Older people health and wellbeing in rural Ribble Valley

May 2011

Intelligence for Healthy Lancashire (JSNA)

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The Lancashire Joint Strategic Needs Assessment (JSNA) team were approached by the manager of the Ribble Valley District Partnership to provide intelligence support to the Healthy Valleys concept. A series of projects have been developed to support the creation of Health and Wellbeing Centres in Village Halls under the overarching theme of the Healthy Valley. This needs assessment was one of the identified projects.

A steering group was identified for this work with members from Ribble Valley District Partnership, Ribble Valley District Council, NHS East Lancashire, Help Direct and Lancashire County Council. This group met regularly until December 2010. The purpose of the needs assessment was to find out what older people (those aged 50+) in the Ribble Valley need now and in the future to be healthy and happy.

The first stage of the needs assessment was to conduct an analysis of existing secondary data sources such as the Indices of Deprivation 2010, Census 2001, MADE, NHS Comparators and the Quality Outcomes Framework. The next stage was the delivery of a survey in target areas to identify the most important areas of need. Target villages were selected for the survey on the basis of the secondary data analysis. Surveys were delivered to households whose occupants were thought to be within the target age group and collected by volunteers. The survey was accompanied by a one page covering letter explaining the purpose and branded with the Ribble Valley District Council, NHS East Lancashire and Lancashire County Council logos. The fieldwork ran from September to November 2010 and 402 completed surveys were collected.

Context

A series of national papers are relevant for this work including the NHS White Paper, Equity and Excellence: Liberating the NHS (2010), the Public Health White Paper: Healthy Lives, Healthy People (2010), A vision for Adult Social Care: Capable Communities and Active Citizens (2010), No Health without Mental Health (2011), the Equalities Act (2010) and the Localism Bill (2010).

The local context of importance for this needs assessment includes the Sustainable Community Strategy Ambition Lancashire, the Lancashire Strategy for an Ageing Population, Lancashire County Council's Corporate Plan, Lancashire Adult Social Care Commissioning Intentions (2009-13) and the Ribble Valley Sustainably Community Strategy (2007-13).

The study population

Ribble Valley is geographically a very large area and more than a third of the population resides in the towns of Clitheroe and Longridge. This leaves a further two thirds of the estimated 53,800[1] total population living in smaller villages throughout the remainder of the district. Using Mosaic, a tool which segments the population based upon differing household types, it has been possible to identify eight small areas with the largest population of interest: that of people aged over 50 with likely current or future health problems.

Based upon this exercise, villages were chosen by the project team where the primary research to be conducted. The selected villages were:

- Waddington
- Ribchester / Hurst Green
- Chipping
- Barrow / Wiswell / Pendleton
- Gisburn
- Downham / Chatburn
- Slaidburn / Newton / Dunsop Bridge
- Balderston / Osbaldeston / Mellor

Health needs analysis

This chapter provides an analysis of routine secondary data sources to establish a picture of needs for the target areas. The analysis is structured around the themes of material deprivation, resilience to inequality and deprivation, health behaviours, accessible, equitable and effective health services, and health outcomes.

The traffic light summary of key health indicators at middle layer super output area (MSOA) highlight good levels of general health in the population with the vast majority of indicators below or not significantly different to the national average.

[1] 2007 mid-year population estimates, Office for National Statistics

Healthy Valley survey

The summary results from the survey are shown below:

Health and wellbeing

- 72% rate their health as good or very good
    - Only 4% rate their health as bad or very bad
    - Yet 17% have a long term illness or disability
- 89% are satisfied with their life as a whole

Your local area and its amenities

- 96% are satisfied with the local area
- Leisure facilities are the most difficult to access service but at the same time the least popular
    - Limited access to a vehicle an apparent causal factor
- Post office, GP and chemist are the most important local services
- A shop/ post office is the main thing missing from the local area
- 79% chat with family/ friends at least 2-3 times a week
- 76% chat with neighbours at least 2-3 times a week
    - But 22% occasionally or often feel lonely
- 86% agree that friendships in the local area mean a lot to them
    - But 34% don't have someone they can turn to for advice in the local area

You and your household

- 38% have lived in the village for at least 30 years
- Most households are either single or double occupancy
- 93% are satisfied with their home as a place to live

  - Property size and location within the village main cause for dissatisfaction

- 9% receive care from a friend, relative or neighbour for a long term illness/ disability
- Current needs include help with food shopping, garden/ home maintenance and getting out and about
- Future needs include support from family/ neighbours, help getting out and about and more money
- Transport services and social services see the biggest jump in importance over the coming years

Conclusions and recommendations

Keep the momentum going

The Healthy Valley survey has simply scratched the surface and highlighted areas where action may need to be taken. But much greater understanding needs to be obtained in order to take things forward in a way that meets the needs of the village and also the needs of the service provider. Keeping decision makers and residents involved and informed along the way will be a crucial, but also difficult, process.

Utilise the willingness to get involved

From a service providers perspective, it is vital that for some services to continue (or new ones to be implemented), responsibility has to be taken up by the voluntary sector. The survey clearly highlights that there is the desire out there to help people and to give something to the community. With the assistance of the Ribble Valley CVS, this could be the start of a fruitful partnership and the beginning of delegated services to the local community. By working together initially, this will help to build relations, confidence and understanding and ultimately allow the public sector to take a step back once the service is up and running and all volunteers comfortable and happy with the set up. Example projects might include:

- Not for profit community shop – providing basic fundamentals (bread, milk etc), the opportunity to meet and interact with others and the opportunity for younger residents to get some work experience and commercial knowledge
- Village hall coffee mornings – providing a regular, consistent meeting point in a warm safe environment

- Care and share scheme – providing vulnerable residents with access to the community, someone to talk to and to share their concerns with. This scheme would also provide volunteers with the opportunity to help the most vulnerable and give something back to their village

But the important thing here is not to be seen to be 'passing the buck'. This will not be a quick fix and will take months if not years to fully establish - without the dedication of all parties it will be unlikely to succeed.

A series of specific recommendations have been identified by the project team:

- Partner organisations should identify opportunities to deal with the needs identified in the secondary analysis, for example, tackling fuel poverty.
- The variations in practice and prevalence by GPs serving the areas should be investigated to consider whether it is appropriate.
- The survey highlighted some service gaps, real or perceived, in terms of the post office and dentists. These should be investigated.
- The survey identified willingness for people to lend their skills in support of improving their local area. Opportunities to use local skills should be explored on a village by village basis. Timebanks may be a practical way for people to provide their time but also receive back.
- The results of this health needs assessment, particularly on the findings around community spirit and the positive village mentality, should be reported back to:
    - The sponsoring organisations, Lancashire County Council, NHS East Lancashire and Ribble Valley District Council.
    - The Ribble Valley Health Improvement Group
    - The Ribble Valley Seniors Forum
- The results of this needs assessment should be presented to the Parish Councils as this will foster engagement with villages. Villages should be supported to use the intelligence to develop their own solutions to needs. This could be used as an opportunity to identify village enablers.

