



Improving health outcomes in deprived communities  
**Evidence from the New Deal for Communities Programme**





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February 2010

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The findings and recommendations in this report are those of the authors and do not necessarily represent the views of the Department for Communities and Local Government.

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# Abbreviations

ABI	Area Based Initiative
CLG	Communities and Local Government
DAT	Drug Action Team
GP	General Practitioner
HAZ	Health Action Zone
HLC	Healthy Living Centre
LIFT	Local Improvement Finance Trust
LSP	Local Strategic Partnership
NDC	New Deal for Communities
NSF	National Service Framework
NHS	National Health Service
PA	Participatory Appraisal
PCT	Primary Care Trust
SLA	Service Level Agreement
SMR	Standard Mortality Ratio



# Summary

## Introduction

This report presents the findings of one element of the second phase of the National Evaluation of New Deal for Communities (NDC) Programme: research in four case study NDC partnerships focusing on interventions and outcomes designed to improve health outcomes for NDC residents.

The NDC Programme was announced in 1998 and was designed to reduce gaps in outcomes between some of the most deprived areas in England and the rest of the country. Thirty-nine NDC partnerships were established, each implementing an approved 10-year delivery plan which has attracted an average of £50m of Government investment.

## Improving health outcomes in deprived neighbourhoods

Over the lifetime of the NDC Programme there have been a plethora of **national policies**, strategies, programmes and actions which aim to tackle health inequalities and to reduce the gap in health outcomes between deprived and wealthier communities.

Extensive evaluation of specific projects and programmes, notably HAZ (Health Action Zones) (Bauld, et al., 2005) and Sure Start,<sup>1</sup> is building evidence in relation to 'what works' in tackling health inequalities in deprived communities. Studies have emphasised the importance of a holistic approach based on partnership working, responding to community priorities, and establishing robust mechanisms for governance and review (see, for example, Anning, 2007 in relation to Sure Start programmes; also Department of Health, 2008a) and there is clear resonance here with earlier findings from the New Deal for Communities interim evaluation (CLG, 2005).

But there has also been acknowledgement that **tackling health inequalities** is a long term process. In this context it is important to note despite over a decade of policy interventions which have aimed to tackle health inequalities, and overall improvements in the health of deprived communities, the gap between those worst off and the national average has not narrowed since targets were first set in 2002, a point acknowledged in the recent Department of Health review of health inequalities (Department of Health, 2009b) and in the commitment for Professor Sir Michael Marmot to lead a strategic review of post 2010 health inequalities, due to report initially in late 2009.

<sup>1</sup> The Sure Start programme is subject to an independent evaluation being led by a team based at Birkbeck, University of London. The evaluation runs to 2012 and supports a website at [www.ness.bbk.ac.uk/](http://www.ness.bbk.ac.uk/)

## NDC approaches to improving health outcomes

Interventions have been designed to address **three key sets of problems** in NDC areas:

- high rates of illness, low birthweight and perinatal<sup>2</sup> and premature deaths
- lifestyle issues – smoking, lack of exercise, low levels of fruit and vegetable consumption, substance misuse, teenage pregnancy etc
- poor services and problems around access.

There is a wide variety of **approaches** to improving health outcomes across the NDC Programme. However there are a number of recurrent and commonly adopted themes:

- improving access to, and quality of, **services and facilities**: new build or virtual healthy living centres; youth facilities; sports facilities; location of primary (and some secondary) care services in NDC neighbourhoods; targeted outreach; workforce development
- supporting **healthy lifestyles**: smoking cessation programmes; exercise programmes and subsidised access to leisure facilities; diet, cookery and healthy food projects; sexual health projects; alcohol and drug misuse projects
- targeting **vulnerable groups**: children; older people; substance misusers; black and minority populations; teenage parents
- tackling **'upstream' influences** on health outcomes: welfare rights projects to improve income levels; improvements to neighbourhoods and green space; improvements to heating and security in homes
- **partnership working**: notably with Primary Care Trusts (PCTs) but also with social services and third sector organisations
- **community involvement**: in planning and delivery of health interventions (examples include participatory budgeting and peer educators).

Health interventions have attracted a relatively small proportion of NDC **resources**. Spend in the health theme (to March 2008) has amounted to £148m, or 11 per cent of total NDC spend across the Programme.

**Partnership** working with agencies and communities has been a key feature of the NDC partnerships' approaches in health as in other themes across the Programme. In all NDC areas the PCT has been perhaps the most significant partner in the health theme. This is to be expected, as PCTs carry the main responsibility for commissioning and delivery of local and community-based health services. They also have a key role in public health, and in addressing health inequalities. But there has also been a high degree of involvement from third sector agencies and in two of the case study NDC partnerships, local community based organisations had been supported to become social enterprises, making a significant contribution to the mixed economy of health services locally.

<sup>2</sup> Perinatal mortality includes stillbirths and deaths under aged seven days see Office for National Statistics (2009) Statistical Bulletin infant and perinatal mortality 2008: health areas, England and Wales.

**Community involvement** has made a positive contribution to the delivery of health interventions. Local residents have been involved with the health theme in a number of ways:

- identifying issues, through consultation and participatory appraisal exercises
- working with agencies and health professionals via theme groups and working groups, to commission and appraise projects
- participating in evaluation and review to gauge the success of interventions
- as delivery agents – through e.g. peer education and community-based projects
- and as recipients of health services.

But it has not always been possible for NDC partnerships and their partner agencies to address community priorities.

## Change in health outcomes in NDC areas

There has been broadly positive, but modest, **change in health outcomes** in NDC areas. At Programme level most indicators saw some positive change with the exception of some lifestyle indicators, notably exercise. However, this has not always been greater than that experienced nationally or in other similarly deprived communities:

- the proportion of people feeling that their own health was not good fell by four percentage points across the NDC Programme as a whole; for those who remained living in the NDC areas between 2002 and 2008 the decline in self-reported poor health was greater than in the similarly deprived comparator areas
- the proportion of people reporting good mental health also improved between 2002 and 2008, in contrast to a decline in people reporting good mental health in the comparator areas
- NDC residents in 2008 were less likely to be eating healthily and meeting guidelines on taking a healthy amount of exercise than they were in 2002, although the proportion of people smoking had fallen by five percentage points, slightly more than in the comparator areas.

This lack of marked positive change **relative** to other benchmarks is perhaps a little disappointing, given that the case study NDC partnerships have devoted considerable effort and resources to improving health outcomes amongst local residents, and these sorts of efforts have been replicated across the NDC Programme. However, there are a number of reasons why this might be the case:

- NDC supported interventions have, on the whole, been **small scale**: there is ample evidence within the case study NDC areas of positive outcomes for project beneficiaries, but the projects have by their nature reached small numbers of NDC residents and have not impacted significantly on the scale of the problems faced by NDC communities

- there is also the associated issue of the degree to which the benefits of interventions which target small numbers of NDC residents can be picked up by **'top-down' surveys and data**: because health interventions have affected relatively small numbers of people (with the possible exception of Healthy Living Centres) they are unlikely to impact significantly on Programme-wide change data
- NDC partnerships may have sought to address **too many health issues** at a time rather than developing a more sustained focus on aspects of health inequalities most amenable to local intervention
- NDC areas have not been the sole beneficiaries of **developments and investment in health services**: health agencies work to national targets and programmes and investments tend to be rolled out on a national basis. For example, the LIFT<sup>3</sup> programme has supported investment across almost 50 schemes, resulting in more than 200 new primary health care facilities either open or under construction. Clearly some of these will have benefited deprived communities outside NDC areas
- there has been a need, in some NDC areas, to improve the **infrastructure** of local health services, and a consequent early prioritisation of investment in this, as opposed to projects which aim directly to tackle health outcomes. Whilst there may be consequent improvements in the health circumstances of NDC residents, these are unlikely to be evidenced by the six years of data available to the NDC evaluation, and may occur beyond the lifetime of the NDC Programme
- there are also questions about the nature of some NDC interventions: there is a relatively sparse evidence base on the effectiveness of interventions in tackling **health inequalities** between deprived and better off areas. The case study NDC partnerships have endeavoured to ensure that their interventions are based on evidence of what works in improving health outcomes; the Salford NDC Partnership for instance has allocated up to 20 per cent of each health intervention's budget for external evaluation. But it has not always been clear that this will also result in narrowing the gap between NDC areas and their parent local authorities. In health, perhaps more than in any other NDC outcome area, the linkages between interventions and outcomes are not always obvious
- it is also important to consider the role of local communities in devising strategies to improve health amongst local residents: there is some evidence from the case studies that the **priorities** of local residents have not always gelled with those of the local service providers. One obvious example is around complementary therapies and new models of service delivery, which have clearly been priorities for local residents and where NDC partnerships have been uniquely placed to implement innovative approaches which are beyond the scope of statutory agencies. This has been a strength, and an important role for NDC partnerships has been to 'test out' new interventions and approaches. But it has also been true that for some of the interventions valued by local residents there is less than robust evidence of their long-term impact on health outcomes.

<sup>3</sup> Local Improvement Finance Trust (LIFT) is vehicle for the development of new primary and community services. See: [www.dh.gov.uk/en/Procurementandproposals/Publicprivatepartnership/NHSLIFT/index.htm](http://www.dh.gov.uk/en/Procurementandproposals/Publicprivatepartnership/NHSLIFT/index.htm)

## A sustainable approach? The implications for forward strategies

PCTs will be critical to the **sustainability** of health interventions across the NDC Programme. Relationships between NDC partnerships and PCTs have not always run smoothly but in the case study NDC partnerships, as in others across the Programme, close partnership working with PCTs has laid the framework for ongoing sustainability. There is evidence within the case study NDC areas of NDC supported projects, or elements of NDC supported projects, being incorporated into mainstream service delivery.

However, despite positive relationships with PCTs and other commissioning bodies, there are concerns within the case study NDC partnerships about the abilities of these agencies to balance the **priorities** of NDC areas against those of other communities, particularly in the context of restraints on public spending, and new frameworks for commissioning. This will have implications for long-term approaches.

## Conclusions

The research presents a number of conclusions which have relevance for future programmes which aim to improve health outcomes for residents of deprived areas.

NDC partnerships can add a **targeting and outreach** dimension to what larger, mainstream agencies can offer. By developing informal networks and community capacity NDC partnerships can offer effective signposting to and between services that harder to reach groups and individuals might otherwise miss. This can result in a more holistic approach.

**Collaboration** between NDC partnerships and service delivery agencies is likely to continue to be a feature of work to address health inequalities in deprived areas, and was generally agreed in the NDC areas studied for this research to be vital to long-term impact in health outcomes. NDC partnerships can have the freedom to 'think outside the box' and offer mainstream agencies an important test bed facility to try out **new approaches** at low risk. They can also be an effective **catalyst** (what one respondent described as "the yeast in the mix"), bringing big mainstream and third sector agencies together to plug gaps in services.

But the experience of the case study NDC areas also highlights some **challenges** which need to be addressed if partnership working is to be successful. Constant **reorganisations** in agencies make partnership work more difficult and do not allow the agencies to prioritise local work and this has clearly been an issue in relationships with local health commissioning agencies for the case study NDC partnerships. A period of consistency, as opposed to the constant turmoil which characterises the experiences of most PCTs over the lifetime of the NDC Programme, might have allowed relationships to become established earlier, and to be sustained for longer. It is worth noting, however, that at least one observer in a case study NDC partnership thought that reorganisation in statutory agencies offered the potential to '*unblock paths that had appeared to be closed*'.

Government **targets** for agencies sometimes also mitigate against working with area-based initiatives (ABIs) when national, not local, priorities have to take preference and when agencies such as PCTs and local authorities need to spread resources across a range of communities. In Hackney, for instance, there has always been an issue for the local authority and the PCT who are working in an area where every ward in the borough is in the top 10 per cent most deprived and it is difficult to justify contributing more resources – even if just time or effort – to the NDC area. The availability of **NDC resources** has been an incentive to partnership working, and had resulted in some innovative approaches, but it remains to be seen how much of this work will be continued once the NDC Programme draws to a close.

Therefore there is a need for Government to consider the extent to which neighbourhood-level organisations can realistically expect to **influence** the priorities of mainstream agencies with wider, and sometimes conflicting concerns. The case study NDC partnerships featured in this report have established collaborative arrangements with PCTs over time and this has resulted in the transfer of learning and resources on both sides. As a result, projects, or elements of projects, have been introduced into the work of mainstream health delivery agencies, in response to evidence of successful practice and to ensure sustainability of interventions beyond the lifetime of the NDC Programme. PCTs have in most NDC areas been willing to collaborate with NDC partnerships and have been prepared to consider new approaches and modes of service delivery. But there is less evidence that NDC partnerships have been able to fundamentally change the direction or **emphasis of local service delivery**. This problem is not unique to the health theme of the NDC Programme, but maybe particularly acute here because the standard of evidence required to support the commissioning of health services is exceptionally high.

The evidence from this research also emphasises the need for **long-term** and **comprehensive** approaches to improving health outcomes in deprived areas. NDC partnerships cannot stop people getting sick or make them better. They can, though, implement programmes which aim to improve the quality of life for local residents and encourage more people to use the services on offer. Community-led ABIs may be better placed than others to take on this latter task. A strength of the approaches implemented by NDC partnerships has been the ability to get close to local people and find out exactly what is needed, and ABIs may play a key role in supporting statutory duties on the NHS to involve local people. But the need to tackle apathy within local communities, address chronic conditions and embed the benefits of lifestyle changes is a huge challenge, which is beyond the capabilities of relatively small organisations like NDC partnerships, which have limited resources. As one interviewee commented “the more families we helped the more we seemed to find”.

There are difficulties associated with identifying changes in health outcomes at the **neighbourhood level**, particularly when interventions have benefited small numbers of NDC residents. It is probably also the case that any changes in **long-term health outcomes** to which NDC interventions have contributed will take generations to manifest in any observable closing of the ‘gap’ between NDC areas and less deprived communities.

Nevertheless the research highlights a number of **lessons**, which are relevant to community and neighbourhood partnerships and policy makers concerned with improving health outcomes in deprived communities:

- strategies need to be underpinned with solid **partnership** work, but this is time consuming. It is beneficial to build institutional links as early as possible, and Service Level Agreements (SLAs) between delivery agencies and NDC areas appear to be effective in ensuring ongoing levels of service delivery
- it is also be important to seek relevant **expertise** where it is required. The experience of the case study NDC partnerships has been that it is vital to have a budget to pay for the right level of expertise, and to ensure that interventions are appropriate to address the health issues of NDC residents
- robust **evaluation** of local interventions is vital in order to improve the evidence base in relation to what works in tackling health inequalities and to inform succession arrangements, future delivery of interventions and potential for transferability
- **community development** is a vital contributor to improved health outcomes because it can help to increase resident access to services, support healthier lifestyle choices, promote community involvement in service planning, provide a forum for condition management and contribute to improved mental health outcomes. But community development is time consuming in the long-term. Peer education approaches seem to offer a successful model for engaging with harder to reach and newly arrived communities
- NDC partnerships have offered a way to test out new approaches to service delivery and have engaged and developed **third sector** bodies effectively. Early support in the form of grants and organisational development has been effective in the case study areas in supporting community-based organisations to become social enterprises, which are now contributing extensively to mixed models of local health service delivery
- Neighbourhood-level approaches could be more effectively supported if the **priorities** of local commissioning and delivery agencies, and those of neighbourhood renewal partnerships, were more clearly aligned. In particular, it can be hard to balance the priorities of communities with those of agencies driven by national standards and targets.

# 1. Introduction

- 1.1. The New Deal for Communities (NDC) Programme was announced in 1998 and was designed to reduce gaps between some of the most deprived areas in England and the rest of the country. Thirty-nine NDC partnerships were established, each implementing an approved 10-year delivery plan which has attracted an average of £50m of Government investment. Each partnership is working to improve outcomes across five key areas: housing and the physical environment; education; employment; crime and community safety; and health.
- 1.2. This report presents the findings of one element of the second phase of the National Evaluation of the NDC Programme: research in four case study NDC partnerships focusing on interventions and outcomes designed to improve health outcomes for residents living in NDC areas. The research was carried out between July and October 2009. A full description of research methods is included at Appendix 1.
- 1.3. In common with other deprived areas, NDC communities have faced a range of issues in relation to health. In 2002, for instance, 40 per cent of residents in NDC areas smoked, compared to a national average of 27 per cent. And 23 per cent of residents felt that their own health was not good, 9 percentage points higher than the equivalent national figure. More than one in four residents (26 per cent) reported a long-standing limiting illness compared to only 21 per cent of people nationally. Standardised illness and mortality ratios, which take account of differences in age and sex structures of local populations, showed wide disparities between NDC areas and England as a whole.
- 1.4. Health problems can also be compounded by lack of access to services or by poor quality in local services. In 2002 there was very little difference in the proportion of residents in NDC areas as a whole who had visited their GP in the last 12 months, despite significantly higher levels of self-reported ill-health amongst NDC residents.
- 1.5. For this study, four case study NDC partnerships have been identified to illustrate the nature and impacts of NDC supported interventions to improve health outcomes. The case studies have been selected to reflect a range of relevant factors, including:
  - those with high and low concentrations of minority ethnic communities
  - a range of different approaches to improving health outcomes (including a mix of capital and revenue spend)
  - a spread of NDC partnerships located in different areas.
- 1.6. But selection of the case studies has also been influenced by more pragmatic considerations including, at this late stage in the NDC Programme, the availability of participants able to provide evidence in relation to the research



questions. As the NDC Programme draws to a close NDC partnerships are streamlining their activities and focusing on succession arrangements. As part of this process staff teams in most NDC partnerships have reduced and not all have retained staff with a specific remit for health.

- 1.7. The four case study areas and their associated NDC partnerships are Hackney (Shoreditch Trust); Hammersmith and Fulham (North Fulham NDC); Sandwell (Greets Green Partnership) and Salford (Charlestown and Lower Kersal NDC).
- 1.8. Table 1.1 contains a brief outline of each of the NDC case study areas.

