Scrutiny Committee

Mind the Gap

Review of Health Inequalities in South Ribble: a partnership challenge

Final Report - September 2013

Task Group:

- Councillor Mick Titherington (Chair)
- Councillor Colin Coulton
- Councillor Derek Forrest
- Councillor Susan Jones
- Councillor Frances Walker
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Foreword

Health inequalities mean very different things to different people. It is a very difficult topic area to review for this very reason. There are no magic answers to this issue and any improvements can take at least a generation to make significant change and to see the difference that can be made. We have taken a partnership view of health inequalities as we believe a partnership approach is the only way to improve health inequalities. This view builds on South Ribble Borough Council's important role, commitment and significant investment in improving health in the Borough.

Throughout this review the Task Group has tried to be as inclusive as possible and is very grateful for the support that has been given. It has been evident that there are issues in South Ribble, that the review has been welcomed and there is a commitment to tackle health inequalities and improve the lives of local people. A key theme of the review is how to turn this commitment and the enthusiasm of individuals into positive action and many of our recommendations are about better co-ordination, communication and working together.

We have also been mindful that this review has to be the start of tackling this issue and have concentrated our recommendations on strategic high-level actions that organisations can take on board to start the journey of narrowing the health inequalities gaps in South Ribble. We feel that if organisations embed health inequalities into their work that this will lead to improved health and wellbeing for all our residents.

This review has also come at a very opportune time with the national changes to public health and empowerment of GP surgeries. We hope that this review will help with the new structures and healthcare prevention and delivery in South Ribble.

We hope that you find the report interesting and that you are able to help us step up to the challenge of reducing health inequalities and help to make South Ribble a great place to live, work, visit and play!

Councillor Mick Titherington
on behalf of the Scrutiny Task Group

For further information on this review or to view the background information and research, please contact Darren Cranshaw, Scrutiny & Performance Officer on 01772 625512 or email: dcranshaw@southribble.gov.uk.

Rationale for the Review

South Ribble Borough Council's Scrutiny Committee has a strong track record of scrutinising health and championing health issues in the Borough. This review therefore builds on our experience and helps to inform the way we will scrutinise going forward.

The health of residents in South Ribble is varied, with deprivation rates relatively low. However, there are health inequalities in South Ribble with women in the least deprived areas expecting to live over 8.5 years longer than men in the most deprived areas and for women this difference is over 6.8 years. This gap is continuing to rise. The task group has therefore been created to look at the reasons for this and what can be done to improve life expectancy and quality of life in South Ribble.

The review also comes at a time of unprecedented change in the health service and wider public sector with public health responsibilities returning to local government, creation of clinical commissioning groups and the economic situation.

Scrutiny Committee Review Team

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- Councillor Colin Coulton
- Councillor Derek Forrest
- Councillor Susan Jones
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Review Aims and Objectives

- To review the research and information available on life expectancy and health inequalities in South Ribble

- To audit what existing work is being carried out to improve life expectancy in South Ribble

- Consider the factors that contribute to health inequalities in South Ribble

- Look at what the Council, its partners and individual communities can do to improve life expectancy and quality of life in South Ribble

- Make recommendations to the Council and its partners on improving life expectancy

Methodology

The Task Group met on 12 occasions as part of the review, in addition to attending a number of health events and workshops during the period of the review.

At the start of the review a very useful Q&A Scrutiny Committee themed meeting on health reforms in South Ribble was held in January with help from the Chorley & South Ribble and Greater Preston Clinical Commissioning Groups, Public Health Lancashire designate and the Council's Cabinet Member. This was a valuable opportunity to gather information, raise the profile of the reforms and engage with partners and the wider community.

As part of the review, the Task Group met with over 50 representatives of partner organisations in South Ribble who have an impact on Health Inequalities. Please see Appendix 4 for a full list of all those involved in the review.

The Task Group organised a very successful workshop which was attended by over 60 people from a wide variety of partner organisations which looked at some of the key issues and found the process a useful networking opportunity. 96% of attendees responding rated the workshop as very or fairly good.

Representatives of the Task Group attended two seminars organised by the University of Central Lancashire, UK Healthy Cities Network, Centre for Public Scrutiny and the two-day Health Champion Course organised by North West Employers' Organisation.

The Task Group has also reviewed existing research and information held by the Council, external experts, partners and national organisations.

A watching brief overview of the Wade Hall Neighbourhood Health pilot has also been taken and some of the initial learning has been taken into account as part of the review.

The Task Group also commissioned more extensive research into the high number of road casualties and deaths which it highlighted as a concern as part of the review.

All of the above extensive research has been used as part of the review to:

- Identify the areas where health inequalities are highlighted
- Explore the factors that may contribute to the difference in life expectancy
- Meet with relevant councillors, partners and community representatives
- Investigate those factors (health determinants) that are in the remit of the Council and its partners

- Examine how the various partner organisations can work in a more integrated, co-ordinated and effective way.

Review Background

National Context

Health inequality has always been an area that has attracted the attention of politicians, health professionals and all those who recognise the moral and economic damage it does to our society.

The Health and Social Reform Act is said to be the biggest shakeup in health provision for generations. The expressed desire of the Government is that Health Provision and services should be integrated with a more joined up approach. In the Act, the responsibility for Public Health is transferred back to Local Authorities. This is a significant move and will see the setting up of a number of bodies such as Health and Well Being Boards, Clinical Commissioning Groups (CCGs), Public Health England and Healthwatch.

Although overall responsibility for Public Health lies with the upper tier in Lancashire, this does not and must not deflect responsibility from the Districts in the drive to reduce health inequality in the Borough.

To give an idea of the scale of the problem that exists in South Ribble, reference only has to be made to the successive Health profiles for the borough in 2011 and 2012.

In 2011 the profile reported that life expectancy was 8.6 years lower for men and 6.3 years lower for women in the most deprived areas of South Ribble than in the least deprived areas (based on the slope index of inequality published 5th January 2011).

In 2012, despite all the publicity and the declared desire to narrow this, the profile showed the difference in life expectancy actually increased to 8.5 years for men and 6.8 years for women. This must be a cause for concern for all of us.

Although deprivation is lower than average in South Ribble compared with both the England and Lancashire county average, the profile reports that 2,400 children in the Borough live in poverty. Life expectancy for men in the Borough is higher than the England average and although the nation's health has generally improved since the late 1990's for the better off, the improvement has been greater. The reason for this is that health literacy is greater amongst the better off. They are likely to be better informed and therefore better placed to take advantage of health advice and initiatives. They limit what is called 'risky behaviour'.

As Tanya Gold writing in the Guardian Newspaper put it: “However, the uneducated continued to puff, quaff and stuff. In 2003, they were three times more likely to destroy their health as the Educated; in 2008 they were FIVE TIMES as likely. So this is a bad news story hiding a good one. Health inequality has widened and, as unemployment grows and the cuts slice, it will get worse.”

Commentators have put forward different reasons for this but most agree on the causes of inequality and, what we do know is, that 70% of Health Determinants are outside of Health Services and fall within the domain of Public Health. This, then, gives an idea of how much the involvement of local authorities can influence the outcomes in the battle against inequality not just in health; but in all of those areas that directly impact and feed into Health and Well Being.

Against this backdrop, health inequalities are best tackled through encouraging more people to have the information and skills to lead a healthy lifestyle and prevent ill-health. The Health Secretary has made health inequalities a priority for the NHS for the first time and stresses the importance of involving local communities. Health Secretary Jeremy Hunt said on the BBC: "Everyone should have the same opportunity to lead a healthy life; no matter where they live or who they are which is why we must continue to work to narrow the gap in health inequalities.

"We have set out the first ever specific legal duties on health inequalities for the NHS and I recently set out my challenge on reducing premature mortality.

He added: "Local areas must work together to address the health needs of their population and make a real difference in tackling health inequalities."