Introduction and methodology

Introduction

A **"Healthy Valley"** is a concept being developed by Ribble Valley Borough Council, the Ribble Valley Strategic Partnership and other partner organisations to increase the health and well-being of the Ribble Valley residents.

A series of projects have been developed to support the creation of Health and Well Being Centres in the Village Halls under the over arching theme of the Healthy Valley. This needs assessment is one of the identified projects.

Delivery

The Healthy Valley project is being developed in the Ribble Valley, a predominantly rural area in Lancashire. This population is around 56,900 spread over 585 square kilometres. Although often viewed as an affluent area the Ribble Valley is faced with a number of key issues, particularly an ageing population, rural isolation, poor access to services and unmeasured pockets of deprivation.

The Healthy Valley Project will work to tackle inequalities in access to health and social care services in rural parts of the Ribble Valley and support community ventures and social enterprises working from Village Halls. This project is not about changing policy; it is about changing practice and will focus on how and when services are actually delivered, identifying changes which could be made that will enable key organisations to work together to deliver their services more effectively creating a synergy that can only be achieved in partnership.

This will be achieved through the coordination and development of local grass roots service delivery which will seek to maximise the opportunities for people to access services locally, with vibrant market towns and villages acting as thriving service centres. A key outcome of the project will be the development of social and public health infrastructure across the Ribble Valley, with the development of coordinated health and social care service provision from the Village Centres.

The project will build on the key strengths of the voluntary and community sector to involve and consult with local communities and will empower them to develop services that they value and have ownership of.

The project will work with a range of service providers, from all sectors to provide enhanced, 'joined up' service provision at local level. The outcome of this will be to enhance and support the work of all agencies involved in the delivery of health and social care services at a local level in order to avoid duplication and make the best use of all available resources.

Beneficiaries

Key beneficiaries of the project are likely to include:

- **Women** – Particularly mothers and families, carers, those at risk of rural isolation
- **Isolated Communities** – Particularly the farming community where national suicide rates are high.
- **Older People** – The area is characterized by an ageing population. The project will support those at risk of rural isolation and those who wish to maintain independent living
- **Carers** – It is estimated that 10.9% of residents provide unpaid care to family members or neighbours due to a long-term physical or mental disability. This is a higher proportion than is reflected nationally. (State of Lancashire Report – 2003)
- **Sustainability -** This project will work primarily to build the infrastructure of the local rural and health and social care system. It is anticipated that once this structure is in place, and that the positive implications of coordinated health and social care service are recognised, core service providers can build this approach into their own business plans, mainstreaming rural outreach provision.

Outcomes

Support for the sustainability of local services including the development of local community and voluntary sector organisations and the sustainability of Community and Village Centres is recognised by all the partners particularly when they address outreach service provision.

The ability and capacity of the community and voluntary sector will have been strengthened, but more importantly attitudes to connect and complimentary service delivery will become normal practice, with mechanisms and networks in place to make it easier and more productive to work together than individually.

A coordinated sustainable service will benefit communities and raise awareness of all service available, by sharing resources, organisations will be able to market and promote what support they can offer and offer professional support to new services. As outlined, this approach will support the development of local rural infrastructure, particularly supporting the use of community buildings and resource centres.

The strategic aim of the project is to help service providers make better use of their resources and budgets by working together, this will not necessarily need additional funding, and indeed the aim

will be to re target resources, pool budgets and costs, avoid duplication and use all the knowledge and expertise available, this is a long term objective. It is hoped that the project will be a catalyst for change and therefore once systems and protocols have been established and recognised as a useful tool for service delivery, the project will have achieved its aim.

Ongoing consultation with villages through established networks and structures will provide a local focus to how services are delivered after the project has ended, these will be able to link directly to other projects within the Ribble Valley Strategic Partnership.

Methodology

The Lancashire Joint Strategic Needs Assessment team were approached by the manager of the Ribble Valley District Partnership with a request to provide intelligence support to the Healthy Valleys project. Government Office North West had suggested that work should be undertaken to identify the needs of older people in Ribble Valley due to the fact that it is so characteristically different to other Lancashire districts. It was agreed that the JSNA team would project manage a needs assessment. A steering group was identified for the piece of work, with the following members who met regularly until December 2010:

- Kristian Barker – Consultation Co-ordinator, Collaborative Research and Consultation
- Gemma Barrow – JSNA Research Officer, Lancashire County Council
- Heather Catt – JSNA Research Analyst, Lancashire County Council – Project manager
- Kate Hardman – Senior Research Officer, NHS East Lancashire
- Michelle Howarth – Corporate Policy Officer, Ribble Valley Borough Council
- Rachel Hughes – Field Navigator, Help Direct
- David Ingham – LSP Manager - Ribble Valley – Project sponsor
- David Jenks - Information and Research Officer, Accessibility Planning, Lancashire County Council
- Julie Lawton – Principal Officer Transport Policy, Lancashire County Council
- Sarah McTigue – Development and Commissioning Officer, Lancashire County Council
- Moira Mortimer – Rural Policy Planning, Lancashire County Council
- Mary Palmer – District Manager Library and Information Service, Lancashire County Council
- Saeed Sidat – Equalities and Cohesion Senior Policy Officer, Lancashire County Council
- Janet Simpson – Acting District Partnership Officer, Ribble Valley
- Anthony Sudell – Consultant in Public Health Medicine, NHS East Lancashire
- Neil Wigglesworth – Registrar in Public Health, NHS East Lancashire

Using the JSNA health needs assessment toolkit, the steering group identified the purpose of the needs assessment is to answer:

- What do older people in Ribble Valley (people aged 50+) need now and what will they need in the future to be healthy and happy?

It was believed that the findings of the needs assessment will influence:

- The development of projects under the Healthy Valley initiative
- Local transport policy
- Local climate change strategy
- Ribble Valley Sustainable Community Strategy

The agreed output of the report will be:

- A single report which prioritises the key issues affecting older people in rural areas of the Ribble Valley and makes recommendations
- The project would involve:
    - Identification of target areas in the Ribble Valley on which to focus using Mosaic geo-demographic profiling to highlight those areas that are likely to experience poor health.
    - An analysis of secondary data sources to identify the health needs of the target areas and a picture of the socio-economic determinants of health. This includes a traffic light summary of data to show whether the target areas are significantly above, below or not different from the national average.
    - A primary research questionnaire to identify localised health need within rural villages in the target areas. There was no funding available for the research. It was decided to undertake the fieldwork using volunteers from Help Direct and members of the local voluntary sector who hand delivered the 8 page survey to targeted villages in Ribble Valley.