**Table 1.1: Case study NDC areas**

Case Study NDC area	Description
Hackney	The Hackney NDC area, Shoreditch, has a population of 21,500 and includes three distinct neighbourhoods: Wenlock Barn, Hoxton and Haggerston in an area which is mixed residential and commercial use. Black and minority ethnic communities constitute 44 per cent of the NDC area population, an increase from 37 per cent in 2002. Seventeen per cent of households are lone parents, a figure which has remained constant over the lifetime of the NDC Programme. Shoreditch has similar health problems to the borough generally. Hackney is the second most deprived borough in the country and all of its wards are in the top 10 per cent most deprived. Hoxton ward is third worst in Hackney in terms of child poverty with over twice the London average.
Hammersmith and Fulham	The North Fulham NDC area houses a population of just over 8,000 residents. It lies in the west of the borough of Hammersmith and Fulham. The population is ethnically diverse but includes a relatively stable and established white working class community. The non-white community (almost a third of total population) is mainly established black African and Caribbean families. The proportion of black and minority ethnic groups in the NDC area is greater than for the borough as a whole, and in recent years there have been increases in the numbers of refugee communities, particularly from Eastern Europe. Almost 20 per cent of residents do not count English as their main language. There is a particularly high proportion of lone parent families which make up more than half of all family units. Seventeen per cent of the adult population are of retirement age and 20 per cent are under 16s.
Salford	The Salford NDC area comprises the neighbourhoods of Charlestown and Lower Kersal in the east of Salford and covers substantial parts of the Pendleton and Kersal wards. The area is predominantly residential, with a roughly equal mix of social and private housing. The age of the housing stock varies and includes pre-1919 terraces (across all tenures), as well as social housing developed in the 1960s/70s and privately owned houses and flats built in the 1990s. The area accommodates just less than 10,000 people, almost 95 per cent of whom are white. Fifteen per cent of the adult population is aged over 65, and less than five per cent of the total population are lone parent households. Eighteen per cent of the population are aged below 16 years.
Sandwell	The Greets Green NDC area lies to the south and west of the town centre of West Bromwich and part of the main high street is within the NDC area. The area covers three wards: Greets Green/Lyng, West Bromwich Central and Great Bridge. The area is mixed residential and commercial. Most of the housing is pre-1919 and is a mixture of public and private, owner occupied and rented. The Birmingham to Wolverhampton metro link runs through Greets Green as does the main Black Country spine road. The NDC area has a population of just over 12,000 people in 4,900 households. <b>Greets Green is an ethnically diverse area with 37 per cent black and minority ethnic communities, including Pakistani, Indian, Yemeni, Bangladeshi and African- Caribbean. Just over 22 per cent of the population is under 16, and 23 per cent is over 60. The percentage of lone parent households in Greets Green is similar to that in the host borough Sandwell, (approximately 9 per cent respectively) but higher than that experienced nationally (7 per cent).</b>

## Health issues in the case study NDC areas

- 1.9. Despite variation in the physical, economic and socio-demographic profiles of the case study NDC areas (Table 1.1) there is a degree of congruency in the health-related problems and issues which faced the case study NDC partnerships at the outset of the Programme. There have been three key sets of issues, which are common to most deprived neighbourhoods:
- high rates of illness, low birth-weight and perinatal<sup>4</sup> and premature deaths
  - lifestyle issues – smoking, lack of exercise, low levels of fruit and vegetable consumption, substance misuse, teenage pregnancy
  - poor services and problems around access.
- 1.10. In Sandwell for instance, low incomes, poor housing, unemployment, poor diets and a degraded living environment were recognised in the Greets Green Partnership's original delivery plan<sup>5</sup> (1999) as contributing to poor health outcomes. At the start of the Programme the Greets Green area scored higher than expected given the gender and age structure of the local population on a range of standardised health ratios (mortality, illness, drug misuse, alcohol misuse, cancer admissions, heart disease admissions). Cancer death rates for under 75 year olds in Greets Green were higher than those for the rest of the borough. Perinatal mortality was also high, as was the incidence of low birth weight babies (at almost double the national rates), and there were a significant number of pregnancies amongst teenagers. Mental ill health was also more common than in other areas of the borough. Other conditions of concern included blood disorders such as sickle-cell anaemia and thalassaemia, which are of particular relevance to sections of the local minority ethnic population. Perhaps unsurprisingly, the proportion of people believing their health was not good was high in comparison to the national rate.
- 1.11. And in Hackney, data analysis and consultation at the outset of the local NDC programme identified a range of similar issues. Premature death rates were higher than the national average, and male life expectancy was particularly low and mainly related to lifestyle factors like smoking. Mental health admissions were almost five times the national level for men and over double for women. Issues articulated by the community included access to services and affordable complementary services. There was also a feeling in the community that people were not aware of the services that were available or what they could be doing to look after themselves.
- 1.12. In Fulham a health and wellbeing baseline survey conducted by the NDC partnership in 2003 provided detailed evidence on a range of issues including incidence of ill health, access to and satisfaction with existing services, and interest in take up of additional services. Findings revealed high levels of physical and mental ill-health and disability and high rates of smoking

<sup>4</sup> Perinatal mortality includes stillbirths and deaths under aged 7 days see Office for National Statistics (2009) Statistical Bulletin infant and perinatal mortality 2008: health areas, England and Wales.

<sup>5</sup> Helping Make Greets Green Great, Greets Green NDfC Delivery Plan (12 November 1999).

and alcohol use. The study also revealed interest amongst local residents in accessing complementary therapies and services supporting healthier lifestyles.

- 1.13. And similarly in Salford, issues identified through participatory appraisal at the outset of the local NDC programme included a lack of health infrastructure and a Standard Mortality Ratio<sup>6</sup> of more than twice the national average. There were also high levels of long-term limiting conditions (affecting more than one in three households) and mental ill-health: 15 per cent of households had a member being treated for depression, 10 per cent of households had a member being treated for stress and a further 10 per cent of households had a member being treated for anxiety.

The remainder of this report is structured as follows:

- Chapter 2 sets the context for NDC supported health interventions by outlining the key developments in national health policy over the lifetime of the NDC Programme
- Chapter 3 looks at NDC partnerships' strategies for improving health outcomes, spend within the health theme, and issues associated with working in partnership with agencies and communities
- Chapter 4 highlights the interventions supported by NDC partnerships to improve health outcomes in the case study areas
- Chapter 5 reviews the extent to which there has been positive change in health outcomes for NDC residents over the lifetime of the NDC Programme
- Chapter 6 addresses the issue of sustainability, and looks at arrangements for continuing interventions to improve health outcomes in the case study NDC areas
- Chapter 7 contains conclusions from the study
- Appendix 1 details the research approach
- Appendix 2 provides references to literature drawn on for the study.

<sup>6</sup> Standard Mortality Ratio (SMR) is the ratio of observed deaths to expected deaths within a population. An SMR of 1.0 means the number of observed deaths is equal to that of expected cases. If the ratio is higher than 1.0 a higher number of deaths than expected have occurred.

## 2. Improving health outcomes in deprived neighbourhoods

### Introduction

- 2.1. The NDC Programme had a remit to provide a programme of work in 39 communities, targeted to reduce the inequalities in health prevalent in many areas in England. Over the lifetime of the NDC Programme there have been a plethora of national policies, strategies, programmes and actions which aim to tackle health inequalities and to reduce the gap in health outcomes between deprived and wealthier communities. This chapter summarises the key developments in health, and related, policy areas with a view to setting the health interventions of the NDC Programme within the existing national health context and climate.
- 2.2. The chapter begins with a brief background of work on health inequalities around the time that the NDC Programme was being developed (Social Exclusion Unit, 1998). Health-related policies, programmes, and strategies issued during the following ten years (1999–2009) are then identified and links made, where they exist, to activities implemented through the NDC Programme. Other health and non-health programmes and initiatives implemented in parallel with the NDC programme are also outlined briefly. Finally a comment is made about the evidence base available to inform NDC interventions and the actions being taken to improve it.

### Background to health inequalities

- 2.3. The issue of health inequalities is not new. The Black Report, published in 1980 highlighted disparities in mortality rates between social classes, and in particular identified the high numbers of premature deaths amongst people in social class five compared to those in social class one. The report made a number of recommendations to address this problem and although many of its recommendations were not adopted by the government of the day, it had a significant impact on subsequent health inequalities policies and actions.
- 2.4. In the 1990s it has been recognised that the determinants of health (and ill health) are broader than those associated with the traditional medical model.<sup>7</sup> One aim of the consultation paper *Partnership in Action*,

<sup>7</sup> Social factors, ranging from individual risk behaviours such as smoking, through to broader factors such as poverty and wealth, housing, environment, employment and education (Graham, 2006) have been identified as additional determinants of health outcomes. Authors, e.g. Davey Smith, et al (1990) and Whitehead (1988), have also examined issues around social variation and inequalities, and the concept of social capital (Putman, 1993), (described as 'the resources within a community that create family and social organisation') (Swann and Morgan, 2002), has become more prominent as a health determinant.

(Department of Health, 1998a) was to address social versus medical conflict by bridging the gap between health and social services.

- 2.5. Evidence at the outset of the NDC Programme suggested that whilst health as measured by life expectancy was improving overall, morbidity and mortality rates varied across the social strata, and class-based differentials in these health indicators were becoming more marked, resulting in a health divide or health gap. The Government-commissioned *Independent Inquiry into Inequalities in Health* (Acheson, 1998) reiterated the differences in death rates identified in the Black report. Acheson's policy proposals focussed on socio-economic factors to be addressed through financial incentives, education, employment, housing and the environment, with initiatives targeted at specific population groups. However, as Oliver (2000) has highlighted, a great many of the recommendations of the Acheson Report were health promoting rather than health inequality reducing. Nevertheless Acheson's report gave rise to two further publications; the white paper, *Saving Lives: Our Healthier Nation* (Department of Health, 1999a) and the report on action to tackle inequalities (Department of Health, 1999b).
- 2.6. The white paper recognised that since the root causes of ill-health, and potential health inequalities, are very varied they cannot be dealt with by focusing on health alone. Among the recommendations were prioritisation for policies aimed at reducing poverty and social and emotional isolation in families; and policies to support older people in material well being, independence, mobility, and access to services. The needs of minority ethnic groups were also recognised.
- 2.7. As part of the *Saving Lives: Our Healthier Nation*, targets were set in four public health priority areas: coronary heart disease and stroke, cancer, injury prevention, and suicide. The Action Report (Department of Health, 1999b), outlined the range of actions across government to tackle inequalities.

## Tackling health inequalities: policy and action during the NDC Programme

### Cross government working

- 2.8. One strategy developed to address health inequalities has been to embed health inequalities-related policy areas across government departments and wider. Evidence of this can be found in *Tackling Health Inequalities: 2002 cross-cutting review* (HM Treasury/Department of Health, 2002) which called for the mainstreaming of health inequalities, to be facilitated through the development of partnership working between national and local government, academia and the private and voluntary sectors. *Healthy lives, brighter futures – the strategy for children and young people's health* is another more recent cross-government action (Department for Children, Schools and Families/Department of Health, 2009) that should have an impact on inequalities around children's health.

### Strategies and actions

- 2.9. The National Health Inequalities Strategy, published in *Tackling Health Inequalities: A Programme for Action* (Department of Health, 2003a), set out plans to tackle health inequalities. The programme was designed not only to improve health overall but to also accelerate health improvement of the bottom 30–40 per cent of the population. In 2004, the white paper *Choosing Health: Making Healthy Choices Easier* (Department of Health, 2004a), set out the challenge to change health behaviour by making healthy choices easier for everyone, with the aim of both improving health and reducing health inequalities.
- 2.10. However, as discussed above, policies that address health determinants do not always tackle inequality. As Graham has pointed out, ‘linking the concept (of social determinants) to both health and health inequalities can make it harder to see the difference between tackling a major cause of ill-health and tackling inequalities in this cause’ (Graham, 2006). More recently social marketing<sup>8</sup> principles are being applied to strategies. Change4life is an example of a society-wide approach that aims to prevent people from becoming overweight by encouraging them to eat better and move more (Department of Health, 2009a).

### Target setting

- 2.11. A third approach has been to address health inequalities through target setting. Health targets, proposed initially in 2002 and reformulated in 2003, (Department of Health, 2002a, Office of the Deputy Prime Minister, 2003) to be achieved by 2010, were:
- to reduce by at least 10 per cent the gap in infant mortality between manual and occupational groups and the population as a whole
  - to reduce by at least 10 per cent the gap between the fifth of local authorities with the lowest life expectancy at birth and the population as a whole.
- 2.12. Subsequent Treasury spending reviews have updated the public service agreement (PSA) targets aimed at tackling health inequalities (infant mortality and life expectancy), and new Public Service Agreement (PSA) targets have been added with a focus on reducing the increase in obesity among children under 11, reducing adult smoking rates, and reducing under 18 conception rates (Department of Health, 2007a). However, it is not yet obvious whether the current PSA targets based on relative change by 10 percent will be met by 2010 (Department of Health, 2008a, 2009b).

### Partnership working

- 2.13. Partnership working is a theme that runs through policy to reduce health inequalities and the success of multifaceted approaches to addressing health inequalities depends upon successful partnerships being established between

<sup>8</sup> Health related social marketing is defined as ‘the systematic application of marketing, alongside other concepts and techniques, to achieve specific behavioural goals, to improve health and reduce inequalities’. See: [www.nsmcentre.org.uk](http://www.nsmcentre.org.uk)

different agencies. The concept of partnerships between organisations was introduced in *The NHS Plan* (Department of Health, 2000a) with a proposal for Local Strategic Partnerships between different sections of the public, private and voluntary sectors involved in service provision. The white paper, *Strong and Prosperous Communities* (Communities and Local Government, 2006) reiterated the focus on multi-agency working as well as proposing more choice over local services for individuals and communities. The aim of the *Local Government and Public Involvement in Health Act 2007* was to promote further, joint working and shared commissioning by the NHS through PCTs and local authorities in order to reduce health inequalities and improve population outcomes. Identification of local need and execution of the health inequalities policy is now carried out through Joint Strategic Needs Assessments, LSPs, Local Delivery Plans and Local Area Agreements (Department of Health, 2008b).

- 2.14. There has also been a strong focus on community engagement. In common with other policy areas, the involvement of local communities in the planning, delivery and review of services to tackle health inequalities has been seen as critical to their success. The Department of Health's cross cutting review of 2002 reported that successful interventions were those in which local communities and networks were involved in a range of ways: assessment of local needs; working together with other organisations; design of initiatives; planning and management arrangements; support and training (Department of Health, 2002a).

## Policy with a focus on health related behaviour and healthy lifestyles

- 2.15. Many of the health theme interventions implemented by the NDCs have been targeted at promoting healthy activities, such as exercise or prevention of ill health or inappropriate activity, such as drug taking, cigarette smoking. These have been supported by a raft of policies which have aimed to promote healthier lifestyles.
- 2.16. *The NHS Plan* (Department of Health, 2000a) introduced policies to improve the diet of the population, with initiatives such as the 'five a day' scheme (Department of Health, 2001a). The white paper *Choosing Health: Making Healthy Choices Easier* (Department of Health, 2004a) proposed personalised services to encourage healthy lifestyle, address different living conditions and support individual choice. *Choosing a Better Diet: a food and health action plan* (Department of Health, 2005a) and *Choosing Activity: a physical activity action plan* (Department of Health, 2005b) were additional actions plans. More recently, *Healthy Weight, Healthy Lives: A cross-government strategy for England* (HM Government, 2008) sets out a national obesity strategy. It includes initiatives which aim to make healthier lifestyle and food choices easier: the Healthy Community Challenge Fund and Healthy Towns programme.

## NHS related initiatives

- 2.17. Although the NHS has a key role to play in tackling health inequalities, there has been inconsistency in the degree to which some of the more clinically orientated health initiatives have contained reference to health inequalities. There have been a number of national service frameworks (NSFs) to address specific disease areas: mental health (Department of Health, 1999c), heart disease (Department of Health, 2000c), diabetes (Department of Health, 2001d), renal conditions (Department of Health, 2004b), long term conditions (Department of Health, 2005d), stroke (Department of Health, 2007c); or population groups such as older people (Department of Health, 2001e), and children (Department of Health, 2004c). Most of the standards, especially in the earlier frameworks, related to clinical outcomes with few on ill-health prevention and reducing health inequalities.
- 2.18. Health inequalities were made a key priority for the NHS for the first time in 2003 in the *Priorities and Planning Framework for 2003–2006* (Department of Health, 2003b) and are still a priority for the NHS for 2009–10 as set out in the *NHS Operating Framework* (Department of Health, 2008c).
- 2.19. The NDC programme, in its broad brush approach to its remit of tackling health inequalities has implemented initiatives that relate to the National Health Service and address health service-related issues, such as shortage of nurses, new GP practice venues, and improved access to services. This also now fits well with Government policy as health inequalities are also a key priority for the NHS as well as for the public health agenda.

## Area based interventions

- 2.20. The NDC Programme has overlapped, temporally and geographically, with a number of other targeted programmes to address health inequalities such as Health Action Zones (NHS Executive, 1997) and Healthy Living Centres (Department of Health, 1998c).<sup>9</sup> The aim of Health Action Zones was to bring together all those contributing to the health of the local population to develop and implement local agreed strategies for improving the health of local people. They were also expected to pioneer new ways of tackling local health inequalities with potential mainstreaming and wider dissemination of successful models (Benzeval, 2006). Healthy Living Centres had a remit to reduce health inequalities through meeting the health needs of specific communities. They were meant to be 'local flagships' for health in the community, reaching out to people who had been excluded from opportunities for better health and providing powerful catalysts for change in their neighbourhoods (Department of Health, 1998c). Both Health Action Zone interventions and Healthy Living Centres addressed health inequalities

<sup>9</sup> In 2008 each NDC area contained, on average, six other ABIs, with numbers of ABIs in individual NDC areas ranging from one to 16. The most common ABIs were Drug Action Teams (DATs), European Structural Fund Programmes, Sure Start Partnerships, Neighbourhood Wardens teams and Youth Inclusion Programmes (YiPs); see Communities and Local Government (2008) *The 2008 Partnership Survey: Evidence from the New Deal for Communities Programme*.



within local geographical areas for specific client groups, defined by e.g. health condition, ethnicity, and age.

- 2.21. The Sure Start Programme launched in 1999 and ongoing, was designed to achieve better outcomes for children, parents and communities by increasing the availability of childcare for all children, improving health and emotional development for young children ([www.surestart.gov.uk/](http://www.surestart.gov.uk/)). Sure Start Plus provides support to pregnant teenagers, to enable them to make responsible and well informed decisions according to their individual circumstances, and supports teenage parents around issues such as healthcare, childcare, parenting skills, education, training and employment (Department of Health, 2001b).
- 2.22. Additionally, in 2004, John Reid, as health secretary, announced that the 20 per cent of areas in England with the worst health and deprivation indicators would be made into Spearhead PCTs. These trusts, comprising 70 local authorities and 88 PCTs, were given financial support, through partnership working, to pilot new initiatives such as health trainers, healthier school meals, and advanced stop smoking programmes (Department of Health, 2004e). By mid 2009 Spearhead areas will have a health inequalities national support team, and there is already a Public Health national support team to support PCTs (HM Government, 2009). Not unsurprisingly, those areas identified as eligible for Spearhead PCT status have considerable overlap with those already functioning as NDC areas.
- 2.23. Similarly, the 'Communities for Health' initiative, proposed in the *Choosing Health* white paper (Department of Health, 2004a), set up in 2006, and funded for a further three years from 2008, has a similar approach in that it aims to build capacity in local authorities so their communities work to tackle local health inequalities and provide leadership and wellbeing. The intention is also to foster a joined-up approach to health improvement through LSPs and Local Area Agreements.
- 2.24. All of the initiatives outlined above are designed to address health inequalities in specific geographical regions or with specific population groups. All are relatively recent and as such, whilst some are being formally evaluated, the full evidence-base for their effectiveness has yet to be assembled. Joint activities between the NDC Programme and one or more of these other interventions, or an activity by a local NDC team to support one or more of these other initiatives have taken place. With many concurrent policies and programmes, all designed to address and reduce health inequalities, it is not straightforward to attribute any change, whether positive or negative, to a specific programme and because they are all of relatively recent implementation, evidence of benefit is still being accrued.

