals are to enable, support, develop, and connect service users. They offer a wide range of services to this group, including:

- Children's services (4-11)
 - Family swimming club, music therapy, Saturday play, and school holiday play schemes
- Youth services (12-18)
 - Complex needs specific days, dance sessions, day, overnight, and weekend breaks, family swimming club, social events, youth clubs, and holiday schemes
- Adult services (18+)
 - Adult nightclub, college holiday schemes, choir, horse riding, keep fit classes, social clubs and events, swimming club, and trips out, overnight, and weeks away

7.12 St. Paul's and St. Michael's churches

St. Paul's church is an Anglican church in Maybury, and St Michael's is an Anglican church in Sheerwater. St Michael's hosts a range of community groups, including a parent and toddler group and MIND, the mental health charity. St. Paul's church seeks to engage in the community's health and wellbeing through these initiatives:

- MASCOT – Maybury and Sheerwater Community Trust, a charity together with St Michael's church to meet the needs of the communities in Maybury and Sheerwater
- Street Angels – providing care and practical support for people in the town centre as pubs and clubs close
- Good Neighbour Scheme – a scheme to help people to get to hospital appointments, doctors appointments, shopping etc.

7.13 Emmanuel chapel

Emmanuel chapel is a church in Maybury, and hosts a toddler group on Friday mornings, together with Reflex Woking – a programme to empower children, young people, and young adults to break the cycle of offending and reoffending.

7.14 Al-Birr and Shah Jahan mosques

Al-Birr and Shah Jahan are the two mosques in Woking, the latter being the first purpose build mosque northern Europe. They serve the large local Muslim population, with Shah Jahan mosque able to hold 1000 men and 600 women for Friday prayers.

Public health and Woking Council regularly work together with the Shah Jahan mosque to deliver health and wellbeing messages. One example of this was a 1 hour weekly health improvement slot on Ramadan Radio run by Shahnaz Bano a public health development worker in Surrey, covering diabetes, smoking, and other health topics. Another example is a health promotion stand at the mosque summer fair in 2013, delivering messages about NHS health checks, stop smoking, and Change4Life to the Muslim community. A common theme in both the community feedback and the service provider feedback was the desire to see increased/regular delivery of health messages and healthcare through the mosque, particularly after Friday prayers. This model has also been used elsewhere, for example:

Health fair in a mosque: putting policy into practice (abstract)¹¹⁶

BACKGROUND: Towards the end of 2001, the Scottish Executive Health Department published a unique report, 'Fair for All', on the issue of addressing the health needs of ethnic minorities. One of the recommendations contained within the report was that different groups and organizations within communities should work together to provide services to minority groups. This descriptive paper is an illustration of how a settled community, in this case a Muslim community, was encouraged to become involved in its own health care by holding a health fair at its mosque.

PLANNING: The health fair was organized by the Minority Ethnic Health Inclusion Project, in collaboration with the Local Health Care Co-operative, and in co-operation with Edinburgh Central Mosque. The health fair was held over two consecutive Fridays in May 2003 and focused primarily on diabetes, high blood pressure, healthy eating and oral hygiene, as well as providing information on cancer and local community services.

OUTCOMES: The health fair was well received on both days, with around 200 men and 120 women participating. In total, there were 99 recorded blood pressure measurements and 81 blood glucose checks, and the community dental service was very well received.

EVALUATION: Strong participation by the community shows that people from ethnic minorities are interested in their health and will participate in health-related activities arranged for them. The success of this health fair shows that, as proposed by the Scottish Executive, different groups and organizations within the community can work together to provide services to minority ethnic groups.

7.15 Green spaces

Maybury and Sheerwater ward has at its northern border two large green spaces: Boundary Road Recreation Ground and Sheerwater Recreation Ground. These are connected by a towpath that runs along a stretch of the Basingstoke canal, where residents can fish, walk, cycle, and canoe. The canal itself has been designated a Site of Special Scientific Interest (SSSI) in light of its importance as a wildlife area.

¹¹⁶ Ghouri, N. Health fair in a mosque: putting policy into practice. Public Health 2005;119(3):197-201 available at [http://www.publichealthiml.com/article/S0033-3506\(04\)00119-2/abstract](http://www.publichealthiml.com/article/S0033-3506(04)00119-2/abstract) accessed 27th August 2013

Conclusions and final thoughts

The summary and recommendations for each section have been included in those sections, and an overview of the whole HNAA is provided in the Executive Summary, following which all of the recommendations are listed. Accordingly, there is no merit in reproducing any of that information at the end of what is already a (very) lengthy report.

Instead, there are two final thoughts that fit most naturally at the end of the report. The first is that the vast majority of recommendations for improving the health of the residents of Maybury and Sheerwater centre around 3 themes: partnership working, ill-health prevention through improving healthy behaviours, and tackling deprivation and social inequalities. The importance of the latter two points are comprehensively covered in the Executive Summary and the early chapters of this report, but can be summed up by noting that together they probably account for around 80% of health outcomes. The importance of partnership working is self-evident: health improvement requires the participation of many actors, providing different roles, all working together. No one actor can improve health without the help of others. Accordingly, if the reader takes away nothing else, they should take away those three messages.

Finally, the Sheerwater Regeneration Scheme, and alongside it plans for developing Maybury, represent a once in a generation opportunity to tackle all of the issues raised in the report. It is therefore absolutely critical that alongside community feedback on the development plans, planners have regard to the data sources covered in this report. This will ensure that services are planned appropriately according to need, and delivered in a way that will maximise uptake, leading to sustained improvements in health and wellbeing for the whole community.

Dr Nadeem Hasan
BM BCh MA MSc DRCOG
Specialty Registrar in Public Health

August 2013