Secondary data analysis

The first stage of the needs assessment was to conduct analysis of a range of secondary data sources including the Indices of Deprivation 2007, Census 2001, community safety data from

MADE (http://www.saferlancashire.co.uk/2011/), Lancashire Sport Partnership, NCHOD, LaSCA, NHS comparators, the North West Public Health Observatory, and the Quality Outcomes Framework (QOF).

The data used is for the smallest geographies possible. These are known as super output areas. There are two types of super output areas: lower layer and middle layer. Lower layer super output areas (LSOA) are geographical areas that include approximately 1,500 persons. They are designed to have the same numbers in each area and such that the population in each are as homogenous as possible. Middle layer super output areas are larger than LSOAs and usually contain about 5,000 to 7,500 people. They are grouped up from LSOAs so that LSOAs will not cross the boundaries. Where available, data has been used for LSOAs. Where not available, data for MSOAs has been used. Where this level of data has not been available, ward data has been used. One drawback of ward data is that the boundaries are not necessarily coterminous with LSOAs or MSOAs. However, they are a geography that makes more intuitive sense to non analysts.

Primary research

Primary research was conducted in the target areas to identify the most important areas of need to support improved health and wellbeing in the population.

Target villages were selected for the survey on the basis of the analysis conducted using secondary data.

Surveys were delivered to households whose occupants were thought to be within the target age group (50 years and above). These were then left with the occupant if they did indeed fit this criteria and the volunteer then agreed a convenient date and time to collect the completed survey.

The survey was also accompanied by a one page covering letter, explaining why the work was being done and who was responsible for it. There was also the opportunity for residents to register their details and requirements with Help Direct.

Primarily, the approach ensured that the needs of the target audience were being met. Completing the survey online or whilst stood at the front door wouldn't have resulted in as many residents being willing or able to participate. This approach also helped to keep costs down whilst at the same time utilising a methodology which is typically the most expensive of them all.

Fieldwork started on 1st September 2010 and ended on 10 November 2010. In total, 402 completed surveys were collected. The data was scanned in electronically and weighted to address the disproportionate response by gender and age.

Robustness of the data

How well the sample represents the population is gauged by two important statistics – the survey's margin of error and confidence level. For example, this survey has a margin of error of plus or minus 4.8% at a 95 percent level of confidence. This means that if the survey was conducted 100 times, the data would be within 4.8 percentage points above or below the percentage reported in 95 of the 100 surveys (see figure 1.1 below). Given that nationally a margin of error of +/- 3% is considered acceptable, the data presented here is slightly outside this limit.

Table 1: Margin of error at 95% confidence

Survey Sample Size	Margin of Error Percent
402	+/- 4.8
250	+/- 6.2
100	+/- 9.8
50	+/- 13.8

Report structure

The remainder of the report is structured as follows:

- Background and context, which discusses the national context for this work, the local context and a literature review of guidance related to providing services for older people and those in rural areas.
- The study population, which discusses the method of identifying the study areas, in particular the villages of interest.
- Health needs analysis, which provides a summary of: material deprivation; resilience to inequality and deprivation; health behaviours; accessible, equitable and effective support services; and health outcomes in the target areas.
- Questionnaire, which provides discussion of the methodology and the results of the questionnaire undertaken in the target villages.
- Summary and recommendations from the analysis in total.

Context

National context

White Papers – NHS White Paper, Equity and Excellence: Liberating the NHS, and Public Health White Paper, Healthy Lives, Healthy People (2010)

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

http://www.dh.gov.uk/en/Publichealth/Healthyliveshealthypeople/index.htm

NHS East Lancashire (the Primary Care Trust) has responsibilities for the health and healthcare of the population of Ribble Valley. It discharges those responsibilities by commissioning healthcare for the population registered with Ribble Valley general practitioners, and seeks to improve health by partnership working and commissioning to enable the population to make healthy choices which will lead to improvements in the length and quality of life. The PCT's SMYL (saving a million years of life) strategy gives a specific momentum to this agenda. This work is driven by needs assessment and this work will provide a valuable contribution to that needs assessment.

The National Health Service is currently being changed, with new GP consortia taking over responsibility for healthcare commissioning, which will be overseen by a national NHS Commissioning Board. Health improvement and public health responsibilities will transfer predominantly to upper tier local authorities, linking into district authorities, and working closely with the national departmental body known as Public Health England. All of these will have a need for health needs information.

Healthcare services are provided by general practitioners and other independent contractors, by NHS Trusts (which will manage hospitals and community services) and independent sector organisations in contract with NHS Commissioners.

A Vision for Adult Social Care: Capable Communities and Active Citizens (2010)

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508

Lancashire County Council have responsibility for adult social care for the population of Ribble Valley. Support is commissioned and delivered by a range of organisations. The new vision for adult social care sets out the role of local authorities to lead reform and highlights seven principles. These include: Prevention; Personalisation; Partnership; Plurality; Protection; Productivity and People. The main emphasis is on devolving power and responsibility closer to individuals through

personalisation and the big society. There is continued focus on outcomes, working in partnership and shaping a diverse market including all sectors, user-led organisations and social enterprises.

No Health Without Mental Health (2011)

http://www.dh.gov.uk/en/Aboutus/Features/DH_123998

No health without mental health is the new cross-government mental health outcomes strategy for people of all ages. This strategy sets out the ambition to mainstream mental health and to establish parity between services for people with mental and physical health problems. This highlights how mental health is everyone's business and that good mental health and resilience are fundamental to living well and achieving our potential. Communities, as well as the state are looked to for promoting independence and choice. As well as treating mental illness promoting positive mental health and wellbeing is encouraged across all ages including later life.

Big Society

http://www.cabinetoffice.gov.uk/news/building-big-society

The Big Society is about helping people to come together to improve their own lives. It's about putting more power in people's hands – a massive transfer of power from Whitehall to local communities. There are three key parts to the Big Society agenda:

- **Community empowerment**: giving local councils and neighbourhoods more power to take decisions and shape their area.
- **Opening up public services**: Coalition's public service reforms will enable charities, social enterprises, private companies and employee-owned co-operatives to compete to offer people high quality services. The aim is to generate more innovation, diversity and responsiveness to public need.
- **Social action**: encouraging and enabling people to play a more active part in society and the government to foster and support a new culture of voluntarism, philanthropy and social action.

Equalities Act (2010)

http://www.equalities.gov.uk/equality_act_2010.aspx

The Coalition has already taken steps to implement most of the Equality Act 2010 which simplifies the legislative framework. Theresa May, Home Secretary and Minister for Women and Equalities stated that equality underpins this coalition's guiding principles of freedom, fairness and

responsibility. The Coalition have outlined in their Equality Strategy that Equality is not an add-on, but an integral part of the government's commitment to build a stronger economy and fairer society.