## Non-health initiatives with an impact on health inequalities

- 2.25. It has long been recognised that the determinants of health are wide and varied and compounded by the interactions between factors. For instance, evidence from the evaluation of the Decent Homes programmes suggests that improvements to housing conditions will also contribute to improvements in the health and quality of life of residents by reducing heart and respiratory disease, reducing the number of accidents in the home and promoting greater security and mental well-being.<sup>10</sup> Reducing health inequalities has become a priority across multiple government departments, with policies and/or interventions in education, regeneration, criminal justice, culture and sport, and child poverty also addressing health inequalities issues (Graham, 2006). Examples of such policies which could impact upon health include: the Fuel Policy Energy Strategy and Warm Front programmes to help pensioners keep warm in the coldest weather (Department of Environment, Food and Rural Affairs, 2008); the National Minimum Wage to ensure that adults earn sufficient to live above the poverty level; the *Child Poverty Strategy* and *Child Poverty Review* which addressed tax credits and employment issues among others (HM Treasury, 2004); and *Every Child Matters*, whose five key themes are: being healthy; staying safe; enjoying and achieving; making a positive contribution; and economic well-being (Department for Education and Skills, 2003).

## Evidence of effectiveness of interventions to tackle health inequalities

- 2.26. Kelly (2006) has highlighted that whilst health inequalities can be demonstrated, the evidence base on effectiveness of interventions to address these inequalities in health is lacking, and Bauld and Judge had previously pointed out that very little research in the area of inequalities in the 1990s had a policy or practice orientation (Bauld and Judge, 1999).
- 2.27. To address this lack of evidence, a number of actions have been taken over the past decade. The 1999 white paper and Action Report (Department of Health, 1999a and 1999b) launched Public Health Observatories whose roles are to provide a regional health intelligence service, provide a focus for capacity building and skills development for health intelligence staff, and provide a 'bridge' between academic public health and practice (Association of Public Health Observatories, 2008). And nationally the Public Health Consortium (Department of Health, 2004a), funded by the Department of Health Policy Research Programme, has the aim of strengthening the evidence base for interventions to improve health, with a strong emphasis on tackling socioeconomic inequalities in health.

<sup>10</sup> Gilbertson, J. et al. (2006) *Decent Homes Better Health: Sheffield Decent Homes Health Impact Assessment*. Sheffield: Sheffield Hallam University.

- 2.28. The Modernising Government agenda (Cabinet Office, 1999) established a central role for evidence in policy making, leading to the development of the Health Development Agency in 2002 as a special health authority to develop the evidence base around reducing health inequalities. The Agency was actively reviewing evidence on health inequalities and the effectiveness of interventions to address this issue between 2000 and 2005<sup>11</sup> in parallel with the implementation of the NDC Programme (Kelly, 2006). Thus whilst individual NDC partnerships were attempting to improve health and reduce health inequalities within their communities, the evidence base of relevant appropriate robust effective interventions in this public health-related field was still being thoroughly appraised and was also very limited.
- 2.29. Extensive evaluation of specific projects and programmes, notably HAZ (Bauld, et al., 2005) and Sure Start,<sup>12</sup> is building evidence in relation to 'what works' in tackling health inequalities in deprived communities. Studies have emphasised the importance of a holistic approach based on partnership working, responding to community priorities, and establishing robust mechanisms for governance and review (see, for example, Anning, 2007 in relation to Sure Start programmes; also Department of Health, 2008a) and there is clear resonance here with earlier findings from the New Deal for Communities interim evaluation (CLG, 2005).
- 2.30. But there has also been acknowledgement that tackling health inequalities is a long term process. In this context it is important to note despite over a decade of policy interventions which have aimed to tackle health inequalities, and overall improvements in the health of deprived communities, the gap between those worst off and the national average has not narrowed since targets were first set in 2002. This point was acknowledged in the recent Department of Health review of health inequalities (Department of Health, 2009b) and in the commitment for Professor Sir Michael Marmot to lead a strategic review of post 2010 health inequalities, due to report initially in late 2009.
- 2.31. This chapter has summarised key developments in health policy and evidence, with a view to contextualising the work of NDC partnerships. The next chapter looks at the approaches that the case study NDC partnerships have taken to improving health outcomes.

<sup>11</sup> When the National Institute for Clinical Excellence took over its evidence and guidance functions.

<sup>12</sup> The Sure Start programme is subject to an independent evaluation being led by a team based at Birkbeck, University of London. The evaluation runs to 2012 and supports a website at [www.ness.bbk.ac.uk/](http://www.ness.bbk.ac.uk/)

## 3. NDC partnerships' approaches to improving health outcomes

### Introduction

- 3.1. As outlined in Chapter Two, the period in which NDC partnerships have been addressing health outcomes in their communities has also been characterised by rapid and wide ranging policy developments which have aimed to tackle health inequalities.
- 3.2. But at the same time, NDC partnerships have also been working in an environment in which the evidence base for interventions which might narrow the health 'gap' between deprived and better off communities has been developing and remains partial.
- 3.3. Evidence from *The 2008 NDC Partnership Survey* (CLG, 2009b) suggests a wide variety of approaches to improving health outcomes across the NDC Programme. However there are a number of recurrent themes:
- improving access to and quality of **services and facilities**: new build or virtual healthy living centres; youth facilities; sports facilities; location of primary (and some secondary) care services in NDC neighbourhoods; targeted outreach; workforce development
  - supporting **healthy lifestyles**: smoking cessation programmes; exercise programmes and subsidised access to leisure facilities; diet, cookery and healthy food projects; sexual health projects; alcohol and drug misuse projects
  - targeting **vulnerable groups**: children; older people; substance misusers; black and minority ethnic populations; teenage parents
  - tackling **'upstream' influences** on health outcomes: welfare rights projects to improve income levels; improvements to neighbourhoods and green space; improvements to heating and security in homes
  - **partnership working**, notably with PCTs but also with social services and third sector organisations
  - **community involvement** in planning and delivery of health interventions (examples include participatory budgeting and peer educators).
- 3.4. Different NDC partnerships have focused on these themes to a greater or lesser extent, depending on local circumstances. Some interventions, such as those which aim to improve service access and healthy lifestyles, are common to almost all local NDC programmes. Others, such as welfare rights campaigns and participatory budgeting, are less frequent.

- 3.5. This chapter provides an overview of the approaches implemented by four case study NDC partnerships to narrowing the gap in health indicators between the NDC neighbourhoods and their wider areas.
- 3.6. The chapter begins by looking at the ways in which the case study NDC partnerships identified local health issues. It reviews the approaches adopted by the NDC partnerships and addresses issues around strategy development and working in partnership with agencies and communities.

## Identifying issues and developing strategies

- 3.7. The approaches taken in the case study NDC partnerships to addressing health issues have evolved over time. An early 'vision' or overarching statement has often set the framework for the NDC partnership's approach. In Sandwell, the vision contained in the original delivery plan was maintained throughout the lifetime of the local NDC programme:

*'to improve the health, well being and quality of life of residents through the integration of health and social care services that are flexible and responsive to the diverse needs of the community'*

- 3.8. But it has also been the case that early interventions have perhaps been less strategic. Whilst the Greets Green Partnership had supported some early stage health interventions and projects over the period 2000–2004, the activities of the health theme group had largely been ad hoc in nature and were not driven or informed by an overarching strategy. There were a number of contributing factors:
- the alignment of PCT and NDC outcomes had not been agreed
  - partnership arrangements between the NDC partnership and delivery agencies had not been agreed or established
  - there were workforce constraints within the PCT which limited the amount of dedicated support that it could provide
  - the NDC partnership was in its early stages and had not yet implemented robust project appraisal procedures.
- 3.9. In order to address some of these issues a Neighbourhood Health Management Team was established in 2004. With the team in place the theme flourished and scoping work began to identify what was needed in the area. Outcomes were re-visited and more realistic indicators were identified through which the progress of the health theme could be tracked. In the opinion of the theme manager, the new approach successfully managed to "balance the needs and wants of the community with national and local priorities."
- 3.10. In Hackney, the Shoreditch Trust has worked with the local PCT to improve the wellbeing of local people by reflecting on the needs of targeted groups and developing interventions to meet those needs, based on evidence about

the efficacy of public health interventions. The Ipsos Mori household surveys, combined with administrative data supplied by the NDC evaluation team and local data highlighted local problems. Extensive consultation with the community pinpointed their priorities.

- 3.11. In Fulham, the NDC partnership had a systematic approach to assessing need and creating a workable baseline in 2002, including a household survey and a participatory appraisal (PA) exercise conducted involving residents.
- 3.12. The NDC's strategy, developed in response to the survey and PA findings, identified six core issues: high incidence of cancers; drugs and alcohol; teenage pregnancies; mental health; child and family health and wellbeing; poor access to healthy living opportunities.
- 3.13. Priorities have increasingly been developed jointly with the PCT. Two years ago NHS Hammersmith and Fulham and partners produced a Joint Strategic Needs Assessment (JSNA). Fulham NDC Partnership carried out community consultation, including a public event, and a number of workshops to review key questions. There is now (for the first time in the borough) a jointly funded JSNA officer.
- 3.14. Participatory Appraisal has also helped to identify early priorities for the health theme in Salford where an initial strategy (developed in 2001) focused on the development of a 'Community Health Action System' which centred on the involvement of local residents in reshaping local services. Priorities included:
  - increase local health facilities
  - improve the range, take-up and impact of services
  - support community involvement in and influence on health and health care provision in the area.
- 3.15. The focus of the theme was revised in 2006–07, leading to the launch of a Health Investment Strategy. The production of the Strategy was informed by commissioned research on the available evidence base, together with local evidence of need and community consultation. This Strategy, which will direct the activities of the health theme to the end of the NDC Programme aims to improve the health and happiness of Charlestown and Lower Kersal residents and to provide an agenda for engaging and influencing mainstream health commissioning and provision. Priorities for the new strategy are:
  - increased physical activity
  - a reduction in smoking
  - a reduction in the use of alcohol, especially by children and young people
  - a reduction in social isolation
  - increased support for pregnant women and mothers with children under five

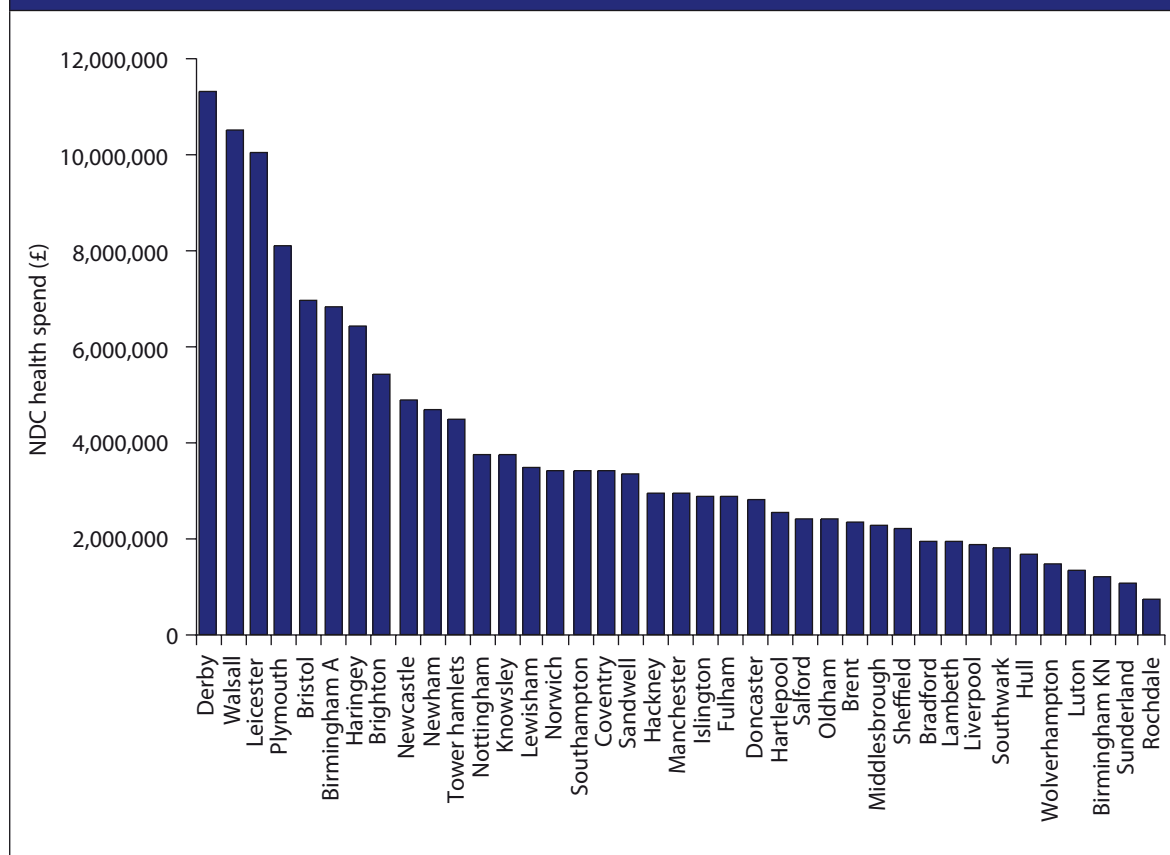
- a decrease in poor mental health, and especially reductions in depression, anxiety and stress.
- 3.16. The strategy sets a framework for the commissioning of health services (as part of the wider move towards commissioning across all NDC themes) and aligns closely with 'Choosing Health' outcomes (Department of Health, 2004a) and the agenda of the Salford PCT. The Health Investment Strategy is wholly revenue based and NDC funded, with a strong emphasis on third sector delivery (all but one intervention are delivered by third sector agencies).
- 3.17. Salford NDC area is working towards a number of broad health outcomes, progress towards which is monitored using Ipsos Mori household survey data and other evidence.
- 3.18. One key feature of activities in the case study NDC areas has been the sheer number of interventions. In Salford, for instance, the health theme has funded over 20 projects addressing a range of health and related issues. And in Sandwell, 40 projects have funded 26 separate activities. On the one hand, this level of activity has reflected the extent of local need in relation to health issues. But it has also been true that NDCs have taken something of a scattergun approach: devising or commissioning a project to address each separate issue as it presented, rather than using resources to comprehensively address a more limited range of problems. An Assistant Director for Health Improvement at the PCT for one case study area commented thus:

*"If we had another 10 years I would want to do it differently, to take a more programmed approach. Just putting additional resources into (service delivery) won't make a difference. NDC offered a great opportunity to make a big investment in one area but there has been too much emphasis on projects. If I had the time again the planning would be different – much more focused, with a real focus on families and a comprehensive attack on a much smaller range of problems"*

## Resources

- 3.19. Across the programme health interventions have attracted a relatively small proportion of NDC resources. Spend in the health theme to March 2008 has amounted to £148m (current prices), or 11 per cent of total NDC spend. However, there has been a high degree of variation in spend across individual NDC partnerships, ranging from £700,000 (2 per cent of partnership spend) in Rochdale to £11.3m (36 per cent of partnership spend) in Derby (Figure 3.1).

Figure 3.1: NDC health expenditure, by NDC partnership: 1999/2000 to 2007/08 (current prices)



Source: CEA, System K

3.20. In the case study NDC partnerships, health spending has been relatively low, accounting for 7 per cent of spend in Hackney (£2.9m), 8 per cent in Salford (£2.4m) and 9 per cent in both Fulham and Sandwell (£2.9m and £3.4m respectively).

3.21. There are a number of potential reasons for this apparent low level of spend:

- moderate capital investment<sup>13</sup>
- availability of alternative funding streams – the health theme is one in which there has been a rich stream of additional investment<sup>14</sup> and other resources, notably the LIFT programme which has financed the development of Healthy Living Centres in a number of NDC areas<sup>15</sup>
- a focus on small-scale projects, targeting small sections of the population

<sup>13</sup> Although the health theme has the second highest percentage of capital expenditure amongst the NDC themes (at 44 per cent, equating to approximately £65m) this can be contrasted with the housing and environment theme, for instance, which has attracted the bulk of NDC resources for physical redevelopment and where 74 per cent of spend has been allocated to capital projects (Communities and Local Government, 2009).

<sup>14</sup> Up to 2007 the health theme had attracted third highest level of additional investment, at 43p for every £1 of NDC resources spent. Lottery funds accounted for 19 per cent of additional funds, 17 per cent came from PCTs and 13 per cent from local authorities. See Communities and Local Government, 2009.

<sup>15</sup> NHS Local Improvement Finance Trust (LIFT) is a vehicle developing new primary and community care premises. Investment is channelled through public/private collaboration via a LIFT Company. The limited Company owns and maintains the premises which it leases to PCTs and health care providers. See [www.dh.gov.uk/en/Procurementandproposals/Publicprivatepartnership/NHSLIFT/index.htm](http://www.dh.gov.uk/en/Procurementandproposals/Publicprivatepartnership/NHSLIFT/index.htm)



- the likelihood that some projects with health outcomes will have been funded through other NDC themes (for instance housing and the physical environment).
- 3.22. However, it is also likely that health interventions have simply been given less priority by NDC boards and communities. Early emphasis on tackling 'crime and grime' issues and plans for longer term physical redevelopment have in some NDC partnerships overshadowed health issues which, by their very nature, affect limited numbers of NDC residents. In Salford for instance, health issues did not feature as an issue in early participatory exercises which informed the development of the Delivery Plan and in which 'cleaner/greener' priorities were to the fore. Additional appraisal exercises conducted by the (then) Health Action Zone Co-ordinator revealed a high degree of acceptance of ill-health as the norm and a lack of expectation around services and facilities. However, when local residents were engaged in dialogue around health issues they were keen to articulate what could be changed or put in place to make a difference.
- 3.23. Additional resources have been brought to NDC areas through partnership working with agencies. PCTs have contributed £15.1m (current prices) to local NDC programmes up to 2007–08, although this equates to just 2 percent of all levered-in spend across the NDC Programme as a whole. However, much additional support has been 'in kind'. In Hackney, for instance, the NDC partnership was clear from the beginning that it could not improve the health of local people alone. The development of a Service Level Agreement (SLA) with the local PCT relied heavily on PCT resources and continues to do. An extension of a bus route, whilst initially funded wholly from NDC funds, has relied on cooperation from London Transport to provide drivers, manage timetables, etc.
- 3.24. Direct funding has also been available from a range of statutory and third sector providers. The Hackney experience provides an illustration, where funders contributing to health theme initiatives included: PCT; Big Lottery; New Opportunities Fund; Warm Front; local hospital Trust; local government; third sector agencies; Football Foundation.

## Working with agencies

- 3.25. Perhaps because of the broad scope of interventions in the health theme, the case study NDC partnerships have worked with a wide range of partners in designing, financing and delivering services. For example, the range of partners involved in a selection of the NDC supported health projects in Sandwell is outlined in Table 3.1.