Marmot Review

In the review carried out by Michael Marmot – *Fair Society, Healthy Lives* – he concludes in the Executive Summary, amongst other things (a full list of the summary is produced in the Appendix):

3. *Health inequalities result from Social inequalities. Action on health inequalities requires action across all the social determinants of health.*

4. Focussing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of social gradients in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportional universalism.

The task group has been directed in its deliberations by these key messages and was particularly mindful of the view expressed in point 8 of the summary where it declares:

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 equality in all policies.*

Mindful of the above and the scale of the challenge the Task Group recognised the importance of the need to work with partners for mutually desired aims and outcomes. It was further recognised that any recommendations made must be in the context and acknowledgement of the feasibility of achievement (a reasonable chance of a positive outcome), be able to be practically applied and recognise the extent of influence that can be brought to bear.

The Local Picture

The Lancashire Joint Strategic Needs Assessment identifies those determinants that have most impact and provides a model for tackling the issue of health inequality in Lancashire.

Against this background we have attempted to draw together the different factors over which the Borough can have influence and make a major contribution. Recalling the Marmot Report declaration that *focusing solely on the most disadvantaged will not reduce health inequalities sufficiently – but to reduce the steepness of social gradients in health actions must be universal, but the scale and intensity of that is proportionate to the level of disadvantage*.

The Task Group felt the need, therefore, to recognise where those areas of most disadvantage exist in the Borough and to focus attention on where to funnel resources into tackling the issues central to the cause and effect of inequality. Only by doing this could we begin to make any appropriate recommendations on where to direct and invest time and effort towards the effective delivery of the strategies contained in the needs assessment.

Clearly the evidence is already available and in the public domain as to where the areas of deprivation and therefore disadvantage lie within the Borough. It may be worth reminding ourselves how these are measured and identified:

Super output Areas

Super Output Areas (SOAs) are a national geography created by the Office for National Statistics (ONS) for collecting, aggregating and reporting statistics to a more local area smaller than ward areas.

Vulnerable People

"A vulnerable adult is someone who may be at risk because of mental, physical or learning disability, age or illness. Someone who cannot always take care of him or

herself, or protect him or herself against harm or exploitation." (Safeguarding Adults - Multi Agency Procedures 2008 Section 1.1 Vulnerable adult definition)

"Someone of 16 years or over who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or maybe unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation." (Making Decisions" 1997 Lord Chancellor's Department and 'No Secrets' 2000)

Likewise the determinants that directly affect Health and Wellbeing are universally recognised. So the task is in improving the health literacy of those individuals within the targeted groups and/or living in those areas regarded as vulnerable, and then, to convince them of the advantages of making life style changes. Making it easier to make, access and develop those changes is a major factor.

The Task Group acknowledges that the Council and its partners have already been involved in a number of projects and exercises designed with this aim in mind. This is to be applauded and we are happy to recognise this. Some of the projects the Task Group would like to highlight as good practice are:

- Setting up the first Health and Wellbeing Partnership covering Chorley & South Ribble.
- Developing the first joined-up Health and Wellbeing action plan for the partnership.
- Creation of the community 'pow-wow' to improve communication and work across the voluntary, community and faith sector.
- The Wade Hall neighbourhood health project.
- Community engagement through the creation of My Neighbourhood Forums, including working with young people.

Furthermore, we are aware of the enormity of the challenges faced in addressing the major factors behind the causes of health inequality and accept that only by working with Central and Local Government, the NHS and many other partners and agencies, can there be any hope of improving on the current position.

In our consultations and considerations we have been guided by this underlying principle and endeavoured to structure our recommendations accordingly. Furthermore, we have striven to focus on the main areas where impact can be made. Other factors have been highlighted where, with raised awareness and attention and with influential partners, progress can be made in specific areas. Measuring and achieving outcomes can present difficulty because of the problem of determining what the long term effects of actions taken now, will have in the future.

Measuring Improvement

The ultimate measurement will, of course, be not only the reductions in the gap between life expectancy in the Borough, which we would hope would steadily close, but also the quality of life enjoyed by residents.

The Task Group in its finding does not and has never sought to suggest that there is a 'magic wand' or 'cure all' answer to the issue but it is conscious of the need to strive for improvement, fairness and equality in health. Any steps taken will need to be on-going and will require the involvement and commitment of a multitude of agencies and partners in the design, delivery and implementation of various strategies. The desire and willingness to work in co-ordinated coherent manner will be vital to improving outcomes.

From the outset the Task Group readily accepted this and has generally found support of partners, groups and organisations associated with various aspects of public health, either directly or indirectly to be willingly given to this overarching principle. It was seen as essential if any progress was to be made. That is why we organised a workshop at which those involved could exchange ideas and pursue discussion on initiatives, as well as familiarise each other with current activities.

The workshop proved invaluable in collecting data, information and opinion from enthusiastic participants and helped considerably the Task Group's deliberations. It is appropriate at this time to thank all of those people who have willingly given up their time and have been forthcoming with views and experiences in a helpful and constructive manner.

We hope the Task Group's report is received in the context in which it has been produced and will heighten awareness, provoke interest, ideas and promote support for the steps to be taken in tackling the issues raised.

Outcomes

The Task Group found, based on the above evidence considered, that the following has been clearly established as fact:

- Health inequality exists and needs to be tackled.

- Wider public health determinants account for 70% of the determinants associated with health and wellbeing, such as:

  a) Economic
  b) Housing
  c) Nutrition
  d) Environment
  e) Exercise/Leisure
  f) Alcohol/Smoking/Drugs

- Local authorities across the three-tiers of local government are the major players in Public Health and must take the lead.
- South Ribble Borough Council has a major part to play in ensuring local needs are met and local neighbourhood issues tackled.
- Health literacy is greater in those areas of affluence compared to areas of deprivation.
- Greater co-ordination between authorities, agencies, organisations and other partners with full exchange of data to maximise integrated delivery of strategies, is fundamental to improving outcomes.
- Making lifestyle choices has to be made easier.
- The continuing development of approaches and initiatives is necessary if we are to make contact with those groups that are classed as 'hard to reach'.
- It is acknowledged that the emphasis on preventative measures has the support of all parties and will gather momentum.
- It is accepted that treatment at home is preferable to hospital stays.
- The Borough (as with the Nation) has an aging population that will bring with it particular issues that will have to be addressed.
- There are health challenges that we will face as people live longer.
- There has been a deficiency in the treatment of mental health.
- Community champions and leaders will be integral to the effective delivery of strategies.
- A surprising part of the health profile and data for South Ribble is road deaths and casualties, which has been highlighted as a concern during the review with further research carried out.

Conclusions

Based on our research and the above outcomes we feel that all organisations should work more closely together and that health inequalities should be placed at the heart of decision-making and considered in everything that they do. We feel that some of our recommendations such as healthy towns will help to raise the profile of health with partners and residents and galvanise greater joint work and action in the Borough.

We would like to thank all those who have been involved in this extensive review and look forward to continuing to improve the health and wellbeing of our communities.