General duties for public organisations under the recently published Equality Act 2010 are to:

- **Eliminate** discrimination, harassment and victimisation.
- Advance **equality of opportunity** (removing or minimising disadvantage, meeting the needs of people).
- **Foster good relations between people** who share a protected characteristic and those who do not share it

Localism Bill (2010)

http://www.communities.gov.uk/localgovernment/decentralisation/localismbill/

The legislation will help build the Big Society by radically transforming the relationships between central government, local government, communities and individuals. The Bill, laid before Parliament, contains a radical package of reforms that will devolve greater power and freedoms to councils and neighbourhoods, establish powerful new rights for communities, revolutionise the planning system, and give communities control over housing decisions.

The government has published its wide-ranging Localism Bill which it says shifts power from central government to communities - here are some of the measures highlighted by the Department for Communities and Local Government: **powers for councils; directly elected mayors; pay as you throw charges; housing targets; charges on developers; local development; planning permission; social housing; running local services; buying local assets; local referendums; etc.**

The Commissioning Framework for Health & Wellbeing (2007)

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604

Central government has stated a clear intention to shift the focus of healthcare from treating sick people towards prevention and wellbeing. To enable NHS funds to be spent on non-NHS services that have a preventative benefit for the NHS.

The framework is about action, with a particular focus on partnership. It is for everyone who can contribute to promoting physical and mental health and wellbeing, including the business community, government regional offices and the third sector

The Joint Strategic Needs Assessment (JSNA) will assist in informing that process and ensure that resources and services are targeted to where they will have the greatest impact

Putting People First (Department of Health, 2007)

http://www.cpa.org.uk/cpa/putting_people_first.pdf

- A shared vision and commitment to the transformation of adult social care
- Outlines demographic changes and increasing expectations and sets out and supports Governments commitment to independent living for all adults
- Start of exploring options for long term funding of social care between individual and the state
- Public service reform co-produced, co-developed and co-evaluated
- Social Care Reform Grant specific funding to support system wide transformation
- Access to high quality support should be universal and available in every community
- Adult social care to take a leadership role within local authorities, across public services and in local communities
- Every locality should seek to have a single community based support system focussed on the health and wellbeing of the local population
- Organisations together to redesign local systems around the needs of citizens
- New Performance Framework and Statutory requirement for local authorities and PCTs to undertake Joint Strategic Needs Assessment
- JSNA to inform Sustainable Community Strategy
- Personal budgets to ensure people receiving public funding use available resources to choose their own support services
- Person centred planning and self directed support to be mainstream

- Emphasises supporting people to remain in their own homes for as long as possible and the alleviation of loneliness and isolation to be a major priority
- Universal information, advice and advocacy for people needing services and their carer regardless of eligibility

Transforming Adult Social Care LAC (2009)

http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/LocalAuthorityCirculars/DH_081934

- Sets out information to support the transformation of social care
- It describes the vision for development of a personalised approach to the delivery of adult social care and context in which this policy is grounded
- It also includes copy of the Social Care Reform Grant Determination and the details of the new ring-fenced grant to help councils to redesign and reshape their systems over the next 3 years

Sustainable Communities Act (2007)

http://www.communities.gov.uk/publications/localgovernment/sustainablecommunitiesact

- Aims to promote the sustainability of local communities
- Principle that local people know best what needs to be done to promote the sustainability of their area but need central government to act in a way to support this
- It provides a channel for local people to ask central government to take action
- Also a new way for local authorities to ask central government to take action which they believe would better enable them to improve the economic, social or environmental well-being of their area
- Provides a process by which the ideas generated by local communities are fed through their local authority and a body known as the “selector” to central government to respond with planned actions
- The Sustainable Communities Act also ensures that communities are better informed about the public funding that is spent in their area

- New "Local Spending Reports" will provide quick and easy access to information about where public money is spent to enable local authorities, their partners and communities to take better informed decisions about the priorities they choose to pursue to promote the sustainability of their local community
- Links to duty to involve (SC Act panels can also be used for this)

Working together for older people in rural areas (2009)

http://www.cabinetoffice.gov.uk/social_exclusion_task_force/short_studies/working_together.aspx

Key findings of the short study:

- The rural population is ageing faster than other areas of the country
- Many rural areas will increasingly face challenges in delivering services for older people
- Socially excluded older people can be hidden from view in rural areas
- Timely and responsive transport is key to accessing local services
- Public service reform is central to ensuring ageing is a positive experience
- Public services and local communities are already adapting, innovating and learning to thrive in the context of rural ageing
- Policymakers should not create silos for rural areas – but additional support and guidance can be appropriate to assist planning for an ageing rural population

Local context

Ambition Lancashire

http://www.lancashirepartnership.co.uk/content/ambition/final.asp

Ambition Lancashire is the Sustainable Community Strategy (SCS) for Lancashire. It was developed by the multi-agency Lancashire Partnership and its purpose is to promote the economic, social and environmental wellbeing of the county. Ambition Lancashire has two overarching principles. These are:

1. Narrowing the gap - Promoting social inclusion/needs of vulnerable groups/equality and life chances.

2. Active citizens - Stronger communities/cohesion and communities

Underpinning these principles there are five key priorities:

- The economy;
- Health & wellbeing;
- The environment;
- Education, training and skills;
- Community safety.

The 2025 vision for the health and wellbeing priority is to reduce health inequalities by 10% as measured by:

- Life expectancy at birth, and infant mortality;
- The number of adults with learning disabilities, physical disabilities and, mental ill health, and those supported to live at home;
- The quality of life free from long-term illness.

Strategy for an Ageing Population

http://www.lancashirepartnership.co.uk/content/ageing/index.asp

The Lancashire Partnership has produced a strategy for an ageing population, which sets out how organisations in Lancashire are responding to the opportunities and challenges of an ageing society.

Whilst recognising that older people have a wide range of needs their health and wellbeing is also recognised amongst its priorities.

Lancashire County Council's Corporate Plan

http://www3.lancashire.gov.uk/corporate/atoz/a_to_z/dirServices.asp?u_id=1718&strSL=C

The corporate strategy sets out the high level priorities over the three years 2010 to 2013. Nine key objectives have been established under three themes of our citizens, our communities and our county:

Our citizens:

- Growing up prepared for the future.
- Promoting health and wellbeing.
- Supporting people in need

Our communities:

- Making Lancashire communities safer and stronger
- Giving citizens and communities more say
- Delivering value for money

Our county:

- Promoting sustainable economic growth
- Improving roads and transport
- Protecting and improving our environment and culture

Lancashire County Council Strategy for Health and Wellbeing (2008-11)

http://www.lancashire.gov.uk/office_of_the_chief_executive/lancashireprofile/jsna/documents/shwb.pdf

The strategy outlines a commitment to make a significant contribution toward reducing health inequalities and meet corporate responsibilities as community leader, partner, service provider, commissioner and employer.

The aim of strategy is to shape and inform actions to improve the health and wellbeing of all people in Lancashire and reduce health inequalities in outcome for specific groups and in specific geographical locations.