**Table 3.1: Greets Green Partnership – health theme partners**

Partner	Project
Sandwell Council Adult Services (Social Services), Sandwell PCT and Agewell	Helping older people stay healthy and safe through the Healthier and Older Age project
Albion BID Co Ltd, Healthy Hearts Institute, M&T Solutions, Harrington Enterprises and Sandwell PCT	Workplace health screening
Sandwell PCT, the Children’s Fund, George Slater Collegiate Academy and Newton Primary School.	School-based Fit for Life project
Sandwell PCT, Sandwell Youth Services, West Bromwich & District YMCA and Greets Green Children’s Centre	Preventing teenage pregnancy and supporting young parents through the Teenage Pregnancy project
Sandwell PCT, Sandwell MIND and SWAN (Sandwell Women’s Agency Network)	Supporting positive mental health through the Healthy Minds project
Sandwell PCT, UEFA, the FA, Sandwell MBC and West Bromwich Albion Community Programme	The Hat Trick community football project
Sandwell PCT, Sandwell MBC, OSCAR Sandwell and Greets Green Children’s Centre	Child Home Safety project

- 3.26. In all the case study areas the PCT has been the most significant partner in the health theme. This is to be expected, as PCTs carry the main responsibility for commissioning and delivery of local and community-based health services. They also have a key role in public health, and in addressing health inequalities.
- 3.27. Partnership working with PCTs has taken a number of forms, including senior and frontline PCT staff representation on NDC boards, theme groups and forums; PCT funding for projects and interventions; secondment of PCT staff to NDC management teams and involvement of PCT staff in delivering NDC projects. Generally these relationships have been very positive. In Sandwell, for instance, collaboration between the NDC partnership and the PCT has proved to be a valuable asset in driving change. The insights and knowledge drawn from PCT staff, coupled with the alignment of NDC and PCT targets, have helped the NDC partnership to develop its approach to addressing health issues. The health theme manager in the NDC partnership spoke positively about the partnership and described the work undertaken as being ‘embedded within the PCT’.
- 3.28. The commissioning approach adopted by the NDC partnership paved the way for closer working relationships with third sector organisations to be developed. The health theme manager spoke encouragingly about the involvement of voluntary and community organisation in the delivery of projects. However, there were some challenges along the way that the NDC partnership helped to address. Some third sector organisations, although having the capability and expertise to deliver projects lacked basic evidencing, monitoring and evaluation skills. The NDC partnership viewed this as a development opportunity for the organisations and helped them put monitoring systems in place.

- 3.29. In Hackney there was a close relationship with the PCT who were well represented in the NDC partnership's governance structures and helped to react to resident concerns and shape the local programme. The NDC partnership established the Shoreditch Spa to deliver local health services and when the Spa was first set up the relationship continued to work well. The Deputy Chief Executive of the NDC partnership acted as commissioner for health work and a Spa manager was appointed to be the provider. In this way, it was possible for the NDC partnership to be involved in all aspects of designing, tendering, etc. without a conflict of interest. This was also a useful relationship for the PCT who were obliged to work with community groups. However, as over time, the Spa has developed as a provider organisation (see case study, below) it is difficult to have representation from commissioning organisations like the PCT and the local mental health Trust in the Spa's governance arrangements. This presents some issues as close working with the PCT is important for local people and it also took many years for the NDC partnership to develop a good working relationship with the mental health trust, and there is a danger that this may be lost.

### Shoreditch Trust

#### Shoreditch Spa (Healthy Living Centre)

Shoreditch Spa was set up in April 2003 when a £750,000 five year grant from the Big Lottery Fund was matched by Shoreditch Trust, as a means of streamlining its existing portfolio of health projects. The plan was for the Spa to develop holistic services to deliver local and accessible healthy living and wellbeing services aimed at reducing health inequalities. It aimed to:

- engage people into lifestyle changes for the benefit of their health
- deliver a holistic mix of services from healthy eating through to complementary therapies
- influence the local health sector
- become a sustainable business.

The Spa provides a range of services under four programmes:

- **Healthy Goals** – including one-to-one work with people referred by GPs outreach work, and a Health Trainer programme
- **Healthy Eating** – projects can take many forms but often include 'cook and eat' sessions
- **Peace of Mind** – includes mental health support for asylum seekers and new arrivals
- **Complementary Therapies** – the aim is to provide high quality affordable therapies to local people to improve mental health and well-being.

The Spa offers treatment at reduced rates to Shoreditch residents and free to those referred by the NHS.

As part of the NDC partnership's 2006 sustainability strategy, the Spa became a social enterprise. It operates as a distinct organisation that can support and sustain itself and continue to offer something to local people. Part of its sustainability has been to expand to operate a service borough-wide and beyond in order to win contracts. Any surpluses from work outside Shoreditch are reinvested into services for the local community and used to provide subsidised complementary therapies to Shoreditch residents. The Spa currently has a turnover of £1m and a core staff of around 20, plus a further 20 sessional workers.

- 3.30. But there have also been tensions and difficulties with relationships between NDC partnerships and PCTs, particularly in the early stages of the Programme, when there was some evidence that PCTs may have seen NDC partnerships as working in competition, rather than collaboration. Partnership working has also been hampered by re-structuring and staff turnover within PCTs. Over the lifetime of the NDC programme, PCTs and other NHS organisations have been subject to numerous reorganisations and mergers, resulting latterly in the merger of smaller PCTs into single borough-wide commissioning bodies. This has created a number of challenges for local NDC programmes, not least the need to keep building new relationships and to agree common goals with agencies that have a much wider constituency than the NDC area. In Salford, for instance, health improvement services are delivered through eight neighbourhood management areas in the borough. The East Salford area is much larger than the NDC area and, because the NDC area has been seen to have its 'own' resources, health improvement services have been delivered outside the NDC area. There has been continuity in terms of senior PCT representation on the NDC board but at the operational level rapid turnover of leads has created problems for both agencies.
- 3.31. One way in which these tensions have been managed is through secondments and joint funding of posts. In Salford, the NDC partnership benefited greatly in the early stages of the programme from the joint PCT/NDC funding of a Health Action Zone co-ordinator post, seen by the NDC partnership as facilitating the 'unlocking' of resources within the PCT and providing a link between the community and health agencies. Similarly, in Fulham, a secondment arrangement, governed by a robust SLA, will, according to one PCT partner, "become a permanent feature" (which) 'has added value to our public health priorities', (providing) "skills and abilities used effectively to improve patient engagement".
- 3.32. In both these NDC areas detailed evaluation and impact assessment has helped to establish an evidence base for scaling up neighbourhood projects. In Fulham, the NDC partnership describes itself as having "invested heavily in testing projects both at the NDC area level and at a wider scale in partnership with the PCT to maximise the opportunities for mainstreaming of these initiatives in PCT commissioning plans". Aligning NDC initiatives to clear national priorities and targets, such as smoking cessation, has also been beneficial. The implications of the NDC partnerships' approaches for the

sustainability of health interventions are discussed at reviewed at Chapter Five.

- 3.33. A notable feature of the NDC partnerships' work in the health theme has been the degree of involvement from third sector agencies in identifying health issues and delivering solutions. Flexibility in funding has enabled local NDC programmes to support the development of community-based organisations into social enterprises delivering innovative solutions to local health problems. In Salford, all but one intervention under the NDC partnership's health theme are delivered by third sector organisations, including Unlimited Potential, a social enterprise which has grown from a group of local residents concerned about local health issues.

### **Salford NDC**

#### **Community Health Action Partnership/ Unlimited Potential**

In the Salford NDC area a lack of accessible local health facilities was a key priority for the local NDC programme and in particular for a group of residents who formed themselves into the Community Health Action Partnership (CHAP) with a view to lobbying for improved health facilities in the NDC area. CHAP was centrally involved in the consultation and feasibility work for the new Healthy Living Centres in the NDC area and was funded by the NDC partnership to deliver a number of health interventions. Over time CHAP has developed from a local lobbying group into an organisation delivering services locally on behalf of the NDC partnership into its current position as Unlimited Potential, a successful and fast-growing social enterprise delivering health and well-being services across the city for a range of commissioners and with a turnover in excess of £1m per annum.

## Working with local communities

- 3.34. An earlier study on community engagement in NDC programmes (CLG, 2009c) outlined the mechanisms through which NDC partnerships have engaged local residents in the planning, delivery and review of initiatives. These have included:
- community representation on NDC boards
  - community involvement in theme groups, sub-committees and appraisal panels
  - engaging the wider community through forums and events
  - a range of communications media, to keep residents informed about plans, activities and progress
  - dedicated community engagement or involvement teams
  - training for community and agency reps and, sometimes, the wider community
  - community-based small grants and loan schemes.

- 3.35. Similarly, findings from the Communities for Health programme (Department of Health, 2009c) have showcased interventions in deprived areas which have successfully engaged local people in the planning and delivery of interventions and in taking responsibility for their own health outcomes. This evidence echoes that from the NDC evaluation. In particular, the study of community engagement in NDCs (CLG, 2009c) highlighted the important contribution that community involvement had made to health interventions (although it also pointed out that there were some ambiguities in the purpose of residents' involvement, including a lack of clarity in relation to the degree to which residents were expected to identify solutions to local health issues).
- 3.36. In the case study NDC partnerships researched for this report, local residents have been involved in the health theme in a number of ways:
- identifying issues, through the consultation and participatory appraisal exercises
  - working with agencies and health professionals in theme groups and working groups, to commission and appraise projects
  - participating in evaluation and review to gauge the success of interventions
  - as delivery agents – through e.g. peer education and community-based projects
  - and as recipients of health services.
- 3.37. In the Charlestown and Lower Kersal NDC area in Salford community involvement in the health theme has taken a number of forms. This has included participatory appraisal at the outset of the NDC Programme which obtained the view of over 2000 local residents; the development of the Community Health Action Partnership (which eventually became a successful social enterprise); an NDC Health Task Group; community involvement in appraising and reviewing projects; and community involvement in the governance of two healthy living centres.
- 3.38. In all the case study NDC partnerships, community participation has been actively encouraged. In Sandwell, a Community Health Forum provided a vehicle to ascertain a baseline in the first instance and latterly, to exchange information.

## **Sandwell NDC Partnership**

### **Community Health Forum**

Members of the Forum included residents, project sponsors and NDC staff. Functioning as a 'sort of reference group' for the NDC partnership in the early stages of the programme where ideas, gaps, plans etc were put forward, the Forum was used as a sounding board to ensure NDC interventions were needed and welcomed.

The Forum was unique in its format in that it functioned partly as a service to local residents, and partly as a consultation and networking event. A 'drop in' at the start of each meeting enabled residents to discuss any health issues they wished to raise. Guest speakers were also invited, giving talks on a number of health areas. The last half hour of the meeting focused on information sharing and networking.

The NDC partnership's health theme manager spoke highly of the Forum and considered it to have benefitted all participants. Residents liked the 'drop in' and information sharing element of the Forum and it provided an opportunity to disseminate information about the health theme to sponsors and residents.

- 3.39. In the Salford and Hackney NDC areas, the priorities of the health themes were determined by groups of active residents. In Hackney, the health task group was very active from the beginning and well attended by residents. There were also community forums and extensive consultation exercises as well as public events. Residents formed the majority on the task group and on appraisal panels. The Peer Education Project also gave residents a chance to contribute to the projects and programme through feedback, ideas and helping with designs.
- 3.40. And in Fulham, resident engagement in Expert Patient programmes has provided a springboard for wider community engagement. Individually, graduates of the Expert Patient programme and other schemes have become involved in delivery, in the NDC partnership's thematic/consultative groups, and wider consultative processes. They have also served as health champions – for instance one expert patient who had had a liver transplant spent time supporting others about to undergo the process. Local community groups and those serving them are being used to help deliver programmes to harder to reach residents.
- 3.41. There has also been emphasis on community involvement in evaluation and review, using feedback from residents and service users. User feedback is a key element of service planning for the Shoreditch Spa. And in Sandwell citizens' juries and focus groups (named 'Families of 99') have been used to gauge the success of each of the themes and projects, providing useful feedback on the degree to which NDC investments have impacted on residents in the Greets Green area and qualitative evidence to complement that obtained through household survey and other data sources.
- 3.42. But whilst commentators have been positive about the involvement of communities, and their ability to contribute to the successful design and

delivery of health services, there have also been tensions. In Fulham, for instance, resident involvement has been crucial to the effectiveness of the health programme and to the NDC partnership's ability to target hard to reach groups. Developing a 'health literate' cohort of people to engage in the debate has helped the NDC partnership to develop a pragmatic approach which has responded to local needs. Health champions and expert patients have been able to go out into the community in a way that would be difficult for others to do. However, occasionally individuals have been preoccupied with single issues such as teenage pregnancy, which has been unhelpful. There have also sometimes been tensions when residents in one area have felt others were benefiting disproportionately. For instance, some questioned the focus on North Fulham when other parts of the borough might be more deserving.

- 3.43. It has not always been possible to align the priorities of residents with those of health service providers and commissioners. In Salford, for instance, community aspirations for the delivery of local health and wellbeing services via community managed health centres could not be fully realised through the NHS funding mechanism (LIFT) that was used to develop new buildings. Two new healthy living centres provide increased access to GP and pharmacy services, although the range of services has been extended to reflect a more holistic approach since the PCT commissioned a local social enterprise to manage the facilities.



## 4. Interventions in the case study NDC areas

- 4.1. This chapter reviews some of the health interventions supported by the case study NDCs. Across the Programme there has been a wide variety of projects and programmes, reflecting local priorities and issues, and indeed one aim of the NDC initiative has been to pilot new and innovative responses to local issues. This has certainly been true in the case study NDC partnerships, and local NDC programmes have offered PCTs and other health agencies the opportunity to test out interventions at a relatively low risk, many of which have then been rolled out to larger populations.
- 4.2. One key feature of activities in the case study NDC partnerships has been the sheer number of interventions. In Salford, for instance, the health theme has funded over 20 projects addressing a range of health and related issues. And in Sandwell, 40 projects have funded 26 separate activities. On the one hand, this level of activity has reflected the extent of local need in relation to health issues and the desire on the part of NDC partnerships to address a wide range of health outcomes. But it has also been true that NDC partnerships have taken something of a scattergun approach: devising or commissioning a project to address each separate issue as it presented, rather than using resources to comprehensively address a more limited range of problems. This is perhaps a reflection of the evolving evidence base, as a result of which health practitioners and public health agencies have come to understand the need for a more sustained and comprehensive approach to health issues. An Assistant Director for Health Improvement at the PCT for one case study area commented thus:

*“If we had another ten years I would want to do it differently, to take a more programmed approach. Just putting additional resources into (service delivery) won’t make a difference. NDC offered a great opportunity to make a big investment in one area but there has been too much emphasis on projects. If I had the time again the planning would be different – much more focused, with a real focus on families and a comprehensive attack on a much smaller range of problems”*

- 4.3. Nevertheless the case study NDC partnerships have supported projects which have offered enhanced services and support to significant numbers of local populations. In Hackney, activities are aligned under the three strands:
- **improve access:** local blood testing, ante-natal services, diagnostic testing, alcohol counselling, affordable complementary therapies for residents, peer education programmes particularly with black and minority ethnic and refugee communities, information and events, website, advice shop, young people’s provision including outreach and GP services for 16 year olds, drug initiatives with the Drug Action Team, youth outreach

worker, provision of a local venue for community group sessions and services, additional transport to health centres

- **improve services:** SLA with PCT, mental health community development initiative with black and minority ethnic groups, health improvement services for GPs, information resource (website) for primary care teams re local activities/referral agencies, Community Maternity Centre, improvements to GP premises/capacity, local venues for NHS and non-NHS health activities, improvements to quality of interpreters/advocates through accredited training programme, assisting PCT with community involvement, public events and consultation
- **promote wellbeing:** life-style change through activities based on health trainer model, access to healthy eating skills (healthy eating team and training kitchen), accessible exercise programme linked to ongoing exercise on referral, benefits advice in GP surgeries and advice shop, mental health users groups, elders activities, joint work with Children's Centres and schools (healthy eating, developing the Shoreditch Walks health maps, etc), smoking cessation in local settings, self-management of long-term conditions, gardening projects.

4.4. For the remainder of this chapter, interventions (and discussion) are grouped under three headings:

- improving access to services
- supporting healthier lifestyles
- targeting vulnerable groups.

4.5. However, it should be noted that the projects discussed do not represent the entirety of interventions in the case study NDC areas and most of the projects featured contain elements which could fall into more than one of these groups.

## Improving access to services

4.6. Limited health services available locally and poor access to services both within and beyond NDC neighbourhoods were identified as problems in the case study NDC areas. Issues around service access were often a particular priority for communities, as highlighted by data gathering exercises carried out by the NDC partnerships in the early stages of the Programme. There were particular issues around access to primary care services. In Salford, for instance, a lack of accessible local health facilities at the outset of the Programme was a key issue for the NDC health task group, and particularly for a group of local residents, who formed themselves into the Community Health Action Partnership (CHAP) and, supported by the NDC partnership, lobbied for improved local health facilities. Development and a feasibility study carried out by consultants working with CHAP and the NDC partnership identified two potential sites for new healthy living centres, which were financed through the Local Improvement Finance Trust (LIFT) and

opened in 2005 and 2006. These centres offer GP and pharmacy services to two distinct neighbourhoods in the NDC area (Charlestown and Lower Kersal) and are currently managed by the Big Life Group, a social enterprise based in the north of England which runs health and well-being centres across Greater Manchester. CHAP has developed into a social enterprise with a turnover of over £1m per annum which has contracts to deliver services across Salford.

- 4.7. Further improvements to service infrastructure in the Salford NDC area have been achieved via investments from the NDC partnership and the PCT in an additional healthy living centre which provides creative arts-based therapy and training opportunities to people with mental health difficulties (START) and through provision of walk-in primary care facilities.
- 4.8. There has also been an emphasis on testing new methods of service delivery. The enhanced maternity services project has funded a maternity assistant to provide tailor-made support and advice to pregnant women and their families and signposting to other services in the area. And a social prescribing project has offered support to people with low level depression, anxiety and work-limiting illness to identify alternatives to medical prescriptions using community and voluntary sector services. All projects in the Salford NDC Partnership's health theme are currently being evaluated.

### **Charlestown and Lower Kersal NDC area**

#### **Refresh Social Prescribing Project**

Delivered by Salford Health Matters, a Community Interest Company, which was founded by local primary care staff. The Social Prescribing project refers people to non-clinical treatments to complement those offered via mainstream health services.

The project has a strong focus on tackling health and worklessness and aims to support local residents to improve self esteem; gain new skills and/or employment; make new social contacts and make healthier lifestyle choices.

- 4.9. Access to maternity care has also been addressed in Hackney with a view to reducing rates of infant mortality in the NDC area. The Shoreditch Spa has been the NDC partnership's main delivery agency for health interventions, and had had a key role in the development of new services. The Spa is a community based organisation which has developed from being wholly grant funded by the local NDC programme to a social enterprise which delivers health services in several London boroughs.