Recommendation	Lead Partner	Financial	Outcomes/Benefits
1. Further consideration be given to the Council and whole of South Ribble becoming a World Health Organisation Healthy Borough.	South Ribble Borough Council (partnership approach through Health & Wellbeing Board)	None	▶ Raises the profile of health and wellbeing. ▶ Potential for levering in external funding. ▶ Galvanises partnership working. ▶ Provides learning, resources and materials to encourage health and wellbeing. ▶ Targets resources to meet local community needs. ▶ Our neighbouring partner council Chorley have found the status and support beneficial. ▶ The status would help draw in expert research and input into health issues in South Ribble not currently available.
2. The Council and its partner organisations develop health impact assessments as part of their decision-making processes, policy development and project management frameworks.	Chorley and South Ribble Health & Wellbeing Partnership	None	▶ Ensures that health impact is embedded into the work of partner organisations so that any adverse impacts can be mitigated. ▶ Health is considered early on and designed into processes and credit can be given and best practice shared.
3. Each major planning application submitted to the Council should include a health impact assessment.	South Ribble Borough Council	None	▶ This will ensure developers and applicants consider health inequalities as part of their development, their location and fits

Recommendation	Lead Partner	Financial	Outcomes/Benefits
			in with the Local Development Framework. ▶ A light touch approach for residential/delegated applications similar to community safety and other assessments is recommended. ▶ Developers will be expected to design and deliver a health impact assessment on major applications, reducing the resource requirements on the Council. ▶ Ensures partner considerations are taken into consideration.
4. Public health is placed on the agenda of each 'My Neighbourhood' forum, included in 'My Neighbourhood' plans and that each forum appoints a lead member for health.	South Ribble Borough Council – My Neighbourhood Chairs	None	▶ This allows local health issues to be identified and inequalities to be tackled at a local level and joint community action can be planned and delivered. ▶ Engages local communities and residents in improving the health and wellbeing of their communities. ▶ Gives opportunities to councillors to champion health in their communities.
5. Lancashire County Council's Children's Trust in South Ribble is asked to organise a comprehensive programme of activities and events for young people	Lancashire County Council's Children's Trust in South Ribble	Yes – to be assessed (possibly use of reported	▶ To give positive activities for young people. ▶ Keeps young people fit and healthy, encouraging them to lead healthy lifestyles.

Recommendation	Lead Partner	Financial	Outcomes/Benefits
specifically during holiday periods which also involve families.		underspends)	▶ Help provide young people with key skills for the future. ▶ Allows families to consider healthy lifestyles and receive positive messages and support.
6. The Council encourages more councillors to take part in the North West Employers' Health Champion training.	South Ribble Borough Council – Member Development Champions	None.	▶ Equips councillors with the skills to work with their communities to encourage health and wellbeing. ▶ Provides councillors with the skills to work with health and other partners to champion health affecting their residents. ▶ Helps to look at the health issues in local areas so that local interventions and work can be done. ▶ Gives councillors confidence to engage on health issues as part of the My Neighbourhood forums and action plans.
7. The Chorley & South Ribble Health and Wellbeing Partnership develops actions to ensure the effective co-ordination and information sharing across partners to help plan prevention strategies and provide appropriate care packages.	Chorley & South Ribble Health and Wellbeing Partnership	None.	▶ Strengthens existing partnership work to tackle health inequalities. ▶ Roles and responsibilities of health partners under the new health reform structures are understood and used to improve health and wellbeing. ▶ Buy-in to delivering the Health and Wellbeing Action Plan. ▶ Achievement of Action Plan aims and objectives.

Recommendation	Lead Partner	Financial	Outcomes/Benefits
8. Lancashire County Council's three-tier forum is asked to carry out a review of road deaths and casualties in South Ribble.	Lancashire County Council – Three Tier Forum	None.	▶ Further research is carried out to understand the figures and causes of the significant figures in South Ribble. ▶ Appropriate action can be taken to reduce road deaths and casualties.
9. The Scrutiny Committee develop a protocol for how it will scrutinise public health and health services in South Ribble as part of the reforms.	Scrutiny Committee	None.	▶ Improves and more co-ordinated health scrutiny in the future. ▶ Greater partner buy-in to the scrutiny process. ▶ Better scrutiny and health outcomes for local people.
10. Partners work together with the voluntary, community and faith sectors to develop a joined-up referral system to help sign-post and provide holistic support for vulnerable people to improve health and wellbeing from those who visit people in their home.	South Ribble Partnership	To be assessed.	▶ Improved partnership working. ▶ Joint data sharing protocols. ▶ Helps prevent health interventions and expensive care further down the line. ▶ Potential to make financial savings. ▶ Improves health and wellbeing. ▶ Encourages independence and self-help. ▶ Builds on the success of South Ribble Partnership's former health in the home project.
11. Lancashire County Council Public Health, the Chorley & South Ribble and Greater Preston Clinical Commissioning	Lancashire County Council – Public Health	None.	▶ More information is provided to communities and residents to help them to improve their health and wellbeing.

Recommendation		Lead Partner	Financial	Outcomes/Benefits
	Groups establish greater links with bodies like the Tobacco Alliance and Drinkwise to obtain resources and prioritise work in South Ribble.	Chorley & South Ribble and Greater Preston Clinical Commissioning Groups		▶ Public health information is targeted to those that will benefit.
12.	The Scrutiny Committee builds on the learning from being selected by the Centre for Public Scrutiny/Department of Health to pilot the NHS Healthcheck Scrutiny Programme.	Scrutiny Committee	None.	▶ Future targeted scrutiny work on health will be based on this experience, evidence based and working with partners and health providers. ▶ The outcome of the Healthcheck review will inform future health.
13.	The Scrutiny Committee considers the benefits of becoming a Dementia Friendly Borough as part of its review of the ageing population later in the year.	Scrutiny Committee	None.	▶ Allows a full assessment of dementia planning and services to be undertaken.

Appendices

Appendix 1	-	Kings Fund guide to health reforms
Appendix 2	-	Summary extract from the Marmot report
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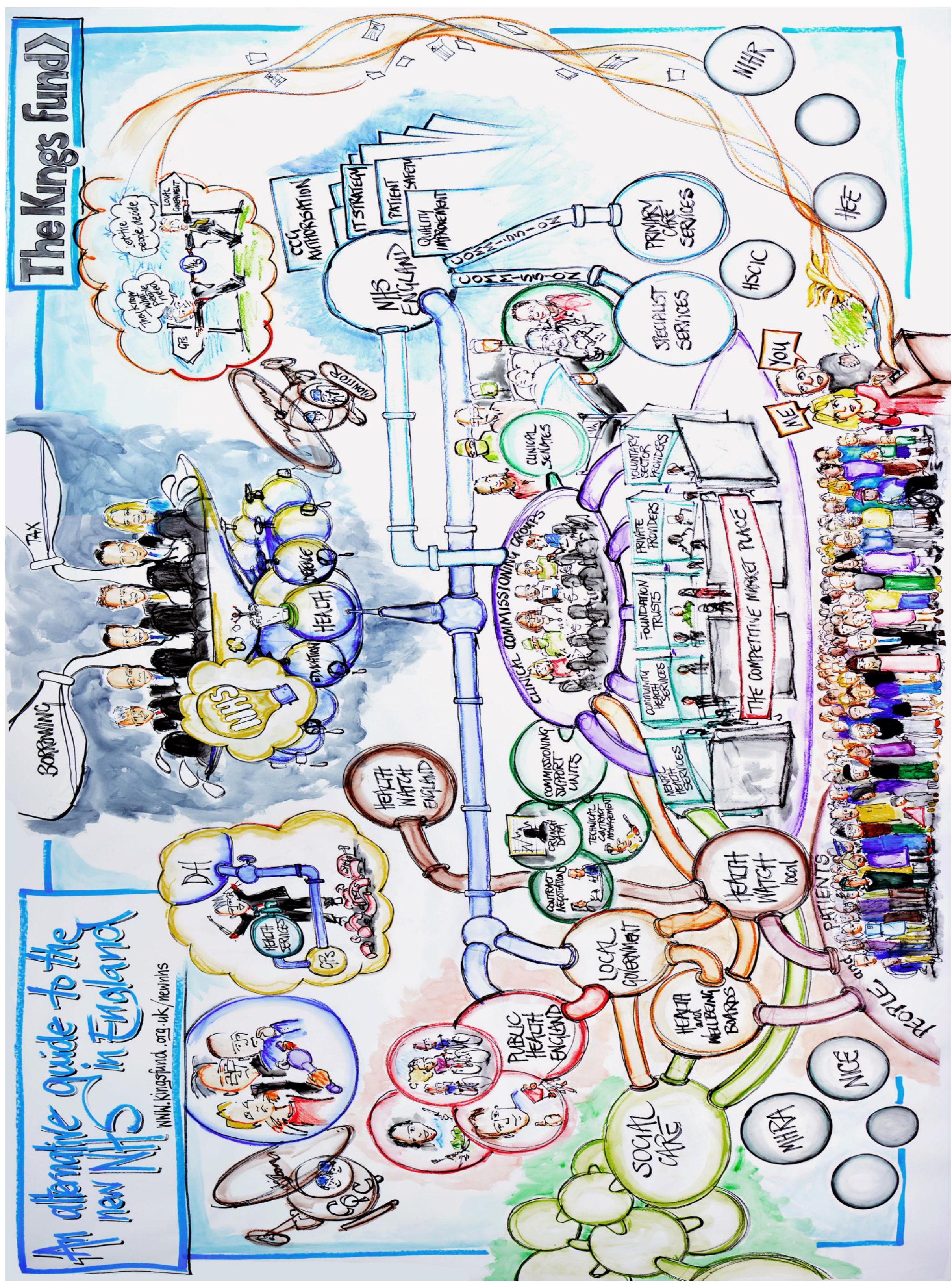
The following appendices include some detailed graphs, maps and information, which it has been difficult to re-produce in this report and might be difficult to read. For a larger or more detailed copy of the appendices or support documents, please contact Darren Cranshaw, Scrutiny & Performance Officer on 01772 625512 or email: dcranshaw@southribble.gov.uk.