Priorities where it is felt LCC can make most impact and link existing strategies:

1. Alcohol: encourage and support sensible drinking, because alcohol misuse is associated with deaths from stroke, cancer, liver disease, injury and suicide; it places a burden on the NHS, particularly on accident and emergency (A and E) departments; and because it is related to absenteeism, domestic violence and violent crime.

2. Mental Health and Emotional Wellbeing: Mental wellbeing is crucial to good physical health and making healthy choices; and because stress is the most common reported cause of sickness absence and a major cause of incapacity; and because mental ill health can also lead to suicide.

3. Worklessness, Poverty and Debt: Poverty directly causes poor health and the reverse is also true and poor health directly contributes to poverty.

4. Workplace Health: LCC is major employer and improved health and wellbeing of our employees will also have a positive impact on their families.

Lancashire County Council Well-being and Prevention Strategy (2009)

This offers a wider definition of well-being and prevention (than 2007/8 strategy) by identifying a framework for understanding how services can support people whether their needs are 'lower level' or complex, whether they require community support or intensive clinical supervision. It proposes action to build well-being and prevention services, in conjunction with statutory and VCFS partners, at a 'primary', 'secondary' and 'tertiary' level.

The strategy is designed to underpin the required shift in investment that the Directorate needs to make, towards prevention and early intervention and supporting people 'upstream' so that these services become the first line of support in the Directorate's transactions with citizens, customers, and communities. The key element of the strategy is the work required to deliver targeted prevention and to identify and support those at risk of losing independence. It includes focused community outreach; case finding to identify people who have reached a 'tipping point' and 'tertiary' prevention services such as rehabilitation and re-ablement.

An outline action plan for the next two years is included in the strategy. The strategy highlights working with Primary Care Trusts to review services which both avoid/delay hospital admission or assist with timely and appropriate hospital discharge (Transitional Pathways) and also to identify other shared commissioning opportunities, particularly around non-care-managed services. Partnership work with the Voluntary, Community and Faith Sector (VCFS) agencies to build community capacity, and improve people's sense of well-being is promoted.

It also specifically states that the rural character of much of the County and the need to design well-being and preventative services to meet this.

Adult Social Care: New Lancashire Offer 2013 (2009)

This brief paper argues that, over the next four years, Adult Social Care will need to deliver a radically different set of services and responses to the communities of Lancashire and its citizens as well as to people who use its services. It sets out the key intentions for communities, citizens, customers and colleagues, the need for change and the outcomes to be delivered.

Lancashire Adult Social Care Commissioning Intentions (2009-13)

These are designed to reinforce the 'Lancashire Offer 2013' approach as well as support the transformation of the business in line with Putting People First. The intentions include specific work to develop the breadth of the well-being and prevention approach in Lancashire from the universal offer of information and advice to the review of transitional pathways for people at risk of needing hospital care, nursing home care or residential care.

The following sixteen commissioning intentions are currently being revised to reflect recent changes in priorities however they provide information on the previously intended focus of service improvement and redesign over the coming years.

1. Work with partners to ensure that people have access to a wide range of practical support and useful information. This will enable them to improve their sense of well-being and independence and help them make choices about their lifestyle so that they can combat loneliness and isolation and make a contribution to their community. Under a prevention and well-being framework for Lancashire, this will include universal access to advice and information, development of practical support services and social activities through Help Direct, improved employment and volunteering opportunities including the promotion of Time Banks, improved networking of resources and activities in the local districts so that people can easily find the support which meets their needs, a more focused role for VCFS commissioned services building the capacity of local communities and communities of interest, improved co-ordination of housing related support with other services.

2. Re-model/recommission hospital avoidance, crisis support, intermediate care, step up/step down rehabilitation and end of life care as part of an integrated care pathway.

3. Re-model/recommission mental health community residential rehabilitation services, utilising principles of a 'socially inclusive recovery model' as part of a clear pathway and stepped care approach.

4. Jointly commission with PCTs a range of carer supports as part of the multi agency strategy.

5. Reduce the number of people entering residential care on a long term basis. This will be achieved by fewer people entering care homes in particular straight from hospital or from sheltered accommodation. re-modelling existing care homes based on self directed supports. For people who need and choose a care home placement a clear specification of what a personalised service should look like will be developed.

6. Commission assertive outreach supports for people with alcohol related issues as part of a stepped care pathway, linking to community based tier 1, 2 and 3 supports.

7. Anyone requiring and eligible for long term social care support will have a personal budget regardless of age and condition. This will include tenants of new housing and support services (including extra care). This will be achieved by re-modelling/recommissioning all long term supported living block contracts, Tier 4 substance misuse rehabilitation services, day time support services and high cost care home placements.

8. Commission community pathway models to support key areas of self directed supports including citizen brokerage, advice and support and training utilising a consortia of user led organisations.

9. Re-model and develop a range of supports to achieve local outcomes based on National strategies for dementia and stroke.

10. The development of accessible e-market systems that allow easy access to information on a wide range of services and facilitate transactions both of services provided by organisations and person to person services.

11. Develop specific housing pathways for people with long term support needs to access a range of housing options, including assured tenancy,shared and full ownership.

12. Work with partners to review and recommission supported housing for people requiring short term services who are socially excluded (eg homeless people, teenage parents, people with substance misuse problems, young people at risk, offenders etc)

13. Review the Telecare service and re-model/recommission to ensure that an affordable and effective service is available across the County as an integral part of the support offer available to people.

14. Delivery of a community equipment service consistent with the retail model.

15. Contribute to the development of an effective transport infrastructure across Lancashire.

16. Joint commissioning of HIV/AIDS community based advice, information and low level support with North and East PCTs.

Increasingly individuals will use their personal budgets more creatively and commissioners will need to understand the overall pattern of choices being made and ensure that providers are aware of changing patterns and areas for development.

This will lead to different types of services possibly being delivered by different types of organisation (such as user led organisations and social enterprises).

Commissioners will encourage innovation and new solutions whilst ensuring that providers are offering high standards of care, dignity and services that are driven by the individual user.