## Shoreditch Trust

### Infant Mortality Reduction Project

The NDC partnership worked with Shoreditch Midwifery Group Practice (SMGP) to provide a more local and individual service for women in the Shoreditch area. In addition, Shoreditch Spa won contracts for two projects which are part of the LSP's strategy: 'Bump Buddies', a peer support project addressing poor pregnancy outcomes amongst British, African-Caribbean and African women in Hackney; and a healthy eating through pregnancy pilot project which developed healthy eating education and assessment tools for use by midwives and ran cooking courses for pregnant women.

The provision of a local maternity service has been a great achievement for the local NDC programme. Positive evidence includes feedback from mothers, support from the hospital based consultant and project evaluations. Still births have gone down in Shoreditch, as has the incidence of low birth weight babies. The programme continues to be evaluated but the combination of all the strands appears to be making a real difference. Bump Buddies met and exceeded targets and there was an increase in bookings by 12 weeks of 24 per cent after the first year of the project.

A new maternity unit is under construction which will bring all parts of the project together in one building, making a more cohesive service. The PCT has taken over responsibility for funding for the community based services, generating an annual income for the Trust of more than £45,000 arising from the rental of space in the new unit.

## Supporting healthier lifestyles

- 4.10. Projects which aim to support healthier lifestyles have been popular options for NDC partnerships. In Fulham, for instance, a central focus has been on developing new models of community-based service delivery to address a range of healthy living issues. Key projects have included:
- **exercise on referral** – with signposting to and from smoking cessation and alcohol services. At its peak the project was operating in 11 GP practices across the borough and two leisure facilities
  - **health and wellbeing services to vulnerable people** e.g. healthy living advice for young people, drug and alcohol services for adults, toenail cutting for older people, disabled people and those with chronic illnesses; winter warmth for low income households
  - from 2002 the NDC partnership alongside the London Borough of Hammersmith and Fulham, commissioned the delivery of the **Family Support/Family Welfare Association Project (FSP)** in North Fulham to offer school-based intensive support to vulnerable and disadvantaged families

- **community-based exercise:** a relationship with Chelsea Football Club engaging relatively marginalised men and women in sport. Participants are linked into other NDC initiatives and local services, including job related training. Some have become volunteers and assistant football coaches in the scheme
- **MEND programme** tackling childhood obesity in partnership with Fulham FC, Hammersmith and Fulham PCT and the London Borough of Hammersmith and Fulham
- **Well London White City** – co-ordinates the Well London White City Programme connecting local residents to new and existing physical activity, healthy eating and mental wellbeing projects, services and facilities through the recruitment, management and development of a local team of volunteers by White City Tenants Association
- **food co-ops** (now self sustaining)
- **Road to jobs** aimed to help people suffering from mental illness into paid work.

#### North Fulham NDC area

##### Smoking cessation project

The NHS six week programme was made more distinctive in North Fulham by increased levels of outreach and drop in sessions (which have now been set up elsewhere in the borough too). For a year the NDC project made contact with smokers via telemarketing. An evaluation suggested this approach resulted in 4 per cent of those contacted quitting. From 2008–11 the cessation work is focussing on tackling local inequalities in smoking levels by working with families through direct outreach on social housing estates. This involves developing cessation groups in local community venues, including pubs and betting shops, training more people as cessation advisers, engaging low income smokers to host cessation groups for their own social networks within their own homes and working with the PCT cessation services to implement a neighbourhood approach.

- 4.11. And in Greets Green, the NDC partnership has supported a range of healthy lifestyle initiatives. The Active Lifestyles project has provided an overarching framework for the delivery of healthier lifestyles interventions by focusing on priority groups including young people, people from black and minority ethnic communities, and older people.

## **Greets Green Partnership**

### **The Active Lifestyles Project**

The Active Lifestyles project was launched in Greets Green in 2006 to develop, implement and evaluate physical activity projects across the area. Originally, it was funded by the Greets Green Partnership and sponsored by Sandwell PCT. Since 2009 the work has been entirely funded by Sandwell PCT, ensuring it can continue into the future and be rolled out to other areas. The project's key aims were to:

- increase access to physical activity in Greets Green
- increase participation in physical activity
- increase the number of local physical activity projects
- increase the number of people who can deliver physical activity sessions at a local level
- improve levels of health and fitness
- increase uptake of mainstream services.

Work has focused on three specific target groups: young people, black and minority ethnic communities, and older people

The project involves local residents, community organisations, schools, voluntary organisations and statutory agencies. A key feature has been to train and employ local people as community champions/trainers to promote and deliver physical activity in Greets Green.

A Community Fund has offered small grants to any group promoting physical activity. Activities supported covered all kinds of sports and age groups, from ladies' aerobics to local football teams and older people's clubs.

The project has a number of strengths:

- a concentrated effort in a small neighbourhood area helped to foster a sense of ownership in the community
- the Active Lifestyles Steering Group, consisting of community representatives became well known in the local area and was the means by which informal comments about the project were fed back. Some members became volunteers and community champions. The project manager considered the Group to be an asset and valued their contributions in shaping the future of the project
- working in partnership, including local residents and representatives from community centres, Sandwell Council, Sandwell Leisure Trust, Sandwell PCT, Greets Green Partnership and West Bromwich Albion Football Club.

But there have also been challenges, including engaging with the white British and African-Caribbean communities, and the over 50's. It has also proved difficult to overcome community expectations in relation to the cost of services.

- 4.12. Part of the Hackney NDC Partnership's approach to the regeneration of the Shoreditch area has been to acquire a portfolio of assets which provide facilities, resources and income for the ongoing benefit of the local community. These assets include restaurants and a barge which have been used to provide small scale innovative projects in sustainable food production, as part of a wider approach to encourage healthy eating amongst the NDC population.

### **Shoreditch Trust**

#### **Green and Growing in Shoreditch**

The Shoreditch Trust is working with local residents to develop new and innovative approaches to sustainable food production. The majority of these projects are part of the Urban Realm Improvements Programme which is in turn part of the Neighbourhood Development Theme, but they also integrate with the health theme in that they are encouraging local people to grow, cook and eat their own vegetables – part of the healthy eating project.

**Waterhouse Restaurant** houses many of the projects. The restaurant is part of the NDC's education and training programme. The restaurant has excellent ecological credentials and uses only fresh, seasonal produce. It is a training restaurant for projects run in partnership with the local NDC partnership and is part of the local NDC programme's portfolio of assets. Projects include the refurbished Waterhouse Courtyard, a social enterprise producing local honey and an edible green wall planned by local children.

**Shoreditch Floating allotment** works with residents of the Kingsland Basin who have formed the Canals of Hackney User Group (CHUG). British Waterways donated a disused 1930s Hopper barge and as part of the London Mayor's Capital Growth Initiative it was renovated and brought back into use. The barge provides 33 square metres of allotment space. CHUG is working on a food growing plan. The barge is owned by the Trust and rented for a peppercorn rent by the residents.

**Haberdasher Estate** –growing bags and structures have been erected at different sites on the estate for residents to grow food in communal and personal growing spaces. Loop.ph designed the structures to fit in with the estate environment.

The projects are, by their nature, small. Disused or abandoned sites are being brought into productive use all around the area but it is relatively costly to renovate small sites and their continued use will rely on the engagement and continued motivation of local people over the long term. There also needs to be agreement between local people about how the sites will be planted and used (although some of the sites have individual dedicated plots like a traditional allotment).

## Targeting vulnerable groups

- 4.13. A key issue for the case study NDC partnerships has been to address health inequalities, not only between NDC areas and better-off communities but also *within* NDC areas by supporting projects which have aimed to address the specific health needs of particular populations and/or to target groups which are less likely to be in contact with mainstream health services.
- 4.14. In Fulham, for instance, the Lifestyle Fridays project uses community settings to provide basic health promotion and screening services to 'hard to reach' populations. The project has been extended across the borough and provides a model which has informed the development of the health trainers<sup>16</sup> service in the area.

### North Fulham NDC area

#### Lifestyle Fridays

These community-based outreach health promotion and screening sessions are delivered by a Lifestyle Team comprising a Registered Nurse, Clinical Exercise Specialist and Dietician. They can test and give professional advice on cholesterol, glucose, blood pressure, height, weight and BMI.

Sessions are delivered in non-medical settings such as the mosque, supermarket, pubs, betting shops and drop in nursery. The team can connect its visitors to a variety of services, including smoking cessation, GPs, exercise on referral, and dietary advice.

Project development is informed by a range of evidence:

- an annual survey of users identifies health issues around which people would like more information and support
- analysis of routinely collected quantitative data from participating GPs explores differences in referral, uptake and adherence
- qualitative research to gain an understanding of the barriers and facilitators to adopting healthier lifestyles.

External evaluation has assessed the viability of extending Lifestyles Friday and provided evidence for the PCT to commission the Lifestyle Friday project as a mainstream health service in 2008–09.

Since its adoption by the PCT, Lifestyle Fridays provides a borough-wide service targeted at at-risk communities, providing health screening and motivational support for lifestyle change. It will in future provide the structure within which Health Trainers work.

<sup>16</sup> Health Trainers were introduced in the 2004 *Choosing Health* white paper (Department of Health, 2004a), with a commitment that from 2006, NHS Health Trainers would be providing advice, motivation and practical support to individuals in their local communities. Health Trainers reach out to people who are in circumstances that put them at a greater risk of poor health. They often come from, or are knowledgeable about, the communities they work with and, in most cases, work from locally based services which offer outreach support from a wide range of local community venues.



- 4.15. The Salford NDC Partnership has funded Me2, a project which addresses drug and alcohol misuse in families.

### **Charlestown and Lower Kersal NDC area**

#### **Me2**

The Me2 pilot project was funded by Salford NDC Partnership and delivered by a small team of workers within Salford SMART, a project which works with young people aged 21 and under. Me2 is a preventative support service offered to the school aged children of substance misusing parents. It offers a combination of play and deeper therapeutic support through one to one and group work.

The project has been externally evaluated. Positive impacts include:

- increase in confidence and good behaviour in the children
- increased engagement and support for children and their families
- reduction in risk factors and secrecy through peer group support.

- 4.16. And in Sandwell, football has been a vehicle for addressing health issues amongst children and young people, as part of a national programme to promote physical activity and community cohesion in deprived areas.

### **Greets Green Partnership**

#### **Hat Trick Community Football Project**

Hat-Trick was part of a national scheme to tackle social issues through football in some of England's most deprived communities. In 2005, Greets Green was identified as one of the 19 areas suitable for the allocation of a community football worker to provide football opportunities for children, young people and adults, while addressing issues such as health, community safety and education.

The Hat-Trick Community Football project was jointly funded by the Greets Green Partnership, the Football Association, UEFA and West Bromwich Albion Football. It worked closely with schools, local clubs and the community in Greets Green to:

- increase participation in football
- develop sustainable opportunities for children through FA Charter Standard clubs
- develop leaders and coaches from within local communities
- support the Government target of providing two hours of PE in school every week.

More than 1,100 young people aged 16 and under have been engaged in the Hat Trick project, representing over 40 per cent of the young people in the Greets Green area. 106 residents gained an FA award such as a Level 1 or Level 2 coaching qualification and the project provided training for 66 local people.

Hat-Trick's achievements over the last three years have included supporting the development of community teams and clubs, promoting girls' football, developing a high quality coaching pool available locally, and promoting sport in schools.

- 4.17. NDC partnerships have also been keen to build on the capacity of local communities and to engage local people in the delivery of interventions to address health issues. A variety of projects have trained local people to interact with others in their community to promote healthy living and access to health services. The Shoreditch Peer Education Projects offer one example.

### **Shoreditch Trust**

#### **Peer Education Projects**

The first Peer Education<sup>17</sup> project in Hackney began in 2002 and targeted Turkish and Kurdish communities and recent arrivals (particularly non-English speaking groups) to help improve access to health services.

Extensive research was carried out with agencies and community organisations to assess the health and access needs of the target groups. Volunteer trainees were recruited from the relevant communities. Initiatives are trainee-led and owned and there are many 'spin-offs'. For example, one group ran a book making and story telling workshop that included the cultural traditions and stories of all those involved. Another made a video in Turkish about drugs, funded by the Drug Action Team.

The project has enabled the Shoreditch Trust to engage with hard to reach communities. The NDC partnership now has much wider community representation than in its first years, due partly to the peer education work.

It has also had a positive impact on the people involved, making them feel more confident and more part of their local community. Cross-cultural exchange has been significant and much appreciated by the participants. Jobs and opportunities have also been created, local people are now governors and board members, and have become community researchers, and taken part in projects, volunteering and work.

A wide range of organisations have contributed including the University of Kent, Save the Children, Sure Start, Princes Trust, and a wide range of community groups.

- 4.18. Similarly in this category, are groups of projects which have aimed to support NDC residents to manage chronic health problems. In Salford, for instance, a range of interventions have aimed to address issues associated with the high levels of long-term limiting illness and mental health problems amongst the NDC population. Projects have included:

<sup>17</sup> The concept of peer education is that people of equal status share information and learn together.

- **Local Pharmaceutical Pilot** – A pharmacist available to review the medicines of people with long-term health problems and to deal with minor ailments
- **Expert Patients Programme** – free courses run for local people with long-term illness to support them to understand and manage their own health
- **START** – refurbishment of a centre for arts, training, education and related services for those with mental health difficulties (START Healthy Living Centre)
- **Re-energise** healthy living project worker – provides support to local people with diet, nutrition and exercise as part of a strategy to manage and prevent coronary heart disease and other major diseases
- **Time Banking** – project aims to reduce social isolation and improve mental health, using Time Banks UK model
- **Social Prescribing** – project supports people with low-level depression, anxiety or work-limiting illness to identify alternatives to medical prescriptions.

### Charlestown and Lower Kersal NDC area

#### Re-energise

The Re-Energise service is provided to residents of Charlestown and Lower Kersal who are inactive, but who want to change, with an underlying medical condition or risk, and whose participation in society is limited by economic, environmental or social disadvantage, exclusion or marginalisation. It prioritises people who are socially isolated and/or have mild to moderate mental health problems such as depression, anxiety or stress. Access to the Re-Energise service is through active outreach, self-referral or referral by health and care professionals.

The objectives of Re-Energise are:

- to enable people to be more physically active
- to create opportunities for people to develop stronger social networks
- to reduce levels of depression, anxiety and stress

The expected outcomes of Re-Energise are:

- increased levels of physical activity
- improved diet and nutrition
- improved social activities
- improved physical health
- improved mental and emotional well-being

An interim external evaluation (March 2009) indicated that the service has been well-received by NDC residents. 118 people had been helped to access new services since the project started in 2007. Clients considered that they had become more physically healthy since becoming involved with Re-Energise – they noted improved physical activity, better diet and nutrition, drinking less alcohol. A full evaluation is due in March 2010.

- 4.19. The 'Expert Patients' model has been a feature of Fulham NDC Partnership's approach.

### **North Fulham NDC area**

#### **Expert Patients**

The Expert Patients Programme is a six-week course in which participants develop strategies to better self-manage chronic medical conditions.

The course offers an opportunity for participants to share ideas with others living with long-term illness and to learn from each other. Participants do not need written skills to take part in the course and cognitive impairment does not restrict their ability to attend the course or participate.

As part of borough-wide programme, led by Hammersmith and Fulham PCT, the NDC project developed specific and dedicated resources and targets for the NDC area, and focussed on areas of health inequalities. The programme targeted people living with a long-term illness in the NDC area, recruited onto the course via a direct invitation from their GP. NDC funding was for three-years, resulting in between 180 people trained in self-management through the programme. This equates 7.5 per cent of the chronically ill in the NDC area.

Participants have often gone on to become volunteer tutors (one is now a Master tutor), or health champions, and to engage with the NDC/PCT's consultative procedures. There has also been liaison with Jobcentre Plus, Exercise on Referral and joint work with the Dietician. Its manager said "the NDC taught us [in the PCT] how to have more of an outreach approach".

There has been a particular emphasis on targeting harder to reach groups through third sector organisations working with, for instance African-Caribbean communities, Somali women and other African groups. It has also generally been harder to attract men into the groups (there has overall been 70/30 female/male ratio in groups), so some men only groups are also being considered. There may in future also be a one off commission to run a group in Polish.

## 5. Change in health outcomes in NDC areas

- 5.1. This chapter reviews evidence of change in health outcomes in the case study NDC areas and across the NDC Programme. It uses two key data sources:
- households surveys conducted in NDC areas by Ipsos Mori in 2002, 2004, 2006 and 2008
  - administrative data collated and analysed for NDC areas by the Social Disadvantage Research Centre at the University of Oxford. This data covers the period 2001–05, with the exception of indicators for low birthweights and standardised illness ratios which are rolling averages and cover four year periods from 1997 and 1998 respectively. It has not been possible to compile administrative data indicators beyond the period to 2005, as the NDC evaluators have not been able to negotiate the release of relevant data sets from the NHS and other data providers but to restrictions on the release of government data introduced in 2008–09.
- 5.2. Together, these data sets provide evidence of change on a range of health outcomes:
- **self-reported (ill) health:** feel own health is not good; health worse than a year ago; limiting illness; SF36 mental health score
  - **morbidity and mortality:** low birthweight; mental illness; illness; and early death
  - **lifestyle indicators:** smoking; fruit and vegetable consumption; exercise
  - **use of, and satisfaction with, health services:** seen a local doctor/GP in the last year; easy/fairly easy to access a local doctor/GP in the last year; satisfaction with local doctor/GP; trust in local health services.
- 5.3. These are outlined in turn, below. Where relevant, data is benchmarked against change occurring at a national level and in similarly deprived (or comparator) areas.<sup>18</sup>
- 5.4. Appendix 2 contains some additional supporting data, including:
- the degree to which change in health outcomes has impacted differently on different groups of NDC residents, including analysis by age, sex and ethnicity
  - changes in self-reported ill health for individual NDC partnerships
  - data on low birth weight rates and mental illness rates for the case study NDC areas.

<sup>18</sup> The NDC evaluation compares change with that occurring in similarly deprived areas. Household surveys are carried out in similar, but non-contiguous, areas within NDC local authorities providing benchmark data at the Programme level. Administrative data is also collated for areas with similar levels of deprivation to NDCs.

## Self-reported (ill) health

- 5.5. One of the key indicators of change in the health status of NDC residents is self-reported instance of ill-health; the degree to which residents feel that their own health is not good.
- 5.6. In general terms, the picture in relation to change in self reported ill-health is positive. Across the NDC Programme there was a four percentage point reduction between 2002 and 2008 in the proportion of residents feeling their own health was not good<sup>19</sup> (Table 5.1). This improvement was slightly better than that occurring both in comparator areas and nationally. All four case study areas saw a reduction in the numbers of residents feeling their health was not good, ranging from two percentage points in Salford to seven percentage points in Sandwell.
- 5.7. The numbers of residents in individual NDC areas reporting that their health was not good varied (see Appendix 2). In 2002 the proportion of residents feeling their own health was not good ranged from 14 per cent in Southwark to 32 per cent in Knowsley (see Figure A2.1). By 2008 the lowest value was 12 per cent in Nottingham and the highest 28 per cent in Hull, showing a slight convergence. Between 2002 and 2008:
- 36 NDC areas saw a reduction in the proportion of residents feeling their own health was not good
  - only three NDC areas (Haringey, Oldham and Hartlepool) saw this proportion increase
  - Doncaster and Knowsley saw the greatest improvement: ten and nine percentage points respectively.