Appendix 1 – Health Reforms Diagram



An animated and narrated version of this poster is available at:

http://www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england

Appendix 2 - Summary of Marmot Review

Executive summary

Key messages of this Review

1. Reducing health inequalities is a matter of fairness and social justice. In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.[1]

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. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.

5. Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for 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. Tackling social inequalities in health and tackling climate change must go together.

7. Reducing health inequalities will require action on six policy objectives:
   - Give every child the best start in life
   - Enable all children young people and adults to maximise their capabilities and have control over their lives
   - Create fair employment and good work for all
   - Ensure healthy standard of living for all
   - Create and develop healthy and sustainable places and communities
   - 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 effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

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A full copy of the Marmot report is available at:
http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

Appendix 3

http://www.apho.org.uk/resource/view.aspx?RID=50215&SEARCH=South%20Ribble&SPEAR=

Health Profile 2012

South Ribble

This profile gives a picture of health in this area. It is designed to help local government and health services understand their community's needs, so that they can work to improve people's health and reduce health inequalities.

Visit the Health Profiles website for:

- Profiles of all local authorities in England
- Interactive maps – see how health varies between areas
- More health indicator information
- Links to more community health profiles and tools

Health Profiles are produced by the English Public Health Observatories working in partnership.

www.healthprofiles.info

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Other map data © Collins Bartholomew

Population 108,000

Mid-2010 population estimate

Source: National Statistics website: www.statistics.gov.uk

Department of Health

South Ribble at a glance

- The health of people in South Ribble is mixed compared with the England average. Deprivation is lower than average, however about 2,400 children live in poverty. Life expectancy for men is higher than the England average.
- Life expectancy is 8.8 years lower for men and 6.8 years lower for women in the most deprived areas of South Ribble than in the least deprived areas.
- Over the last 10 years, all cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen and are better than the England average.
- About 16.2% of Year 6 children are classified as obese, lower than the average for England. Levels of alcohol-specific hospital stays among those under 18, breast feeding initiation and smoking in pregnancy are worse than the England average. The level of GCSE attainment is better than the England average.
- Estimated levels of adult smoking and obesity are better than the England average. Rates of road injuries and deaths and hospital stays for alcohol related harm are worse than the England average.
- Priorities in South Ribble include improving access to, and the quality of, local health services in emerging new health and wellbeing structures, tackling health inequalities, and prevention and early intervention to improve health and wellbeing outcomes. For more information see www.centrallancashire.nhs.uk or www.southribble.gov.uk

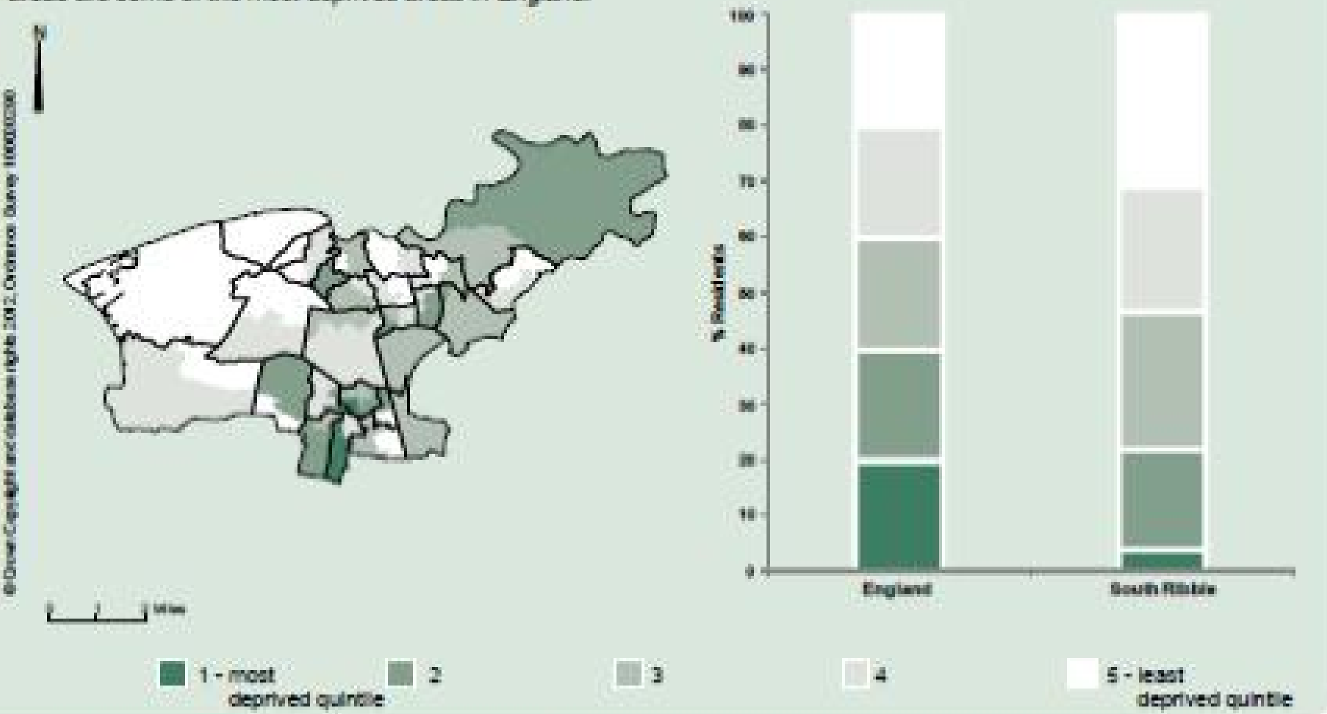
NHS

South Ribble

Deprivation: a national view

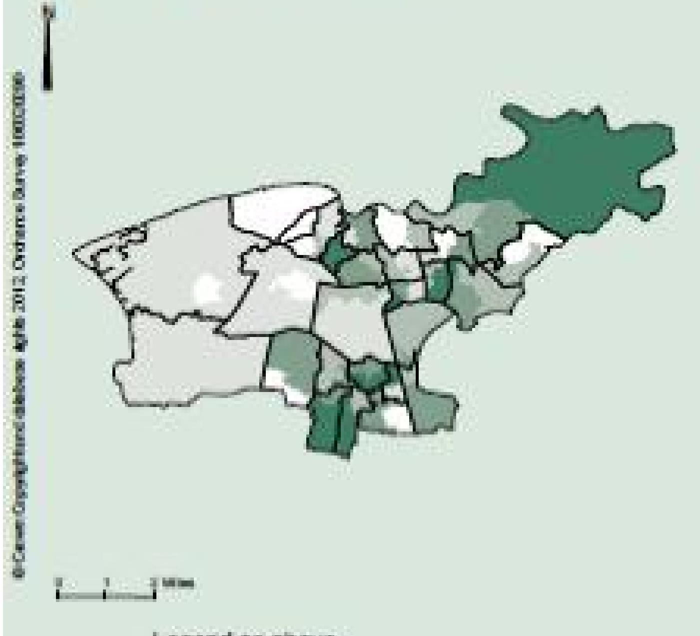
This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.