Lancashire County Council East Lancashire Area Commissioning Plan (2011)

This translates the county wide commissioning intentions into an action plan for commissioning in East Lancashire. The priorities of East Lancashire Area Commissioning Team for the next 12 months include:

- Commissioning Intention 1 – review of commissioning framework for non-care managed support and social activities with the third sector
- Commissioning Intention 1 – ongoing development of Help Direct including Outreach Plus
- Commissioning Intention 1 – Promotion of Leisure services as alternatives to traditional supports
- Commissioning Intention 2/5 - Transitional Care Pathways project including a review of Crisis Intervention Services and a review of night time services
- Commissioning Intention 4 – Implementation of multi-agency Carers Strategy in East Lancashire
- Commissioning Intention 7 – Remodelling/re-commissioning day time support services in line with county wide Older People review. Review of day time support for physically disabled and sensory impaired adults in East Lancashire
- Commissioning Intention 9 – Development of East Lancs joint Dementia Commissioning Strategy and links to county project regarding strokes

- Commissioning Intention 14 – Delivery of community equipment service consistent with retail model and implementation of recommendations from Home Improvement Agency review

Ribble Valley Sustainable Community Strategy (2007-13)

The most recent SCS was published in March 2008. This included a vision to 'make the Ribble Valley an area with an exceptional environment and quality of life for all' and set out what Ribble Valley Strategic Partnership will achieve with people and communities of Ribble Valley by 2013. Consultation with citizens found concerns regarding improving transport and access to health services. Major issues for Ribble Valley include housing, facilities (rural isolation), education and the economy, transport, tourism and health (obesity, mental health, substance and alcohol misuse, health of children, young people and older people). The three key priorities highlighted in the strategy:

People including promoting community cohesion, tackling rural isolation, encouraging community participation, addressing implications of ageing society and maintaining sustainability of rural communities

Places including addressing lack of affordable housing, conserving/enhancing quality/beauty of area, access to public transport, sustainability of town/villages as service centres and equality of opportunity for all community

Prosperity including ensuring opportunities for businesses to thrive, developing tourism and encouraging and supporting social enterprises

Ribble Valley Locality Plan

The Ribble Valley Locality Plan for 2010/11 focussed on the three themes of People, Place and Prosperity. Each theme contained a number of priorities, which in turn were supported by actions. The relevant priorities and actions are listed below. The full version of the Locality Plan can be accessed via the following web link:

http://www.lancashire.gov.uk/corporate/web/view.asp?siteid=3851&pageid=24108&e=e

People

Priority: Support and help older or vulnerable people

- Raise awareness and encourage use of Home Library Service across the borough
- Raise awareness of entitlement to and uptake of welfare benefits

- Hold a Leisure and Learning Information event for local authority and partner organisation staff to raise awareness of opportunities open to adults and older people (including those receiving personal budgets and Carers)
- Carry out a Health Needs Assessment (including a survey involving older citizens) in eight rurally isolated villages.

Priority: Improve community engagement

- Hold Silver surfer sessions at Clitheroe, Longridge and Whalley Libraries to help older people use the internet
- Launch the multi-agency bus, providing increased access to services in rural areas.

Priority: Actively explore opportunities to tap into 'social capital', volunteering and local lobbying

- Promote volunteer opportunities (including traditional countryside skills, help with environmental and community projects, in libraries etc)
- Establish plans to set up a network of Time Banks
- Establish plans to develop a multi-agency strategy for volunteering including vulnerable adults
- Jointly identify existing day time opportunities open to physically disabled and sensory impaired adults

Place

Priority: Develop allotment space

- Support the development of additional allotment space in collaboration with Groundwork

Priority: Improve and expand culture, arts and leisure opportunities

- Promote Bowland Arts Festival in 2010
- Work together to develop opportunities to engage local people in creativity activity

Literature review

NICE public health guidance 16 – Occupational therapy interventions and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care, October 2008

There are 9.7 million people aged 65 and older in the UK and by 2020 one in five UK citizens will be aged 65 or older. Though many older people lead happy, well-balanced and independent lives the transition into later life can be affected by many different variables, including physical health, financial security, societal attitudes, geographical location, access to support and services and responsibility for the care of others (Age Concern England and Mental Health Foundation 2004).

Despite better health and increases in wealth over the last 50 years, there is evidence that many older people are becoming increasingly dissatisfied, lonelier and more depressed, many living with low levels of life satisfaction and wellbeing (Allen 2008). Forty per cent of older people attending GP surgeries, and 60% of those living in residential institutions are reported to have 'poor mental health' (UK Inquiry into Mental Health and Well-being in Later Life 2006). A decline in mental wellbeing should not be viewed as a natural and inevitable part of ageing and there is a need to raise both older people's and societal expectations for mental wellbeing in later life (Mental Health and Older People Forum 2008).

Five key factors affect the mental health and wellbeing of older people: discrimination (for example, by age or culture), participation in meaningful activity, relationships, physical health (including physical capability to undertake everyday tasks) and poverty (UK Inquiry into Mental Health and Well-being in Later Life 2006).

The Social Exclusion Unit reports that many older people continue to experience discrimination despite the establishment of the Commission for Equality and Human Rights (including age equality) and the National Service Framework for Older People, which aims to stop age discrimination in health and social care (DH 2001). Commissioning, service provision and regulatory processes still do not consistently reflect established national policy. Direct and indirect age discrimination is evident through reductions in service and investment for older people's mental health (Mental Health and Older People Forum 2008).

Isolation is a particular risk factor for older people from minority ethnic groups, those in rural areas and for people older than 75 who may be widowed or live alone (Office of the Deputy Prime Minister 2006). Social activities, social networks, keeping busy and 'getting out and about', good physical health and family contact are among the factors most frequently mentioned by older people as important to their mental wellbeing (Third Sector First 2005; Audit Commission 2004).

Health and social care services have an important role in promoting and maintaining physical activity, health and independence (DH 2005a, DH 2005b). There is a decline in physical activity with increased age which may be associated with lack of opportunities and lack of encouragement (UK Inquiry into Mental Health and Well-being in Later Life 2006). Exercise and physical activity can be tailored to an individual's needs and abilities, increasing access for older people with disabilities and mobility needs (British Heart Foundation 2007).

The maintenance of physical activity in later life is central to improving physical health. Regular exercise has beneficial effects on general health, mobility and independence, and is associated with a reduced risk of depression and related benefits for mental wellbeing, such as reduced anxiety and enhanced mood and self-esteem (DH 2005c). Physical health and mental health, in turn, also have an impact on older people's economic circumstances and on their ability to participate in society (Marmot et al. 2003).

Self determination and a level of independence have also been associated with health and wellbeing. Self determination, in daily life, means ensuring that people have as much choice as possible about personal routines and activities (for example, when they eat or sleep, get up, go out or spend time alone) (Personal Social Services Research Unit 2006). Recent guidance for residential care homes reports that the provision of meaningful daily activities can restore and improve the health and mental wellbeing of residents (College of Occupational Therapists and National Association for Providers of Activities for Older People 2007).

Government initiatives at local and national level all emphasise the need for local authorities, health and social care services to prioritise improvement in older people's services. Central to the success of these initiatives is the involvement of older people in service planning, particularly those groups whose health and wellbeing may be compromised by advanced age or disability (DH 2006). Reforms to home care in England in 2008 will give older people greater independence and the right to choose their own home-helps and personal carers through means-tested personal budgets (DH 2007).

Since 2000, local authorities have had discretionary power to promote social, economic and environmental wellbeing, and a duty to engage the local community (including older people) in community planning (Local Government Act 2000). Better Government for Older People is a UK-wide partnership in which older people are the key partners. It aims to ensure older people are engaged as citizens at all levels of decision making, and in shaping the development of strategies and services for an ageing population.