Table 5.1: Feel own health not good: 2002 and 2008			
	Feel own health not good (per cent)		
	2002	2008	Change 2002 to 2008
Fulham	17	13	-4
Hackney	22	19	-3
Salford	21	19	-2
Sandwell	26	18	-7
NDC	23	19	-4
Comparator	21	18	-3
National	14	12	-2

Source: Ipsos MORI NDC Household Survey

Base: All

Note: Rows may not sum due to rounding

<sup>19</sup> Note that some changes in cross-sectional (or area level) data may be due to compositional change.

- 5.8. Longitudinal survey data can be used to monitor individuals' changes in self-reported health over time. Of all those in NDC areas who felt that their health was not good in 2002, 46 per cent felt that their health was good by 2008. The equivalent figure for comparator area residents was only 31 per cent. Meanwhile, 85 per cent of those NDC residents reporting good health in 2002 still felt that their health was good in 2008, slightly higher than the comparator figure of 83 per cent.
- 5.9. Proportions of residents in individual NDC areas reporting that their health was not good varied widely between different areas. In 2002, the proportion of residents in the Knowsley NDC area reporting poor health amounted to almost one in three, and was twice as high as the proportion in the Southwark NDC area. Between 2002 and 2008, all but three NDC areas saw an improvement in the percentage of residents feeling their own health was not good. More detail can be seen in Appendix 2.
- 5.10. There is also a positive picture in relation to resident's perceptions of the deterioration of their own health over time. In 2008 one fifth of NDC residents felt that their health had got worse in the previous 12 months, a two percentage point reduction compared with the equivalent figure in 2002 (Table 5.2). Comparator areas saw a one percentage point increase, also to 20 per cent, while nationally there was a five percentage point increase, although the NDC average remains higher than that nationally. Three out of the four case study areas saw a reduction in the proportion of residents feeling their health had deteriorated.

**Table 5.2: Health somewhat/much worse than one year ago: 2002 and 2008**

	Health somewhat/much worse than one year ago (per cent)		
	2002	2008	Change 2002 to 2008
Fulham	18	11	-7
Hackney	22	21	-1
Salford	19	16	-4
Sandwell	20	20	0
NDC	22	20	-2
Comparator	19	20	1
National	12	17	5

Source: Ipsos MORI NDC Household Survey

Base: All

Note: Rows may not sum due to rounding

- 5.11. When all the NDC areas are looked at, the proportion of residents' who feel that their health has deteriorated over the past year varies. Between 2002 and 2008, most NDC areas had seen a reduction in the proportion thinking their health had deteriorated, with Doncaster NDC experiencing the largest improvement of 8 percentage points. More detail can be seen in Appendix 2.

- 5.12. There have been modest improvements in the percentage of NDC residents reporting a long-standing limiting illness. In 2008 one quarter of NDC residents had a long-standing limiting illness, a two percentage point decrease from 2002 (Table 5.3). This reduction was in line with that occurring in comparator areas and nationally. Fulham had the lowest rate of long-standing limiting illness amongst the four case study areas (18 per cent). Sandwell saw a six percentage point decrease between 2002 and 2008.

	Long-standing limiting illness (per cent)		
	2002	2008	Change 2002 to 2008
Fulham	17	18	1
Hackney	24	23	-1
Salford	26	23	-3
Sandwell	28	23	-6
NDC	26	25	-2
Comparator	26	23	-2
National	21	19	-2

Source: Ipsos MORI NDC Household Survey

Base: All

Note: Rows may not sum due to rounding

- 5.13. Respondents to the Ipsos Mori household survey were asked a series of five questions about their mental health from which a composite score, the SF36 mental health index, can be calculated. This corresponds to the mental health domain of the SF36 health survey. Each respondent is given a mental health index score between zero and 100, averaging 73 across the NDC Programme in 2008.
- 5.14. Again, the data indicates modest positive change. Thirty-eight per cent of NDC residents had a 'high'<sup>20</sup> mental health index score (greater than 80), an increase of four percentage points between 2002 and 2008 (Table 5.4). In the same period the proportion with a high score in comparator areas decreased by three percentage points, meaning that in general NDCs have improved more than similarly deprived areas over the period of review. Three out of the four case study areas saw an improvement between 2002 and 2008, with only Hackney seeing a decrease.

<sup>20</sup> A high score on the mental health index is indicative of a good state of mental health. For the purposes of the research a 'high' score was defined as one of 80 or more.



**Table 5.4: SF36 mental health index, high score: 2002 and 2008**

	SF36 mental health index, high score (per cent)		
	2002	2008	Change 2002 to 2008
Fulham	42	44	3
Hackney	34	32	-2
Salford	38	45	8
Sandwell	35	41	6
NDC	34	38	4
Comparator	39	36	-3

Source: Ipsos MORI NDC Household Survey

Base: All

Note: Rows may not sum due to rounding

- 5.15. Longitudinal data shows that 48 per cent of NDC residents saw an improvement in their mental health index score between 2002 and 2008. However, 40 per cent saw a decrease in their score over this period. In comparator areas a similar proportion saw their mental health score get worse (39 per cent) but only 43 per cent saw an improvement.

## Morbidity and mortality

- 5.16. A further set of indicators provides information on the instance of low birth weight, mental and physical illness, and early death amongst residents of NDC communities. These indicators are derived from data supplied by health authorities and analysed for NDC areas by the Social Disadvantage Research Centre at the University of Oxford.
- 5.17. For most of these indicators, the time lag between interventions and subsequent changes in these clinical outcomes is likely to be long. The ultimate improvements which NDC Partnerships are seeking to achieve may take several generations to manifest in changes in neighbourhood level data. As a result, there has been little observable change in these indicators over the lifetime of the NDC Programme (see Appendix 2 for more detail).
- 5.18. For the percentage of live births classified as low birth weight (less than 2.5kg) over a series of five year periods, 1997–2001 to 2001–2005:
- the NDC and national average rates showed very little change over time, remaining at 9 and 6 per cent respectively
  - across the 39 NDC partnerships, rates in 1997–2001 ranged from 5.8 per cent in Liverpool to 13.5 per cent in Birmingham Aston; in 2001–2005 they ranged from 7 per cent in Liverpool to 12.2. per cent in Birmingham Aston

- Sandwell NDC saw a progressive increase from 10 per cent in 1997–2001 to 12 per cent in 2001–2005
- of the four case studies, Fulham had consistently the lowest rate of low birth weight, just higher than the national average in 2001–2005. For further detail see Appendix 2.

5.19. Rates of mental illness can be assessed by looking at the percentage of adults aged under 60 years who are prescribed drugs for mood or anxiety disorders:

- average rates for NDC areas were no different from national rates at 5 per cent in 2001
- there was generally little change in this indicator between 2001 and 2005. The mental illness rate across the NDC Programme remained almost identical between 2001 and 2005, as did the national equivalent
- in relation to the case study NDC areas, in 2005 7 per cent of adults aged under 60 in Salford NDC area were counted as having mood or anxiety disorders, higher than the NDC and national averages; the other three case study areas had lower mental illness rates than Programme-wide and nationally. For further details see Appendix 2.

5.20. Table 5.5 shows a standardised illness ratio drawn from administrative data on the receipt of health-related benefits (Income Support disability premium, Attendance Allowance, Disability Living Allowance, Severe Disablement Allowance and Incapacity Benefit), adjusted for the age and sex distribution in each area. A figure of less than 1 indicates a lower prevalence of illness and disability than would be expected given the age and sex profile of the area. A figure greater than 1 indicates a higher than expected prevalence of illness and disability.

Table 5.5: Standardised illness ratio: 2001 to 2005						
	Standardised illness ratio					
	2001	2002	2003	2004	2005	Change 2001 to 2005
Fulham	1.351	1.338	1.337	1.370	1.415	0.064
Hackney	1.603	1.641	1.627	1.642	1.609	0.006
Salford	2.231	2.133	2.167	2.105	2.141	-0.090
Sandwell	1.592	1.640	1.651	1.625	1.652	0.060
NDC	1.929	1.930	1.934	1.908	1.924	-0.005
National	1.000	1.000	1.000	1.000	1.000	0.000

Source: SDRC

Note: Rows may not sum due to rounding

5.21. Table 5.6 shows a standardised mortality ratio, measuring the number of deaths in an NDC area in a four year period compared with the expected level given the area's age and sex structure. A figure of less than one

indicates a lower mortality rate than would be expected given the age and sex profile of the area. A figure greater than one indicates a higher than expected mortality rate.

**Table 5.6: Standardised mortality ratio: 1998–2001 to 2002–2005**

	Standardised mortality ratio					Change 1998–2001 to 2002–2005
	1998–2001	1999–2002	2000–2003	2001–2004	2002–2005	
Fulham	1.304	1.244	1.306	1.383	1.368	0.064
Hackney	1.550	1.525	1.320	1.311	1.346	–0.204
Salford	1.770	1.703	1.770	1.736	1.576	–0.194
Sandwell	1.240	1.205	1.171	1.375	1.465	0.225
NDC	1.641	1.614	1.629	1.664	1.681	0.040
National	1.000	1.000	1.000	1.000	1.000	0.000

Source: SDRC

Note: Rows may not sum due to rounding

- 5.22. Again, both of these indicators have changed little over the lifetime of the NDC programme, and rates of both morbidity and mortality have remained higher in NDC areas than nationally.

## Lifestyle indicators

- 5.23. A further set of indicators provides evidence in relation to lifestyle changes amongst residents of NDC areas. These indicators are drawn from household survey data and look at levels of smoking, fruit and vegetable consumption and exercise. These indicators are directly relevant to many of the projects which NDC partnerships have supported.

**Table 5.7: Eat five portions of fruit or vegetables everyday: 2002 and 2008**

	Eat five portions of fruit or veg everyday (per cent)		
	2002	2008	Change 2002 to 2008
Fulham	22	22	0
Hackney	32	33	0
Salford	20	20	0
Sandwell	20	23	3
NDC	23	19	–3
Comparator	23	22	–1

Source: Ipsos MORI NDC Household Survey

Base: All

Note: Rows may not sum due to rounding

- 5.24. There is mixed evidence in relation to changes in fruit and vegetable consumption amongst NDC residents. Across the NDC Programme, both the proportion eating five portions of fruit or vegetables everyday, and the proportion never doing so, decreased between 2002 and 2008.
- 5.25. In 2008 less than one fifth of NDC residents said they eat five portions of fruit or vegetables everyday (Table 5.7), a reduction of three percentage points since 2002. However, it is possible that the high profile generated by national interventions to support fruit and vegetable consumption at the beginning of the NDC Programme (see 2.15) inflated the earlier figures. All four case study NDC areas had a higher proportion than the NDC average, ranging from 20 per cent in Salford to 33 per cent in Hackney.
- 5.26. A further 15 per cent of NDC residents said they never eat five portions of fruit or vegetables in a day (Table 5.8), although this figure has also reduced (by four percentage points since 2002). There is wide variation in fruit and vegetable consumption between different NDC areas. For instance, in Hackney only 3 per cent said they never eat five portions of fruit or vegetables, compared with 27 per cent in Salford.

<b>Table 5.8: Never or rarely eat five portions of fruit or vegetables in a day: 2002 and 2008</b>			
	Never/rarely eat five portions of fruit or veg in a day (per cent)		
	2002	2008	Change 2002 to 2008
Fulham	12	9	-3
Hackney	11	3	-8
Salford	30	27	-3
Sandwell	16	10	-5
NDC	19	15	-4
Comparator	19	12	-7

Source: Ipsos MORI NDC Household Survey

Base: All

Note: Rows may not sum due to rounding

- 5.27. The proportion of NDC residents who smoke has fallen, in line with national trends. Between 2002 and 2008 the proportion of NDC residents smoking cigarettes decreased by five percentage points from 40 per cent to 35 per cent (Table 5.9), although this remains much higher than the national equivalent of 22 per cent. Hackney saw the biggest reduction in smoking amongst the four case study areas, falling from 39 per cent to 27 per cent. Salford NDC on the other hand saw a three percentage point increase.

**Table 5.9: Smoke cigarettes: 2002 and 2008**

	Smoke cigarettes (per cent)		
	2002	2008	Change 2002 to 2008
Fulham	31	22	-8
Hackney	39	27	-12
Salford	38	41	3
Sandwell	28	26	-2
NDC	40	35	-5
Comparator	33	31	-3
National	26	22	-4

Source: Ipsos MORI NDC Household Survey

Base: All

Note: Rows may not sum due to rounding

- 5.28. The proportion of NDC residents taking regular exercise has decreased. In 2008 11 per cent of NDC residents said they did no exercise for 20 minutes or more at a time, a two percentage point increase since 2002 (Table 5.10). Nationally this proportion fell by two percentage points, while there was no change in comparator areas. Hackney and Sandwell NDC areas saw an improvement in this indicator, with rates of no exercise falling to six per cent and eight per cent respectively. In Sandwell, the Greets Green Partnership supported a range of physical activity programmes and met its local targets for improvements in exercise earlier than anticipated.

**Table 5.10: Do no exercise for 20 minutes or more at a time: 2002 and 2008**

	Do no exercise for 20 minutes or more (per cent)		
	2002	2008	Change 2002 to 2008
Fulham	5	8	3
Hackney	8	6	-2
Salford	13	14	2
Sandwell	11	8	-3
NDC	9	11	2
Comparator	8	8	0
National	7	5	-2

Source: Ipsos MORI NDC Household Survey

Base: All

Note: Rows may not sum due to rounding

## Use of, and satisfaction with, local health services

- 5.29. A final set of indicators from the household survey looks at access to, and satisfaction with, health services. Improving access to services has been a key priority for NDC communities, and many NDC partnerships have worked with PCTs in particular to increase the levels of service on offer within NDC areas, and to improve access to services outside the NDC area. These indicators show most positive improvement over time, although improvements are generally in line with those experienced nationally and in similarly deprived areas.

	Seen family doctor/GP in last year (per cent)		
	2002	2008	Change 2002 to 2008
Fulham	69	83	13
Hackney	80	85	5
Salford	75	77	2
Sandwell	78	83	5
NDC	78	81	3
Comparator	79	84	4
National	80	79	-1

Source: Ipsos MORI NDC Household Survey

Base: All

Note: Rows may not sum due to rounding

- 5.30. In both NDC and comparator areas there has been an increase in the proportion of residents visiting their family doctor or GP, whereas nationally there has been a slight decrease (Table 5.11). Of the four case study NDC areas Fulham saw the biggest increase: 13 percentage points. This could be connected to perceived ease of seeing a doctor which also increased between 2002 and 2008 (Table 5.12). Again this was particularly apparent in the Fulham NDC area, where there was an 18 percentage point increase in the proportion finding it very, or fairly, easy to see their GP. Across the NDC Programme there was a small increase in the proportion satisfied with their doctor (Table 5.13). Sandwell was the only case study area to see a decrease in this indicator. In Salford an additional question in the Ipsos Mori household survey measures satisfaction with local health services. Eighty per cent of residents indicated that they were satisfied with local health facilities in 2008, compared to 29 per cent in 2002.
- 5.31. Trust in health services has improved between 2002 and 2008. In NDC areas the proportion of residents trusting local health services a great deal or a fair amount increase from 75 per cent to 81 per cent (Table 5.14). Comparator and national figures improved by the same margin. All four case study areas saw an increase of at least ten percentage points.

**Table 5.12: Very/fairly easy to see family doctor/GP: 2002 and 2008**

	Very/fairly easy to see family doctor/GP (per cent)		
	2002	2008	Change 2002 to 2008
Fulham	65	83	18
Hackney	74	82	8
Salford	71	72	1
Sandwell	72	70	-2
NDC	71	75	4
Comparator	67	78	12
National	76	81	5

Source: Ipsos MORI NDC Household Survey

Base: All seen doctor in last year

Note: Rows may not sum due to rounding

**Table 5.13: Very/fairly satisfied with family doctor/GP: 2002 and 2008**

	Very/fairly satisfied with family doctor/GP (per cent)		
	2002	2008	Change 2002 to 2008
Fulham	83	85	1
Hackney	83	89	6
Salford	80	88	8
Sandwell	84	76	-8
NDC	84	85	1
Comparator	84	86	3
National	90	90	0

Source: Ipsos MORI NDC Household Survey

Base: All seen doctor in last year

Note: Rows may not sum due to rounding

**Table 5.14: Trust local health services a great deal/fair amount: 2002 and 2008**

	Trust local health services a great deal/a fair amount (per cent)		
	2002	2008	Change 2002 to 2008
Fulham	68	83	15
Hackney	71	81	10
Salford	73	88	14
Sandwell	72	82	10
NDC	75	81	6
Comparator	77	83	6
National	79	85	6

Source: Ipsos MORI NDC Household Survey

Base: All

Note: Rows may not sum due to rounding

## Health outcomes for different groups

- 5.32. Appendix 2 provides health indicator change data broken down by age, gender and ethnicity. This shows:
- when health indicators for NDC residents in different age groups are compared it can be seen that on the whole younger people tended to be healthier than older people, as would be expected: the proportion whose health was 'not good', whose health had got worse in the past year and who had long-standing limiting illnesses was higher for older age groups than younger age groups. However, satisfaction with doctors and trust of local health services was also more common amongst older age groups. Young people were less likely to do no exercise and also less likely to eat five portions of fruit or vegetables in a day
  - comparing health indicators for male and female NDC residents shows that in 2008 20 per cent of females felt their health was not good and 22 per cent felt their health was worse than a year earlier, compared with 17 and 18 per cent respectively for males. A higher proportion of men scored highly on the SF36 mental health index. Women were more likely to eat five portions of fruit or vegetables everyday and less likely to do no exercise
  - health indicators for NDC residents can also be compared by broad ethnic group. In 2008 21 per cent of white residents felt their health was not good, compared with 15 per cent of Asian residents and 14 per cent of black residents. Similarly, 21 per cent of white residents thought their health had deteriorated in the past year, compared with 18 per cent of Asian residents and 16 per cent of black residents. Over two fifths of white residents smoked cigarettes, more than double the proportions of either Asian or black residents.