This chart shows the percentage of the population in England and this area who live in each of these quintiles.

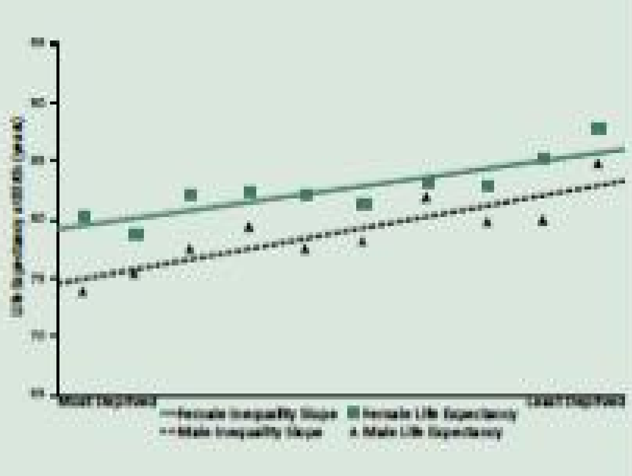


Health inequalities: a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.



The lines on this chart represent the Slope Index of Inequality, which is a modelled estimate of the range in life-expectancy at birth across the whole population of this area from most to least deprived. Based on death rates in 2006-2010, this range is 8.8 years for males and 6.8 years for females. The points on this chart show the average life expectancy in each tenth of the population of this area.



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Health inequalities: changes over time

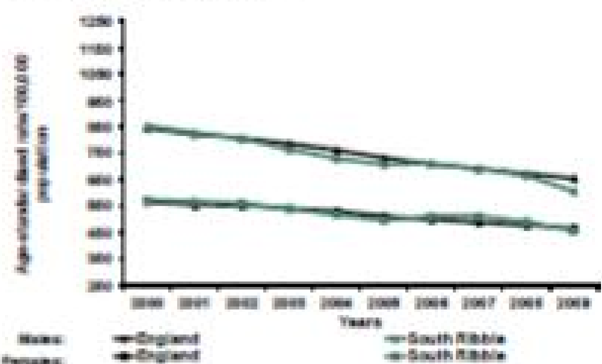
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

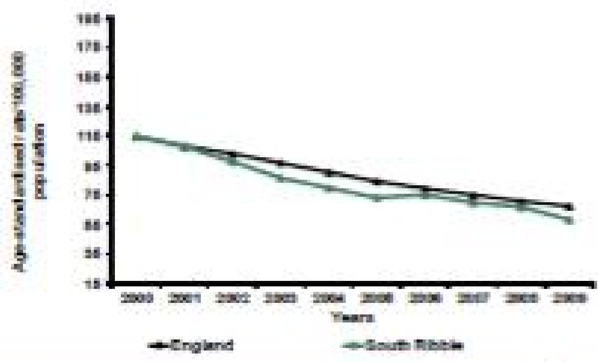
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

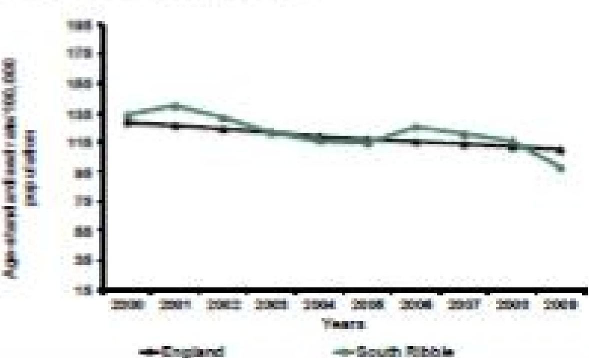
Trend 1:
All age, all cause mortality



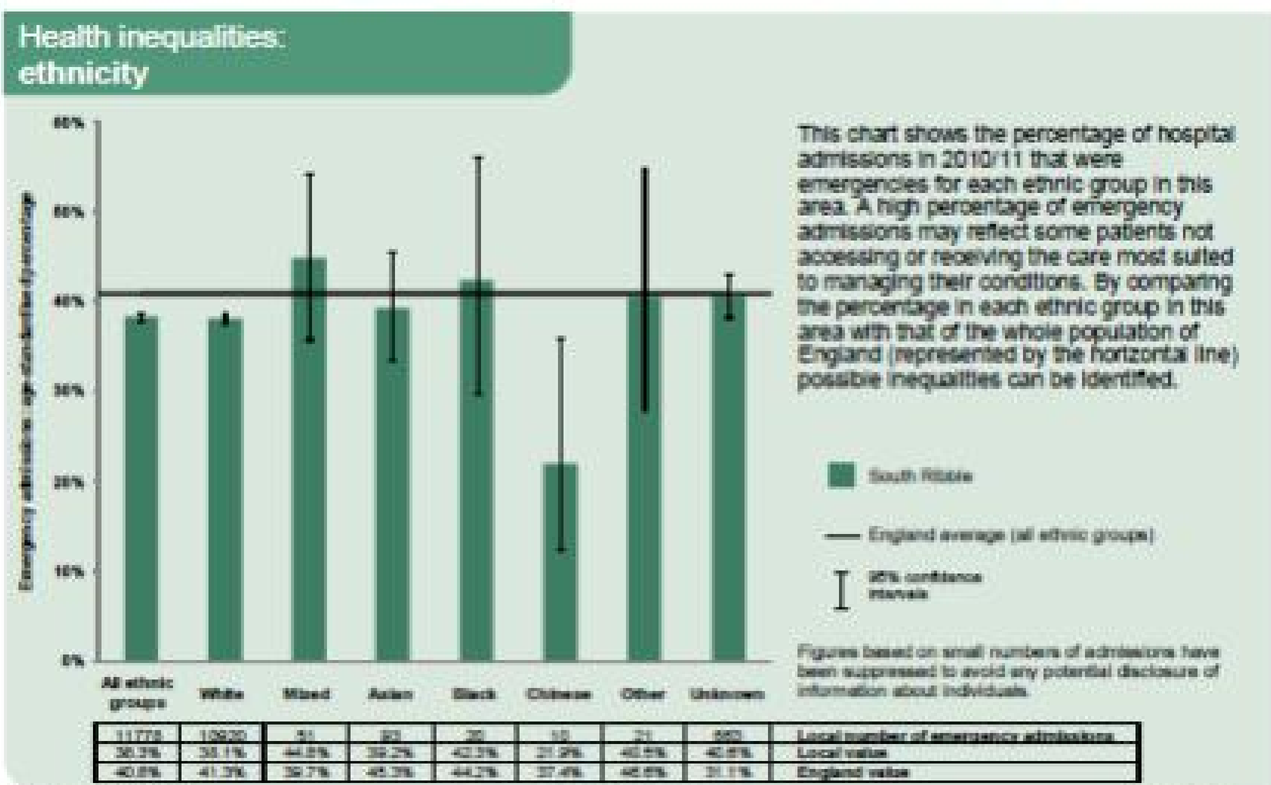
Trend 2:
Early death rates from heart disease and stroke



Trend 3:
Early death rates from cancer



Health inequalities: ethnicity



All ethnic groups	White	Mixed	Asian	Black	Chinese	Other	Unknown	
11778	10920	51	83	30	10	21	665	Local number of emergency admissions
38.3%	38.1%	44.8%	39.2%	42.3%	21.9%	40.5%	40.6%	Local value
40.8%	41.3%	39.7%	45.3%	44.2%	37.4%	46.6%	31.1%	England value

This chart shows the percentage of hospital admissions in 2010/11 that were emergencies for each ethnic group in this area. A high percentage of emergency admissions may reflect some patients not accessing or receiving the care most suited to managing their conditions. By comparing the percentage in each ethnic group in this area with that of the whole population of England (represented by the horizontal line) possible inequalities can be identified.

Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

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Health summary for South Ribble

E07000126

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	Eng Best
Our communities	1 Deprivation	4101	3.8	19.8	83.0	0.0
	2 Proportion of children in poverty ‡	2445	12.8	21.9	55.9	6.4
	3 Statutory homelessness ‡	46	1.0	2.0	10.4	0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)	963	66.1	58.4	40.1	79.9
	5 Violent crime	1239	11.8	14.8	35.1	4.8
	6 Long term unemployment	120	1.7	5.7	15.8	0.9
Children's and young people's health	7 Smoking in pregnancy ‡	212	19.8	13.7	32.7	3.1
	8 Breast feeding initiation ‡	763	66.4	74.8	39.0	94.7
	9 Obese Children (Year 6) ‡	160	16.2	19.0	26.5	9.8
	10 Alcohol-specific hospital stays (under 18)	25	96.0	61.8	154.9	12.6
	11 Teenage pregnancy (under 18) ‡	82	40.0	38.1	64.9	11.1
Adults' health and lifestyle	12 Adults smoking ‡	n/a	16.4	20.7	33.5	8.9
	13 Increasing and higher risk drinking	n/a	23.8	22.3	25.1	15.7
	14 Healthy eating adults	n/a	29.5	28.7	19.3	47.8
	15 Physically active adults ‡	n/a	11.4	11.2	5.7	18.2
	16 Obese adults ‡	n/a	21.2	24.2	30.7	13.9
Disease and poor health	17 Incidence of malignant melanoma	19	18.8	13.8	28.8	2.7
	18 Hospital stays for self-harm ‡	228	225.0	212.0	509.8	49.6
	19 Hospital stays for alcohol related harm ‡	2906	2141	1895	3276	910
	20 Drug misuse	459	5.8	8.9	30.2	1.3
	21 People diagnosed with diabetes ‡	5429	5.2	5.5	8.1	3.3
	22 New cases of tuberculosis	3	2.8	15.2	124.4	0.0
	23 Acute sexually transmitted infections	806	738	775	2276	152
	24 Hip fracture in 65s and over ‡	104	416	452	588	324
Life expectancy and causes of death	25 Excess winter deaths ‡	88	21.8	18.7	35.0	4.4
	26 Life expectancy – male	n/a	79.3	78.6	73.6	85.1
	27 Life expectancy – female	n/a	83.0	82.6	79.1	89.8
	28 Infant deaths ‡	3	2.2	4.6	8.3	1.2
	29 Smoking related deaths	184	207	211	372	128
	30 Early deaths: heart disease and stroke ‡	77	59.2	67.3	123.2	35.8
	31 Early deaths: cancer ‡	139	98.0	110.1	158.1	77.9
	32 Road injuries and deaths ‡	79	73.0	44.3	125.8	14.1

‡ Substantially similar to indicator proposed in the Public Health Outcomes Framework published January 2012

Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2008 3 Crude rate per 1,000 households, 2010/11 4 % at Key Stage 4, 2010/11 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2010/11 6 Crude rate per 1,000 population aged16-64, 2011 7 % mothers smoking in pregnancy where status is known, 2010/11 8 % mothers initiating breast feeding where status is known, 2010/11 9 % school children in Year 6 (age 10-11), 2010/11 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2007/08 to 2009/10 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2008-2010 12 % adults aged 18 and over, 2010/11 13 % aged 16+ in the resident population, 2008/2009 14 % adults, modelled estimate using Health Survey for England 2006-2008 15 % aged 16 and over, Oct 2009-Oct 2011 16 % adults, modelled estimate using Health Survey for England 2006-2008 17 Directly age standardised rate per 100,000 population, aged under 75, 2006-2008 18 Directly age sex standardised rate per 100,000 population, 2010/11 19 Directly age sex standardised rate per 100,000 population, 2010/11 20 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2009/10 21 % people on GP registers with a recorded diagnosis of diabetes 2010/11 22 Crude rate per 100,000 population, 2008-2010 23 Crude rate per 100,000 population, 2010 (chlamydia screening coverage may influence rate) 24 Directly age and sex standardised rate for emergency admissions, per 100,000 population aged 65 and over, 2010/11 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.07-31.07.10 26 At birth, 2008-2010 27 At birth, 2008-2010 28 Rate per 1,000 live births, 2008-2010 29 Directly age standardised rate per 100,000 population aged 35 and over, 2008-2010 30 Directly age standardised rate per 100,000 population aged under 75, 2008-2010 31 Directly age standardised rate per 100,000 population aged under 75, 2008-2010 32 Rate per 100,000 population, 2008-2010

More information is available at www.healthprofiles.info Please send any enquiries to healthprofiles@apho.nhs.uk

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Appendix 4

List of People Involved in the Review (listed in organisation order)

First Name	Surname	Job Title	Organisation
Jan	Ledward	Chief Accountable Officer	Chorley & South Ribble and Preston Clinical Commissioning Groups
Iain	Crossley	Chief Finance & Contracting Officer	Chorley & South Ribble and Preston Clinical Commissioning Groups
Alan	Stedman	Head of Strategy, Quality and Outcomes	Chorley & South Ribble and Preston Clinical Commissioning Groups
Glenis	Tansey	Locality Lead – Greater Preston	Chorley & South Ribble and Preston Clinical Commissioning Groups
Heather	Corson	Domestic Abuse Co-ordinator	Chorley & South Ribble Community Safety Partnership
Paul	Lowe	Joint Community Safety Manager	Chorley & South Ribble Community Safety Partnership
Suzie	Jones	Disability Forum Co-ordinator	Chorley & South Ribble Disability Forum
Eileen	Clarke	Community Volunteer	Giant Veggie Patch
Sheila	Seal	Community Volunteer	Giant Veggie Patch
Aysha	Desai	Community Engagement Officer	Healthwatch Lancashire
Iain	Pearson	Help Direct Manager	Help Direct
Carole	Lee	Chief Executive	Homestart
Jeannie	Stirling	Chair	Homestart
Paula	Garstang	Programme Lead – Long Term Conditions Partnership Programme (Central Lancashire)	Lancashire Care NHS Trust
Karen	Swainston-Thomas	Adult Education Officer	Lancashire College
Bob	Minto	Community Engagement Officer	Public Health LancashireLancashire Commissioning Support Unit
County Councillor Val	Wilson	Cabinet Member for Health & Wellbeing	Lancashire County Council
Gill	Milward	Health Policy Officer	Lancashire County Council
Maria	Neale	Head of Children's Centres – South Ribble	Lancashire County Council
Dr Sakthi	Karunanithi	Director of Population Healthcare	Lancashire County Council
Geoff	Hurst	Chief Inspector	Lancashire Police
Denise	Morris	Public Health Manager	Lancashire Teaching Hospitals NHS Foundation Trust
Diane	Gradwell	District Manager	Lancashire West Citizens Advice Bureau
Matthew	Astley	Project Support Officer	Lancashire West Citizens Advice