## Comment

- 5.33. The data available to the NDC national evaluation suggests that there has been broadly **positive, but modest**, change in health outcomes in NDC areas. At Programme level most indicators saw some positive change with the exception of some lifestyle indicators, notably exercise, but this has not always been greater than that experienced nationally or in other similarly deprived communities. However, analysis of longitudinal data suggests that residents who have stayed in NDC areas between 2002 and 2008 may have experienced better improvements in some health outcomes than residents who have remained in similarly deprived areas over the same period.
- 5.34. This lack of marked positive change relative to other benchmarks is perhaps a little disappointing, given that the case study NDC partnerships have devoted considerable effort and resources to improving health outcomes amongst local residents, and these sorts of efforts have been replicated across the



NDC Programme. However, there are a number of reasons why this might be the case:

- NDC interventions have, on the whole, been **small scale**: there is ample evidence within the case study NDC areas of positive outcomes for project beneficiaries, but the projects have by their nature reached small numbers of NDC residents and have not impacted significantly on the scale of the problems faced by NDC communities
- there is also the associated issue of the degree to which the benefits of interventions which target small numbers of NDC residents can be picked up by **'top-down' surveys and data**: because health interventions have affected relatively small numbers of people (with the possible exception of Healthy Living Centres) they are unlikely to impact significantly on Programme-wide change data
- NDC partnerships may have sought to address too many health issues at a time rather than developing a more sustained focus on aspects of health inequalities most amenable to local intervention
- NDC partnerships have not been the sole beneficiaries of **developments and investment in health services**: health agencies work to national targets and programmes and investments tend to be rolled out on a national basis. For example, the LIFT programme has supported investment across almost 50 schemes, resulting in over 200 new primary health care facilities either open or under construction. Clearly some of these will have benefited deprived communities outside the NDC areas
- there has been a need, in some NDC areas, to improve the **infrastructure** of local health services, and a consequent early prioritisation of investment in this, as opposed to projects which aim directly to tackle health outcomes. Whilst there may be a consequent improvements in the health circumstances of NDC residents, these are unlikely to be evidenced by the six years of data available to the NDC evaluation, and improvements may well occur beyond the lifetime of the NDC Programme
- there are also questions about the nature of some NDC interventions: there is a relatively sparse evidence base on the effectiveness of interventions in tackling **health inequalities** between deprived and better off areas. The case study NDC partnerships have endeavoured to ensure that their interventions are based on evidence of what works in improving health outcomes; the Salford NDC Partnership for instance has allocated up to 20 per cent of each health intervention's budget for external evaluation. But it has not always been clear that this will also result in narrowing the gap between NDC areas and their parent local authorities. In health, perhaps more than in any other NDC outcome area, the linkages between interventions and outcomes are not always obvious
- and it is also important to consider the role of local communities in devising strategies to improve health amongst local residents: there is some evidence from the case studies that the **priorities** of local residents have not always gelled with those of the local service providers. One obvious example is around complementary therapies and new models of

service delivery, which have clearly been priorities for local residents and where local NDC programmes have been uniquely placed to implement innovative approaches which are beyond the scope of statutory agencies. This has been a strength, and an important role for NDC partnerships has been to 'test out' new interventions and approaches. But it has also been true that for some of the interventions valued by local residents there is less than robust evidence of their long-term impact on health outcomes.

- 5.35. The next chapter looks at issues relating to the sustainability of NDC interventions.

## 6. A sustainable approach? The implications for forward strategies

- 6.1. This chapter reviews issues of sustainability in relation to NDC supported health interventions and looks at how the case study NDC partnerships are seeking to ensure that the projects and approaches that they have developed continue to be of relevance beyond the lifetime of the NDC Programme.
- 6.2. One issue for sustainability is the extent to which NDC partnerships have been able to attract mainstream resources to tackle health issues in their neighbourhoods. There have been some successes in the case study NDC areas. In Sandwell, the theme manager considers that ability of the PCT and other organisations to 'take risks' and test out new approaches through NDC funding has been instrumental in developing innovative practices and approaches which have then been adopted by mainstream agencies. Some projects have been mainstreamed in entirety. In others, best practice or partial elements of projects have been mainstreamed. A good example is the Healthier & Safer Older Age project where good practice in the falls prevention programme, carers support and the work of an older people's champion have been taken on board by different organisations and incorporated into mainstream services.
- 6.3. There have also been commitments on the part of the PCT to ensure that the Greets Green area continues to be a priority in the future. The PCT used the opportunity presented by the Greets Green Partnership programme to reconfigure its locality working and to establish a dedicated Neighbourhood Health Management Team, as a single point of contact for all health agencies in the area. This team has now been mainstreamed by the PCT as part of the Wednesbury and West Bromwich Practice Based Commissioning Cluster, ensuring that the Greets Green area remains an area of focus beyond the lifetime of local NDC programme.
- 6.4. In Hackney many of the interventions were designed with mainstreaming in mind and there has been an emphasis on demonstrating that services can be cost effective and are needed by local people. Examples of mainstreaming include local blood testing, local alcohol testing, horticultural therapy, the extended bus service and bump buddies.<sup>21</sup>
- 6.5. In Fulham joint work with NHS Hammersmith and Fulham has embedded most of the local NDC programme into mainstream services and generated a cohort of trained volunteers and helpers to perpetuate much of the community based work. For example, in 2007–08, the Lifestyle Friday's

<sup>21</sup> The extended bus service assists access to local hospital services. Bump buddies provides peer support services to pregnant women.

project was included in the PCT's Strategic Commissioning framework. The GP Exercise Referral project was also considered for inclusion following a positive project evaluation.

- 6.6. Recent interventions and the development of robust Service Level Agreements have been made with mainstreaming and succession in mind. A succession appraisal document suggests that, partnership working has enabled:
- the full-time secondment of the NDC Health and Well being Theme manager to the NHS
  - a secondee to work half time on NDC projects and half time on PCT succession work
  - sharing of resources under a single management/co-ordination for delivery of outputs and outcomes that benefits both parties: delivery of NDC outcomes and for the PCT a focus on neighbourhood health and inequalities
  - linkage of NDC projects to the heart of NHS investment plans, and recurrent commissioning plans.
- 6.7. In Salford, elements of the neighbourhood-based approach have been adopted by the PCT in its approach to health improvement. A mainstreaming strategy approved by the board in October 2008 identified the need to demonstrate that NDC interventions are making a difference via emphasis on external evaluations, many of which are currently underway. Evaluation was built in from the start of projects to ensure that there is a robust evidence base to present to commissioners. In addition for all new and reconfigured health projects potential commissioners are invited to participate in 'development' sessions via the health task group, to ensure that interventions are developed within a strategic commissioning context. The NDC partnership is also currently undertaking a series of discussions with contacts in the PCT and community health and social care services. These focus on arrangements for either capturing the learning from NDC projects or seeking alternative arrangements for funding which will ensure continuing delivery once local NDC programme funding ends expires in March 2010. The NDC partnership has endeavoured through this process to demonstrate the ways in which NDC interventions can meet the strategic priorities of the PCT; one issue that has been critical has been to 'get the timing right' – meeting with commissioners in good time to ensure that interventions can be incorporated into future funding plans. Of the six projects currently in the NDC Programme, three have secured further funding and the other three are well advanced in their mainstreaming discussions.
- 6.8. In addition, the NDC health task group has been merged (from September 2009) with the East Salford Health Action Partnership. This has been re-launched as the East Salford Health and Wellbeing Advisory Group to provide a continuing forum for agencies and the community to come together to highlight and address local health needs in the area as part of neighbourhood management structures.

- 6.9. Clearly PCTs will be critical to the sustainability of health interventions across the NDC Programme. Relationships between NDC partnerships and PCTs have not always run smoothly but it is true that in the case study NDC areas, as in others across the Programme, close co-operation between NDC partnerships and PCTs has laid the framework for ongoing sustainability. In Fulham, the NDC partnership is represented at the Strategic Public Health Alliance, which is responsible for the delivery and monitoring of the LAA targets on health. According to the NDC partnership's 2008 Performance Management Framework report, senior level discussions with the PCT in 2007 "significantly enhanced the value of the partnership between NDC and the PCT with an emerging shared work plan around public health issues being formulated between the two partners".
- 6.10. The move to base the NDC partnership's health coordinator within the PCT and set up a detailed three year SLA for the delivery of NDC programme outcomes marked a change of pace and a key stage in the NDC programme's forward strategy. In February 2009 the theme's 'succession project' was approved. The approach represents a shift from short term, small scale, project-by-project work. It redefines an approach that is integrated with longer term, borough-wide mainstream services capable of addressing the wider contextual barriers to the attainment of local NDC programme outcomes. This is a last push to achieve the NDC partnership's final 10-year health and wellbeing outcomes. It reflects a change to more of a partnership approach – with agencies as well as with residents/patients.
- 6.11. Arrangements approved by the NDC board in February 2009 for outcomes delivery for the remainder of the NDC programme, illustrate the interface between governance arrangements for the NDC partnership's health and wellbeing theme and those for mainstream services at the borough level:
- the Health and Well being Theme Group continues to monitor and review progress of NDC partnership investment in Health and Well being projects
  - the Health and Wellbeing Theme Group represented at the local reference group overseeing delivery of neighbourhood regeneration initiative
  - representatives from Health and Wellbeing Theme Group will be co-opted on to the Self Care Working Group overseeing the NHS Hammersmith and Fulham's Self Care Commissioning Strategy – this is the oversight group for the personalised services (Health MOTs and Health trainers) funded by the NHS. The role of the NDC representatives is to bring the neighbourhood perspective to this group
  - the NDC partnership will become an active member of the Public and Participation Network – a subcommittee of NHS Hammersmith and Fulham Board – overseeing the community engagement and involvement and patient experience agenda the NHS is required to fulfil
  - NDC governors/residents will be invited as a matter of course on to tender and commissioning groups for services that affect NDC area and its people.

- 6.12. In Sandwell, the NDC's successor body, Greets Green Community Enterprises, has developed a succession strategy and agreed reporting and monitoring arrangements via Sandwell Local Strategic Partnership and the Health and Wellbeing Group.
- 6.13. However, despite positive relationships with PCTs and other commissioning bodies, there are concerns within some case study NDC partnerships about the abilities of these agencies to balance the priorities of NDC areas against those of other communities, particularly in the context of restraints on public spending, and new frameworks for commissioning.
- 6.14. In Hackney, the NDC partnership has produced a formal succession strategy, identifying the Shoreditch Spa as one of its social enterprises. The Spa is sustainable and has a sound business plan but will need to find further funding. It expects to continue delivering activities that have been identified as popular with local people and it hopes to fund them by delivering contracts across the whole of Hackney (and beyond), the surplus from which will be re-invested in Spa activities to benefit local residents.
- 6.15. It is working at winning contracts for the delivery of its healthy living services but because of changes in the way the PCT is now required to commission its services, many contracts are contested by arms length organisations originally from within the PCT. This gives them a clear advantage over the Spa, although the Spa is doing its best to maintain and develop relationships with commissioners so that it can feed in the concerns and needs of local people and have an influence over the way that services are tendered.
- 6.16. The concluding chapter of this report looks the implications of the research and highlights lessons for future policy which aims to improve health outcomes in deprived areas.

## 7. Conclusions

- 7.1. This chapter outlines conclusions from the research. The report has drawn on the experiences of a small number of NDC partnerships which should not be taken to be necessarily representative of the Programme as a whole. Nevertheless, the research presents a number of conclusions which have relevance for future programmes which aim to improve health outcomes for residents of deprived areas.
- 7.2. **Partnership** working has been a key element of the approach in the case study NDC areas and indeed a defining feature of the NDC Programme as a whole has been partnership working with agencies and communities. This has been important in the area of health, where the input of PCTs, health practitioners and communities has been invaluable in helping NDC partnerships to identify health issues and devise and implement interventions. A partnership approach, coupled with a neighbourhood focus, has enabled projects to be targeted and delivered locally and this has provided valuable lessons in engaging hard to reach communities and also to establish what works best in a local setting.
- 7.3. NDC partnerships have also been able to add a **targeting and outreach** dimension to what larger, mainstream agencies can offer. By developing informal networks and community capacity NDC partnerships can offer effective signposting to and between services that harder to reach groups and individuals might otherwise miss, and this can result in a more holistic approach.
- 7.4. Partnership working is likely to continue to be a feature of work to address health inequalities in deprived areas, and was generally agreed in the NDC areas studied for this research to be vital to long-term impact in health outcomes. NDC partnerships can have the freedom to 'think outside the box' and offer mainstream agencies an important test bed facility to try out **new approaches** at low risk. They can also be an effective **catalyst** (what one respondent described as "the yeast in the mix"), bringing big mainstream and third sector agencies together to plug gaps in services.
- 7.5. But the experiences of the case study NDC partnerships also highlight some **challenges** which need to be addressed if partnership working is to be successful. One of the key challenges is to build effective partnerships that can last the lifetime of a programme. It often takes many years to build good relationships with agencies and to be trusted by them to deliver. Partnerships are often reaching their peak when programmes end. Constant **reorganisations** in agencies make partnership work more difficult and do not allow the agencies to prioritise local work and this has clearly been an issue in the case study NDC partnerships' relationships with their local health commissioning agencies. A period of consistency, as opposed to the constant turmoil which characterises the experiences of most PCTs over the lifetime of the NDC Programme, might have allowed relationships to

become established earlier, and to be sustained for longer. (It is worth noting however that at least one observer in a case study NDC partnerships thought that reorganisation in statutory agencies offered the potential to *'unblock paths that had appeared to be closed'*.)

- 7.6. Government **targets** for agencies sometimes also mitigate against working with area-based initiatives (ABIs) when national, not local, priorities have to take preference and when agencies such as PCTs and local authorities need to spread resources across a range of communities. In Hackney, for instance, there has always been an issue for the local authority and the PCT which is working in an area where every ward in the borough is in the top 10 per cent most deprived and it is difficult to justify contributing more resources – even if just time or effort – to the NDC area. Across the NDC Programme just two per cent of levered in resources have come from PCTs. The availability of local NDC programme resources has been an incentive to partnership working, and had resulted in some innovative approaches, but it remains to be seen how much of this work will be continued once the NDC programme draws to a close.
- 7.7. Therefore there is a need for Government to consider the extent to which neighbourhood-level organisations can realistically expect to influence the **priorities** of mainstream agencies with wider, and sometimes conflicting concerns. The case study NDC partnerships featured in this report have established collaborative arrangements with PCTs over time and this has resulted in the transfer of learning and resources on both sides. As a result projects, or elements of projects, have been introduced into the work of mainstream health delivery agencies. PCTs have on the whole been supportive of NDC partnerships and have been prepared to consider new approaches and modes of service delivery. But there is less evidence that NDC partnerships have been able to fundamentally change the **direction or emphasis of local service delivery**. This problem is not unique to the health theme of the NDC Programme, but maybe particularly acute here because the standard of evidence required to support the commissioning of health services is exceptionally high.
- 7.8. The evidence from this research also emphasises the need for **long-term** and **comprehensive** approaches to improving health outcomes in deprived areas. NDC partnerships cannot stop people getting sick or make them better. They can, though, implement programmes which aim to improve the quality of life of local residents and encourage more people to use the services on offer. Community-led ABIs may be better placed than others to take on this latter task. A strength of the NDC partnerships' approach has been the ability to get close to local people and find out exactly what is needed and ABIs may play a key role in supporting statutory duties on the NHS to **involve local people**. But the need to tackle apathy within local communities, address chronic conditions and embed the benefits of lifestyle changes is a huge challenge, which is beyond the capabilities of relatively small organisations, with limited resources, like NDC partnerships. As one interviewee commented "the more families we helped the more we seemed to find". There are difficulties associated with identifying **changes** in health



outcomes at the **neighbourhood level**, particularly when interventions have benefitted small numbers of NDC residents. It is also the case that any changes in **long-term health outcomes** to which local NDC partnerships have contributed will take generations to manifest in any observable closing of the 'gap' between NDC areas and less deprived communities.

- 7.9. The **attribution** of any change to local NDC interventions is also complicated by the degree to which NDC areas, and other deprived communities, are subject to **national programmes and interventions**. NDC partnerships have planned their programmes to complement and support the priorities of government and national health agencies. There are clear benefits to this approach but one perhaps unintended consequence is that it is nigh on impossible to disentangle the impact of NDC projects from those, much larger, interventions. In addition there is evidence that in some NDC case study areas NDC resources in the health theme have not been genuinely additional when compared to those allocated by mainstream agencies to other deprived areas. There is currently not the evidence available through which to quantify this or to verify the extent to which this has occurred across the Programme but if this has been the case there are clear implications for the degree to which NDC partnerships could be expected to initiate **change** which is **over and above that occurring elsewhere**.
- 7.10. Nevertheless the research highlights a number of **lessons**, which are relevant to community and neighbourhood partnerships and policy makers concerned with improving health outcomes in deprived communities:
- **strategies** need to be underpinned with solid partnership work, but this is time consuming. It is beneficial to build institutional links as early as possible, and SLAs between service delivery agencies and NDC areas appear to be effective in ensuring ongoing levels of mainstream service delivery
  - it is also important for local programmes to seek relevant **expertise** where it is required. The experience of the case study NDC partnerships has been that it is vital to have a budget to pay for the right level of expertise, and to ensure that interventions are robust
  - robust **evaluation** of local interventions is vital in order to improve the evidence base in relation to what works in tackling health inequalities and to inform succession arrangements, future delivery of interventions and potential for transferability
  - **community development** is a vital contributor to improved health outcomes but is again time consuming in the long-term. Peer education approaches seem to offer a successful model for engaging with harder to reach and newly arrived communities
  - NDC partnerships have offered a way to test out **new approaches** to service delivery and have engaged and developed **third sector** bodies effectively. Early support, in the form of grants and organisational development, has been effective in the case study NDC areas in supporting community-based organisations to become social enterprises,

which are now contributing extensively to mixed models of local health service delivery

- **neighbourhood-level** approaches could be more effectively supported if the priorities of local commissioning and delivery agencies, and those of neighbourhood renewal partnerships, were more clearly aligned. In particular, it can be hard to balance the priorities of communities with those of agencies driven by national standards and targets.

# Appendix 1: Research methodology

Four key research tasks were undertaken in the research for this study.

- evidence review
- documentary analysis
- data analysis
- semi structured interviews.

## Evidence review

A review of evidence was undertaken to explore the existing state of knowledge about the scale, distribution, character and causes of health inequalities outside the context of the NDC Programme. The review drew on a wide range of studies of UK experience, drawn from both academic sources and work commissioned by government. Literature drawn on is listed in the references at Appendix 2.

## Documentary analysis

Documentary analysis was undertaken in all the case study NDC partnerships. Reviewed documents included delivery plans, project appraisal documentation and project and thematic evaluations.

## Data analysis

Quantitative evidence has been analysed to look at changes in health outcomes in the case study NDC areas and across the Programme as a whole.