First Name	Surname	Job Title	Organisation
			Bureau
Lorraine	Simpson	Head of Customer Services	New Progress Housing Association
Steve	Caswell	Town Manager	Penwortham Town Council
Gary	Melia	Operations Director (Housing, Community & Support Services)	Progress Housing Group
Liz	Petch	Public Health Specialist	Public Health Lancashire
Farhat	Abbas	Public Health Intelligence	Public Health Lancashire
Dr Anthony	Sudell	Consultant in Public Health Medicine	Public Health Lancashire
Wendy	Broadley	Principal Scrutiny Officer (Health)	Public Health Lancashire
Gulab	Singh	Assistant Director Healthy Communities	Public Health Lancashire
Poyee	Chan	Head of School of Adult, Social Care & Childhood Studies	Runshaw College
Mark	Snaylam	Contract Manager	Serco Leisure
Cath	Moran	Lead Artist	Shaw Trust
Hilary	Morris	Administrator / Marketing Officer	Shaw Trust
Jane	Maguire	Housing Manager	South Ribble Borough Council
Rebecca	Heap	Senior Community Works Officer	South Ribble Borough Council
Maureen	Wood	Director of Corporate Governance	South Ribble Borough Council
Mark	Gaffney	Director of Neighbourhoods	South Ribble Borough Council
Jennifer	Mullin	Public Health Manager	South Ribble Borough Council
John	Dalton	Director of Planning & Housing	South Ribble Borough Council
Cllr Phil	Smith	Cabinet Member for Regeneration, Leisure & Healthy Communities	South Ribble Borough Council
Darren	Cranshaw	Scrutiny & Performance Officer	South Ribble Borough Council
Denise	Johnson	Director of Regeneration & Healthy Communities	South Ribble Borough Council
Carol	Eddleston	Democratic Services Officer	South Ribble Borough Council
Sandra	Allen	Health & Wellbeing Project Worker	South Ribble VCFS Network
Beth	Blenkinship	Community Development Officer	The Leyland Project
Brian	McGorry	Home Improvement Agency Manager	The Riverside Group
Tony	Spencer	Home Improvement Agency Team Leader	The Riverside Group
Joanna	Maloney	Operations Manager (Contracts)	The Via Partnership
Dr Richard	Kelsall	GP	Worden Medical Centre

Appendix 5

Document/Evidence Sources Consulted

National

Document	Author/Publisher	Date
10 questions to ask if you're scrutinising arrangements for local health	CFPS	November 2011
Accountability and the new health structures	British Medical Association / CFPS	January 2012
Achieving an effective health and wellbeing board	CFPS	November 2011
Health Inequalities: Peeling the Onion	Centre for Public Scrutiny	May 2011
Health Overview and Scrutiny: Exploiting opportunities at a time of change	LGA	November 2011
Marmot Review: Fair Society, Healthy Lives	Prof Sir Michael Marmot	2008
Reaching Out community engagement and health	I&DeA / NHS	2009

Local

Document	Author/Publisher	Date
Broadfield Appreciative Inquiry	South Ribble Borough Council Scrutiny Committee	2009-2011
Draft Health & Wellbeing Action Plan	Chorley & South Ribble Health & Wellbeing Partnership	May 2013
Health Profile DVD	South Ribble Borough Council Scrutiny Committee / NHS Central Lancashire	2011
Health Profile for South Ribble 2012	Department of Health / NHS	2012
Health Profile South Ribble 2011	Department of Health / NHS	2011
Lancashire Joint Strategic Needs Assessment	Lancashire County Council / NHS	Various updates
Minutes of Health Matters themed Scrutiny Committee meeting	South Ribble Borough Council	January 2013
My Neighbourhood Action Plans	South Ribble Borough Council	November 2012
NHS Chorley & South Ribble Clinical Commissioning Group – recommended	Central Lancashire Health intelligence	August 2012

approaches for commissioners within the Chorley & South Ribble health economy	Unit	
NHS Greater Preston Clinical Commissioning Group – recommended approaches for commissioners within the Greater Preston health economy	Central Lancashire Health intelligence Unit	August 2012
Outcomes benchmarking support packs: CCG level – Chorley & South Ribble CCG	NHS Commissioning	2012
Outcomes benchmarking support packs: CCG level – Greater Preston CCG	NHS Commissioning	2012
Road casualty deaths in South Ribble	Lancashire County Council	June 2013

Please note: the above list does not include the handouts/other materials collected on training courses/workshops. All this information is available in the evidence files for the review.

A copy of any of the above documents is available from Darren Cranshaw, Scrutiny & Performance Officer on 01772 625512, email: dcranshaw@southribble.gov.uk

Appendix 6

Scrutiny Committee
Review of Health Inequalities
Verbatim Transcript of Flipcharts from Partner Workshop – 8 April 2013
(unedited comments as they were written on the flipchart sheets)

Group 1

Setting a baseline

1. Where live – linked to deprived areas – health literacy
2. Not always a medical answer
3. Influence of wider economic factors (other boroughs)
4. Access to services – ability, knowledge, what is there, barriers, mental health, transport
5. Areas where some work, some on benefits – not all getting services
6. Health literacy = opportunities, proactive
7. Proactive working in community – getting too hard to reach groups, need to develop, education, other priorities
8. Careers – adult and young carers 50%, link to isolation
9. Why do we go to the doctors? How do we identify the underlying issue? Signpost

The current picture

1. Individual – Disabled facility grants/home improvement agency (SRBC/Energy Switching)
2. Signposting. Maximising income/opportunities to employment
3. Collective – Smoke free places/drink awareness campaigns.
4. Identifying impact on income of reforms (welfare)
5. WTWF
6. Health literacy with Children's Trust
7. Community events
8. Shared experiences on the ground
9. Get to right person at the right time
10. CAB service in GP surgery (Blackburn)
11. Outreach services
12. Need to understand who signposts?
13. Reach those with disabilities
14. Communication issues – GPs
15. Corporate responsibility to share information using employers in business in the area
16. Explore when other service are not accessed e.g. alcohol addiction services so that lead professional and voluntary service understand what services individuals are accessing
17. GP – Wade Hall service delivery model – break the cycle
18. Broadfield Estate – using the community association and community champions

19. IDVA project – Sanctuary Scheme
20. Liverpool – GPs, DFGs/adaptions on prescriptions

The Future

1. Think very differently on how we tackle issues. Traditional ways may not be relevant I austerity
2. Key is working with communities
3. Use good practice examples of models already used
4. Not short term funded by sustainable community driven programmes
5. Expand on models for joining closer working which are in development (e.g. WTWF)
6. Look at impact of withdrawal of services/products i.e. legal aid withdrawn and what impact this has on people's lives and wellbeing
7. Use health equity audits and health impact assessments to drill down to underlying facts
8. Social media for getting to hard to reach groups
9. Voluntary sector – how we can pool resources to make better use of technology to improve communications
10. Data sharing – not hiding behind this issue. Sharing of information is important but how do we get to the point of the individual sharing this, with support, instead of an org?
11. Improving health literacy and where people who cannot navigate through systems go for help?
12. Recognition that 'face to face' interaction instead of use of technology is v.important for good mental health, reducing isolation in older people and early intervention i.e. interacting and talking re healing etc.
13. Support for 16-18 year olds – service gap

Group 2

Setting a baseline

1. What We know:
2. Mental health – impact of economic climate
3. Varying social skills have an impact
4. Parents educate their children differently around health awareness/responsibilities
5. Community based assets offer solutions
6. Older people – loneliness is an issue which can have a health impact
7. Diverse borough – varied needs, rural/urban
8. Benefit dependency – high in some areas/none in others
9. Fire risks
10. Ageing population
11. What we don't know
12. How people interpret the information available (health literacy)

13. How to consult with people who are unknown/don't access services
14. Impact on welfare reform/universal credit
15. How to engage a broad range of the community into volunteering/community efforts
16. Level of understanding – people find ways to makes/disguise e.g can't read = forgotten glasses

The current picture

1. Progress HA – telecare (e,g, motion sensors, panic alarms)
2. Working with Health/Ambulance Service to develop further
3. Riverside HIA – handyperson service providing low cost support to keep people in their homes. DFG's for adaptations.
4. LCC safetrader scheme for approved workmen
5. Singing scheme for people with COPD/chest problems
6. LFRS – home fire safety check – signposting
7. Partners working together through formation of CCGs – trying to be as well informed as possible
8. BRBC – My Neighbourhood approach – evolving
9. Street pastors – outreach work and flip flops
10. Help Direct – signposting
11. Public health e.g. smoking cessation, early signs of cancer campaigns
12. Sanctuary scheme – domestic violence . vulnerable residents – extra security to remain in their own homes
13. Giant Veggie Patch – community food growing
14. Welfare reform – Progress HA Financial Inclusion Team supporting people with changes
15. CCG making plans to extend GP opening hours

The future

1. Make health links to My Neighbourhood Forums
2. Target hard to reach groups
3. Signposting/making referrals from home visits e.g. handyman goes in, sees fire hazard – passes details to LFRS for home fire safety check….and so on
4. Get better at sharing information about services available.
5. Use health needs assessments to determine the issues in a given area
6. Asset mapping – set out what's out there
7. Community focus, not health focus – turn people on, not off
8. What we identify as health improvements needs to be sold as community event
9. Always a need for critical services for dire needs, but also a need to change attitudes/cultures
10. Start young! Influence children as they grow up

11. Community 'pow-wow' – My Neighbourhood Forums development
12. Community based learning

Group 3

Setting a baseline

1. How to compare with national = good, or local = different
2. Consistency of measurement
3. Comparison with similar 'small' places
4. Already clear 5 key 'conditions' for focus and intervention
5. Learning from other areas
6. Patients/community views and perceptions
7. Context of an ageing population
8. Links to other data (housing conditions / unemployment . benefits)

The current picture

1. Learning from each other
2. Variations in service delivery
3. 'Horses for Courses' re messages i.e. young people
4. Health and wellbeing partnership
5. Special initiatives – geographical, client groups
6. Long term conditions
7. Sports Development
8. Community champions (LCC neighbourhood teams / Seven Stars project)
9. Help Direct in GP Surgeries – example of joined up delivery (Liverpool and Stockport)
10. Lack of sustainability (funds expire)

The future

1. Need for programme, need for inter-agency approach, not series of projects
2. Data sharing – analysis, more forecasting/predictions. Combining approaches.
3. 'Joined up' budgets to deal with problem (major cultural change)
4. Need for geographic focus to make 'manageable'
5. Need for exit strategy or sustainability
6. Role of technology – to collect views, messages, engagement, listen to people
7. Focus on areas not currently measured
8. Role of education
9. Focus on 'keeping people at home' – adaptations and service delivery
10. Finite amount of money – need to spend wisely/avoid duplication
11. Mainstream projects

12. Success – communities empowered to be responsible for own health, resilience of community, gap narrowed, 5 key conditions 'less', greater take up of preventative treatment in deprived communities
13. Role of 'big business' – perhaps need for 'semi commercial approach'

Group 4

Setting a baseline

1. Areas of South Ribble – lack of aspiration
2. Ward information
3. Working together helps!
4. Joint working for the future
5. Link with schools
6. Alcohol and older people – what steps, once identified
7. Profile isn't age related
8. Unmet needs – identification
9. Training to where to direct people
10. How do you get community on board
11. Breastfeeding/women working
12. Pockets and access??
13. Poverty
14. Mental health
15. Loneliness

Current picture

1. Working with facilities – 0-5 and 5-11
2. Health Centre/champions
3. 16-18 College
4. Self help – diabetes/champions working in areas
5. LCC apprenticeship scheme
6. Street pastors
7. Groups – healthy eating etc.
8. Reaching out to people
9. Self help for individuals/communities
10. Liaison team @ HC
11. Tech/comm
12. Health/planning
13. Held Direct in surgeries
14. Testing for dementia i.e. memory etc.

The future

1. More up to date information
2. Drill down to understand what else needs to be done re: health inequalities
3. How do the Health and Wellbeing Board fit in re: roles and responsibilities, communication, bring partners into the agenda
4. Identify joint priorities
5. Assess service users views and opinions
6. Tackle hard to reach via community champions
7. How can partners work together? Champions/resources, communications, work on cross cutting themes, training
8. Success - Retaining tenancy, reduce the gap in life expectancy long-term
9. Information sharing between agencies – we need to make better use of the information – different professionals going into homes
10. Ownership important – may be a long-term ambition
11. Effectiveness
12. People Employed
13. Include the private sector

Group 5

Setting a baseline

1. What we know:
2. The local population
3. 9-year gap – affluent borough, its increasing, more deprived areas v. affluent areas
4. Increased living – more demand
5. The big things that need doing
6. What don't we know:
7. Not enough known – evidence needed
8. Benchmarking – start year on year trends
9. Variation of statistical data
10. Cause v. effect
11. How money should be invested locally on health issues
12. Use of community champions
13. Use of best practice what works in other localities/communities

Current picture

1. DFG cap in funding, not able to carry out all adaptations, future funding?
2. Healthy eating and education
3. Gain veggie patch

4. How do we engage the hard to reach?
5. Holistic approach
6. Big picture and local issues via community champions
7. Building self-esteem and making people feel valued
8. Volunteering helps
9. Biding communities
10. Health – self-care agenda
11. Health equalities impact assessment
12. Commitment – CCG moving outcomes in the right direction

The future

1. Money/funding spending on the right areas
2. Joined up approach and better use of resources
3. Removing duplication identifying the gaps
4. Better use of My Neighbourhoods – health priorities, better support partners
5. Focus on the area where we can make a difference – quick wins
6. Teachers/.education – why aren't they involved?
7. Key priorities from the top down – Health and Wellbeing Board, Public Health, CCG, local communities i.e. alcohol
8. Multi-layering

Group 6

Settling a baseline

1. What we know:
2. Lots of statistics
3. Excellent projects
4. Joint strategic needs assessment (JSNA)
5. What we don't know
6. Impact on people
7. Learning from projects not always shared
8. The cost of prevention
9. How to access NHS funding to prevent, reduce costs and improve services
10. Not good at advertising/raising awareness
11. Personal experiences to get message across
12. What agencies do
13. Evaluation/impact
14. Understanding of personal responsibility – consequences of lifestyle (e.g. tattoo removal)
15. Health inequalities expected?

Current picture

1. Carers – restate/nee support, £30M avoiding health inequalities (health and social services), not to underestimate volunteers/VCFS doesn't come free. Tailor made support
2. Homestart – great success story, 80 volunteers, 350 families support, tailored support to families with different needs, people helped often come back to put something back
3. Access to services
4. Once off initiatives and short-term funding undermines health inequalities and partnership working
5. Generally not too good at publicising what we do, use the new community 'pow-wow'
6. Your amazing – good project with women attending a butterflies 12-week course, builds confidence, looking to future/jobs/skills, provides childcare, funded from Children's Centre
7. Families first and working together with families
8. South Ribble Reach showcases physical activity
9. Showcase the VCFS sector
10. Worden Park? Farmers market linked to the Walled Garden/Brothers of Charity
11. Access to services
12. Use of public assets (schools, doctors surgeries when closed and as part of the community)
13. Age Concern/volunteer champions
14. Use the Worden Academy as an example for the health services (how have they turned it around, as a model)
15. How do you translate success in one area with another?
16. Care and repair success – Riverside a good example

The future

1. Improved communication – individually, organisationally, Help Direct and others signposting are aware and also mindful of capacity, join up referrals trail
2. Helper people help themselves – PSHE in schools (real-life talks), awareness of equality
3. Develop an 'adopt a granny' scheme, intergeneration, breaks barriers down and involved schools
4. Education for economic growth – apprentices v. qualifications (example: Waitrose/works with Preston College on CVs and interviews, Eric Wright with Preston College etc.)
5. Take service to people
6. More sharing of information and intelligence (+ what agencies do)

7. Use of the 'public purse' – look at individuals rather than being protective – community assets
8. Skills – ICT (computer skills), library to help, helping different groups, literacy/numeracy
9. Resources: collaborative and make use of what we've got
10. Holistic approach to access to services through doctors surgeries

Group 7

Setting a baseline

1. What do we know? At first glance – not too bad, but… particular inequalities don't necessarily equate to a particular location/homeplace
2. South Ribble does have a few indicators below England average – child/maternal care (smoking/breastfeeding), alcohol related harm/hospital stays, RTAs/deaths
3. This is reported/measureable data
4. Not what is not measured/known e.g impact of welfare reforms – disability/housing benefits – need for budgetary skills/IT skills required to access application systems
5. Are we commissioning for the healthcare provision or inclusive of full pathway (prevention – care – treatment)
6. We need to have detailed info to enable proper/meaningful analysis – link to SOA's, aligned to SR My Neighbourhoods

Appendix 7
Extract from Research on Road Casualties in South Ribble