## Interviews

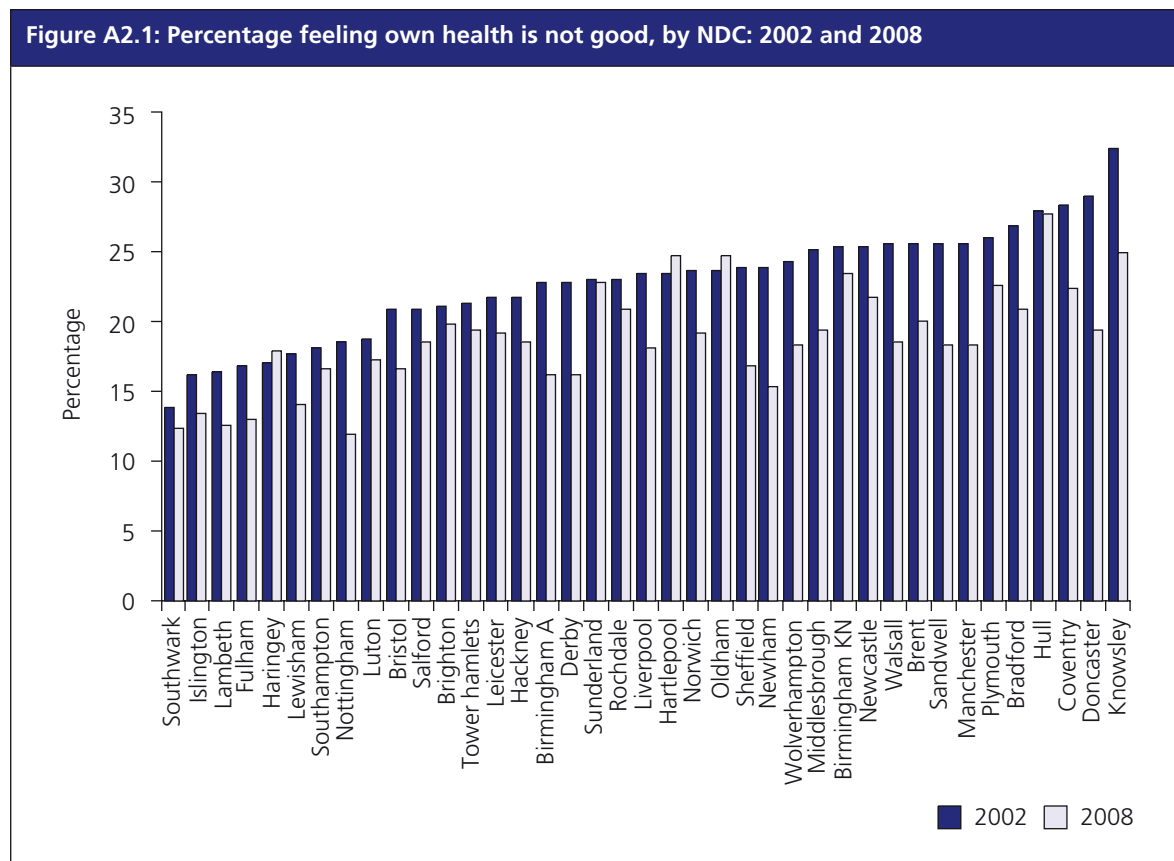
Semi-structured interviews were informed by data and topic guides tailored to reflect the particular circumstances in each case study NDC area. Interviews were used to explore what lies behind changes and variations in health outcomes and to build up explanations for how these outcomes have been achieved.

Interviews undertaken in each case study NDC partnership typically included health theme leader, Board rep(s) involved in theme groups, representatives of relevant agencies (especially PCTs) and projects.

# Appendix 2: Changes in health outcomes- additional data

## Self-reported ill health

The numbers of residents in individual NDC areas reporting that their health was not good varied. In 2002 the proportion of residents feeling their own health was not good ranged from 14 per cent in Southwark to 32 per cent in Knowsley (Figure 5.1). By 2008 the lowest value was 12 per cent in Nottingham and the highest 28 per cent in Hull, showing a slight convergence.



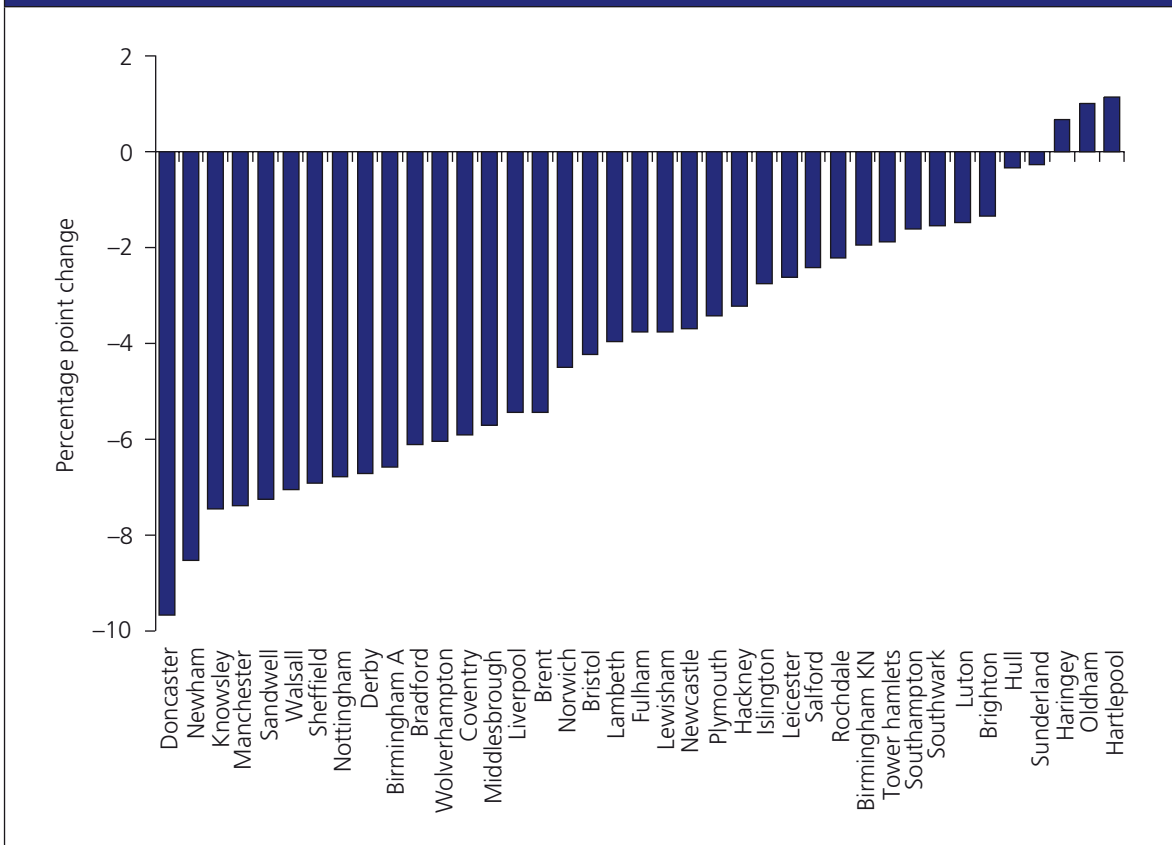
Source: Ipsos MORI NDC Household Survey  
Base: All

Between 2002 and 2008:

- 36 NDC areas saw a reduction in the proportion of residents feeling their own health was not good

- only three NDC areas (Haringey, Oldham and Hartlepool) saw this proportion increase
- Doncaster and Knowsley saw the greatest improvement: 10 and 9 percentage points respectively.

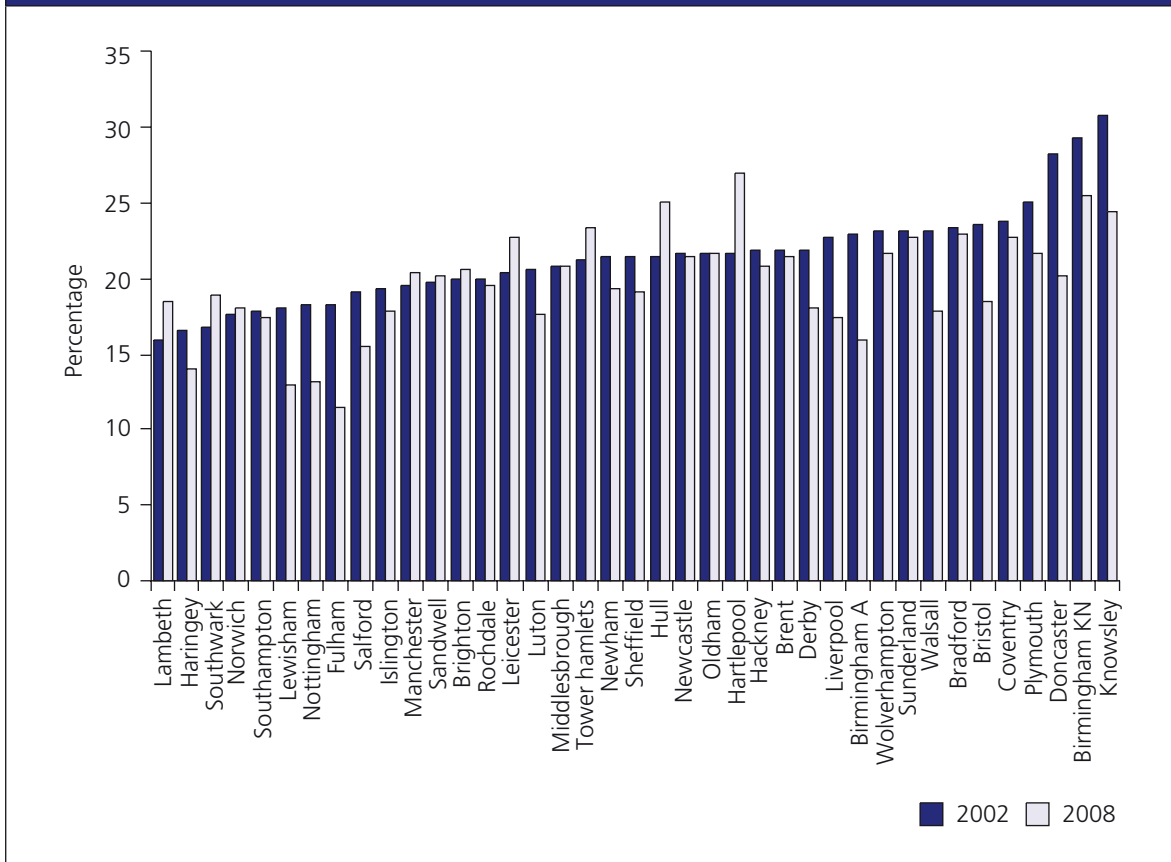
Figure A2.2: Feeling own health is not good, by NDC: percentage point change 2002 to 2008



Source: Ipsos MORI NDC Household Survey  
 Base: All

In 2002 the proportion of residents feeling their health was worse than one year earlier ranged from 16 per cent in Lambeth to 31 per cent in Knowsley (Figure 5.3). By 2008 this range had diverged slightly: the lowest proportion, in Fulham, was 11 per cent and the highest, in Hartlepool, was 27 per cent.

**Figure A2.3: Percentage feeling own health is somewhat/much worse than one year ago, by NDC: 2002 and 2008**

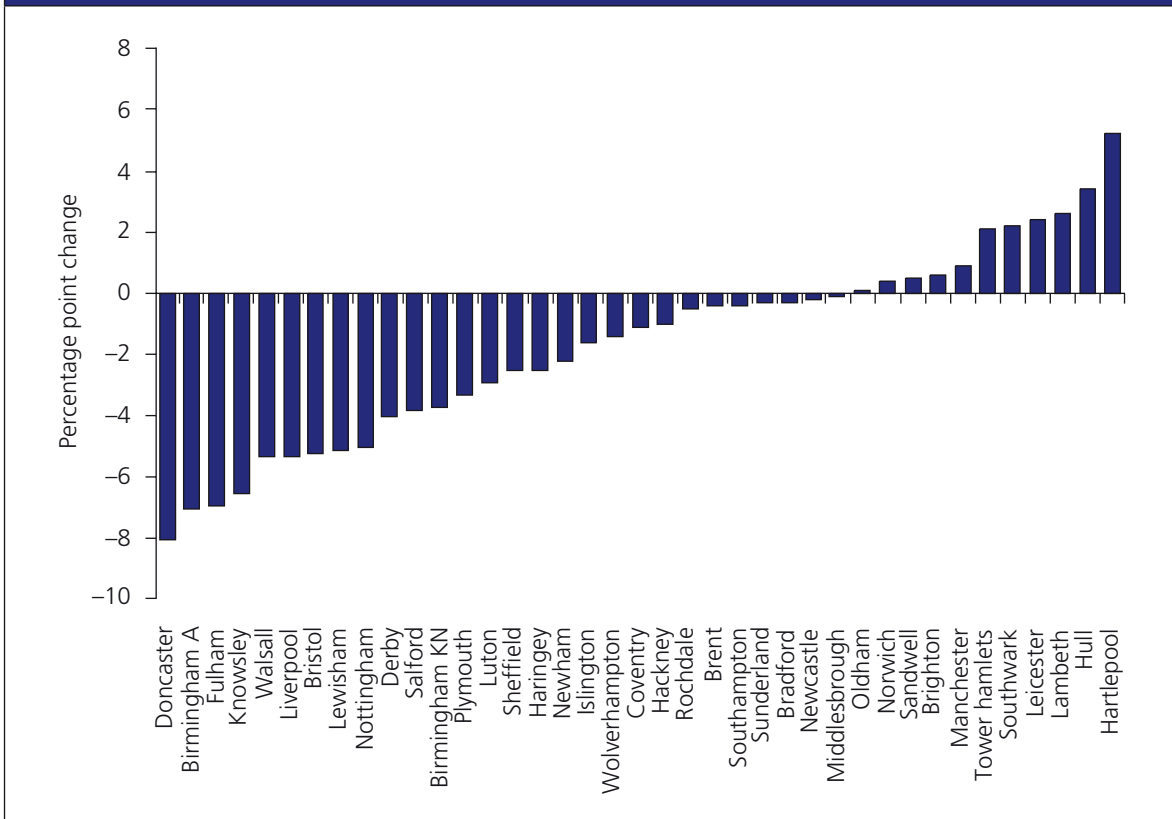


Source: Ipsos MORI NDC Household Survey  
 Base: All

Between 2002 and 2008:

- 28 NDC areas saw a reduction in the proportion thinking their health had deteriorated; 11 saw an increase
- Doncaster saw the biggest improvement: eight percentage points.

**Figure A2.4: Feeling own health is somewhat/much worse than one year ago, by NDC: percentage point change 2002 to 2008**



Source: Ipsos MORI NDC Household Survey  
Base: All

## Morbidity and mortality

This section provides additional data for the rates of low birth weight births and mental illness rates for the case study NDC areas, as well as the national and Programme-wide averages.

**Table A2.1: Low birth weight rate: 1997–2001 to 2001–2005**

	Low birth weight rate (%)					Change 1997–2001 to 2001–2005
	1997–2001	1998–2002	1999–2003	2000–2004	2001–2005	
Fulham	6	7	6	6	7	1
Hackney	10	10	9	10	10	0
Salford	9	10	10	9	9	-1
Sandwell	10	11	11	12	12	2
NDC	9	9	9	9	9	0
National	6	6	6	6	6	0

Source: SDRC  
Note: Rows may not sum due to rounding

Table A2.2: Mental illness rate: 2001 to 2005						
	Mental illness rate					
	2001	2002	2003	2004	2005	Change 2001 to 2005
Fulham	4	5	5	4	5	0
Hackney	4	4	5	5	4	0
Salford	7	7	7	7	7	1
Sandwell	4	5	5	5	5	1
NDC	5	6	6	6	6	0
National	5	6	6	6	6	0

Source: SDRC

Note: Rows may not sum due to rounding

## Differences between groups: age, sex and ethnicity

This section also looks at the degree to which change in health outcomes has impacted differently on different groups of NDC residents by analysing data for age, sex and ethnicity.

Table A2.3: Health indicators by age: 2008 and change 2002 to 2008								
	16–24		25–49		50–59/64		60+/65+	
	2008	Change 2002 to 2008	2008	Change 2002 to 2008	2008	Change 2002 to 2008	2008	Change 2002 to 2008
Feel own health not good	6	–2	15	–4	31	–5	35	–3
Health somewhat/much worse than one year ago	11	0	15	–3	29	–2	35	1
Long-standing limiting illness	8	–1	18	–3	41	–1	48	1
SF36 mental health index, high score	41	4	36	4	36	2	42	5
Eat five portions of fruit or veg everyday	15	–1	19	–3	22	–5	24	–5
Never/rarely eat five portions of fruit or veg in a day	17	–4	14	–4	17	–3	16	–3
Smoke cigarettes	36	–3	39	–6	37	–5	22	–2
Do no exercise for 20 minutes or more	6	1	7	1	14	2	24	3
Seen family doctor/GP in last year	75	2	79	3	85	4	90	2
Very/fairly easy to see family doctor/GP (a)	75	3	73	6	74	2	81	3
Very/fairly satisfied with family doctor/GP (a)	81	0	83	2	88	0	92	2
Trust local health services a great deal/a fair amount	79	6	79	6	82	6	87	7

Source: Ipsos MORI NDC Household Survey

Base: All; (a) All seen doctor in last year

Note: Rows may not sum due to rounding



**Table A2.4: Health indicators by sex: 2008 and change 2002 to 2008**

	Male		Female	
	2008	Change 2002 to 2008	2008	Change 2002 to 2008
Feel own health not good	17	-4	20	-4
Health somewhat/much worse than one year ago	18	-3	22	-1
Long-standing limiting illness	24	-3	25	-1
SF36 mental health index, high score	42	3	34	5
Eat five portions of fruit or veg everyday	17	-3	21	-3
Never/rarely eat five portions of fruit or veg in a day	18	-4	12	-4
Smoke cigarettes	36	-6	34	-3
Do no exercise for 20 minutes or more	13	2	8	1
Seen family doctor/GP in last year	75	3	87	3
Very/fairly easy to see family doctor/GP (a)	78	5	73	4
Very/fairly satisfied with family doctor/GP (a)	85	1	85	2
Trust local health services a great deal/a fair amount	80	6	82	6

Source: Ipsos MORI NDC Household Survey

Base: All; (a) All seen doctor in last year

Note: Rows may not sum due to rounding

**Table A2.5: Health indicators by ethnicity: 2008 and change 2002 to 2008**

	White		Asian		Black	
	2008	Change 2002 to 2008	2008	Change 2002 to 2008	2008	Change 2002 to 2008
Feel own health not good	21	-3	15	-4	14	-5
Health somewhat/much worse than one year ago	21	-1	18	-2	16	-2
Long-standing limiting illness	28	-1	17	-1	17	-3
SF36 mental health index, high score	37	4	37	4	42	5
Eat five portions of fruit or veg everyday	18	-3	20	-5	21	-6
Never/rarely eat five portions of fruit or veg in a day	17	-4	10	-4	11	-2
Smoke cigarettes	41	-4	19	-2	19	-4
Do no exercise for 20 minutes or more	11	2	11	2	9	2
Seen family doctor/GP in last year	80	2	82	4	85	3
Very/fairly easy to see family doctor/GP (a)	74	4	73	6	80	4
Very/fairly satisfied with family doctor/GP (a)	86	1	82	4	86	1
Trust local health services a great deal/a fair amount	81	5	80	8	83	8

Source: Ipsos MORI NDC Household Survey

Base: All; (a) All seen doctor in last year

Note: Rows may not sum due to rounding

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