Partnerships for Older People Projects (POPP), led by the Department of Health, aim to shift resources and culture towards earlier and better targeted interventions for older people within community settings. The pilots deliver a range of interventions aimed at promoting independence for older people in line with local needs. For example, they provide better access to information and peer support for older people, provide health promotion activities to support healthy living, and provide low-level or simple services for older people such as help with shopping, household repairs etc. Early findings from POPP pilot sites have shown improved access for excluded groups and greater involvement of older people within steering groups, commissioning, recruitment, provision and evaluation.

The NICE guidance makes four specific recommendations on how to improve the health and wellbeing of older people:

17. **Occupational therapy interventions** to be supplied by qualified professionals within community settings. Actions include: group sessions to help older people identify, construct, rehearse and carry out daily routines to maintain or improve their health and wellbeing; and increase older people's knowledge and awareness of where to get information and advice on topics such as nutrition, personal care, staying active, accessing benefits and making use of local transport schemes.

18. **Physical activity** to be supplied by professionals and staff from a range of sectors including health, social care and voluntary who have the appropriate skills and training. Actions should include: in collaboration with older people and their carers offering tailored physical activity programmes in the community; ensuring that activities reflect the preferences of older people; encourage older people to attend sessions by explaining the benefits; advise older people how to exercise safely for 30 minutes a day on five days a week and; obtain regular feedback to inform the content of the service and gauge levels of motivation.

19. **Walking schemes** to be supplied by a range of people from professionals and local authority staff to voluntary sector staff and community development groups working with the community themselves. Suggested actions include: in collaboration with older people and their carers, offer a range of walking schemes of low to moderate intensity with a choice of local routes to suit different abilities; promote regular participation in local walking schemes as a way to improve mental wellbeing for older people and provide health advice and information on the benefits of walking; encourage and support older people to participate fully according to health and mobility needs, and personal preference; ensure that walking schemes are led by trained health workers or "Walking the way to health initiative" volunteers who have been trained in first aid and creating suitable routes; incorporate a group meeting at the outset of a walking

scheme that introduces the walk leader and participants; offers opportunities for local walks three times a week, last about an hour with warm up and cool down, and invite regular feedback from participants.

20. **Training** for professionals, staff and volunteers working with older people in the community. Actions should include: involving occupational therapists in the design of locally relevant training schemes for those working with older people to ensure the schemes provide essential knowledge of occupational therapy and health and wellbeing promotion, effective communication skills to engage with older people and their carers, and information on how to monitor and make best use of feedback to evaluate or redesign the service; and ensure practitioners have the skills to community effectively with older people to encourage ideas exchange and peer support, encourage and support older people to identify, construct, rehearse and carry out activities to maintain or improve health and wellbeing, and collect and use regular feedback from participants.

Under Pressure: Tackling the financial challenge for councils of an ageing population, Audit Commission, February 2010

The report identifies the challenge faced by Councils of an ageing population as public spending reduces. An ageing population has a range of impacts. If care costs rise in line with the population they could nearly double by 2026. Older people, however, are more likely to volunteer to support local communities. Carers over 60 provide care worth twice public spending on care services for older people. The findings show small investments in services such as housing and leisure can reduce or delay care costs and improve wellbeing.

The report confirms that improved health and wellbeing reduces demand for services and suggests that Councils and partners should co-operate to tackle the main causes of social care need:

- Poor housing and environment;
- Health and mobility problems;
- Breakdown of informal support; and
- Social isolation.

The report suggests that older people are an untapped source of information about what works and the value of support to independent living. Early intervention can improve wellbeing and save money. One county saves £1million a year on residential care costs by providing telecare

services. Cheaper alternatives were found to often be the most valued services by older people, their families and communities.

Designed to deliver: reducing the isolation of older people in rural communities, hact, November 2007

Published by hact, this report describes and evaluated eight projects established in rural areas to reduce the social isolation of older people. All of the projects worked with, as well as for, the benefit of older people. The projects pioneered solutions for older people living in rural areas, focusing on solutions to social exclusion from rural shopping projects to handyperson services. By focusing on local circumstances, community needs and the specific needs of individuals, each developed insights for government and other Third Sector organisations. All projects recognised that rural services should be designed and delivered according to local need. Similarly, there is no such thing as a typical older people. By making sweeping assumptions about older people in rural communities, service providers tend only to reinforce inequality and encourage exclusion.

The report provides a series of recommendations:

- Services should be designed and delivered for rural, not urban areas – taking urban models and applying them to rural situations doesn't work;
- Research the services people want, and need, using micro studies and recognise that diversity is also a rural issue;
- Imagination and creativity are not confined to urban areas – with adequate resourcing and effective consultation, rural based organisations are just as capable of creating inventive services and products;

Costs of delivering rural services might be higher, but the added value has to be taken into account – it might not show up on the bottom line, but the impact of a well designed, appropriately delivered services can make an immeasurable impact on the lives of older people in rural communities; and sustainability of services is critical in the countryside – without them, the impact on the lives of individuals and the future of communities can be devastating. And partnerships are one key method of ensuring the sustainability of service delivery.

The study population

Introduction

Ribble Valley is geographically a very large area and more than a third of the population resides in the towns of Clitheroe and Longridge. This leaves a further two thirds of the estimated 53,800[2] total population living in smaller villages throughout the remainder of the district. Understanding where and who these people are is the aim of this stage and will help to focus the Healthy Valleys project on a more manageable population. The first step in identifying groups is through the use of Mosaic Public Sector software to type the households through the district.

Mosaic profiling

Mosaic Public Sector provides a family tree which highlights those groups who experience poor health. Collectively these groups are considered to high risk of poor health:

- Group F, welfare borderline;
- Group G, municipal dependency;
- Group H, blue collar enterprise; and
- Group I, (twilight subsistence).

However, the Healthy Valley project is also concerned with rural isolation, an ageing population and service gaps so other groups with such characteristics are considered medium risk as they will also require greater access to services:

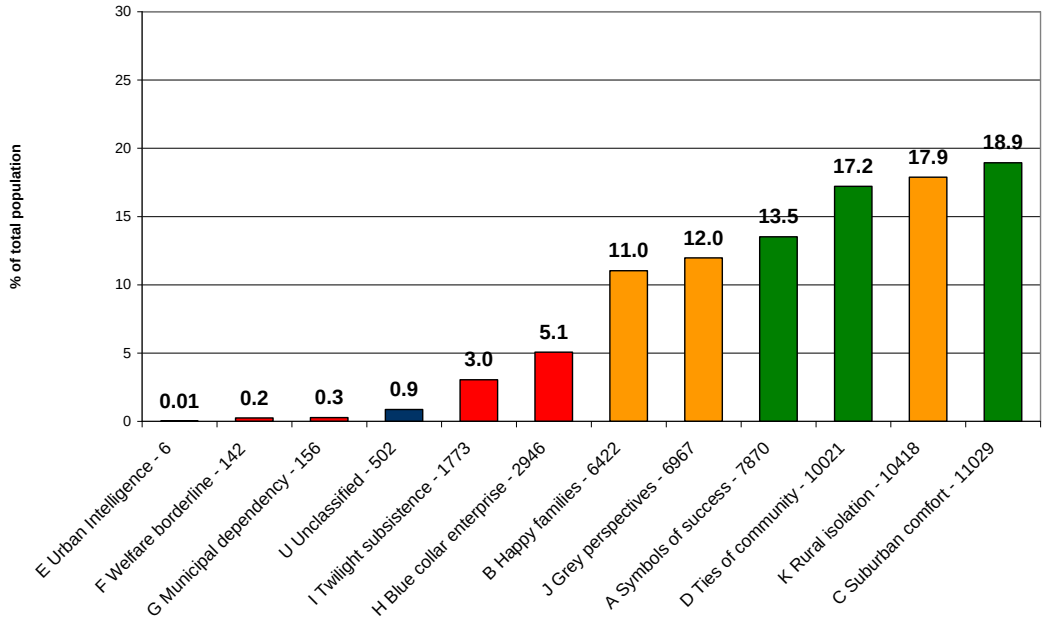
- Group B, happy families, will have high demand for services and therefore their needs and any isolation from such services is important for planning.
- Group K, rural isolation, are considered a medium risk group as their needs for services may not be being met currently and it is important to understand whether their needs will be met in the future.
- Group J, grey perspectives tend to be financially independent and healthy individuals, but they are still ageing and their financial independence may prevent them from accessing services that they need in later life

[2] 2007 mid-year population estimates, Office for National Statistics

Population analysis by Mosaic groups

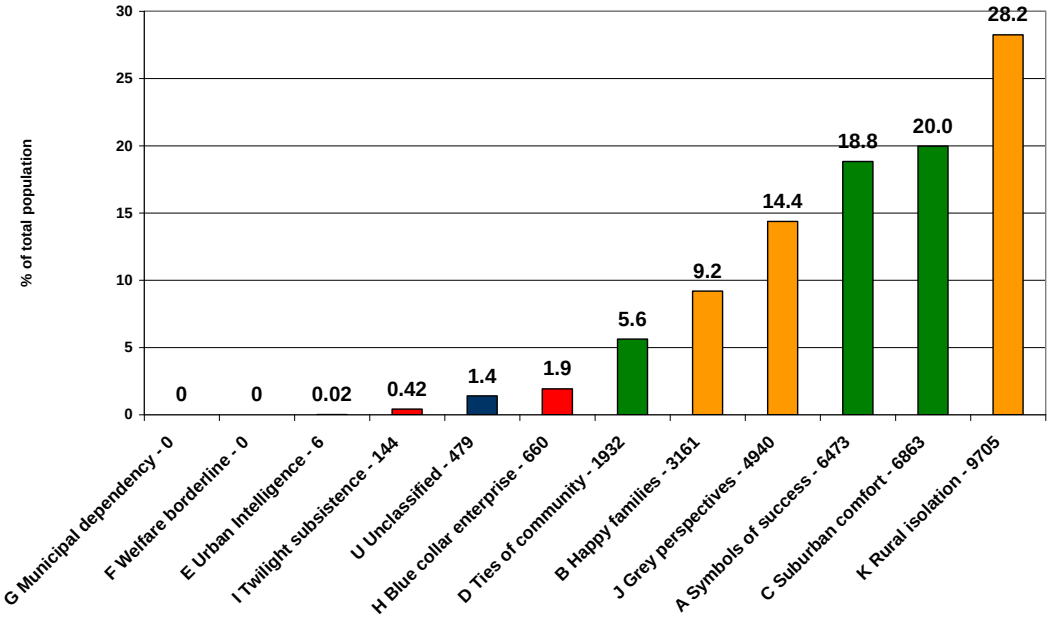
The figure below highlights the Ribble Valley population by the Mosaic groups. There are a few groups deemed to be of medium risk who account for reasonably high proportions of the population (more than 10%). These are groups K, rural isolation, J, grey perspectives, and B, happy families. The majority of the population of the district of Ribble Valley is accounted for by low risk groups.

Figure 1: Ribble Valley population by Mosaic Groups



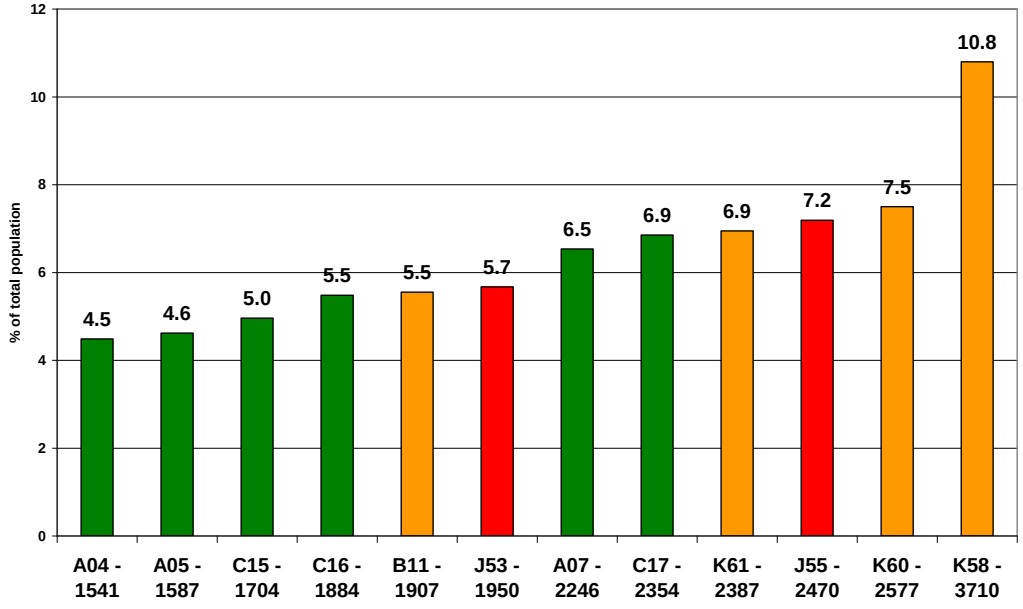
When the larger towns are excluded from the analysis a different picture emerges. More than half of the population of the Ribble Valley villages are classed as being in medium risk groups K, rural isolation, J, grey perspectives, and B, happy families.

Figure 2: Ribble Valley villages population by Mosaic groups



The Mosaic groups can be broken down further to provide narrower categories, known as types. Detailed written profiles are available about each of these household types which provide commentary on their health needs, service use, income and general lifestyle. The figure below shows the population of the Ribble Valley (excluding the towns and urban areas) broken down by the household types.

Figure 3: Ribble Valley villages population by Mosaic household types



Using the figure it is possible to consult the Mosaic profiles from which we identified the three household types that we believe are most relevant to this study. These are shown in the table

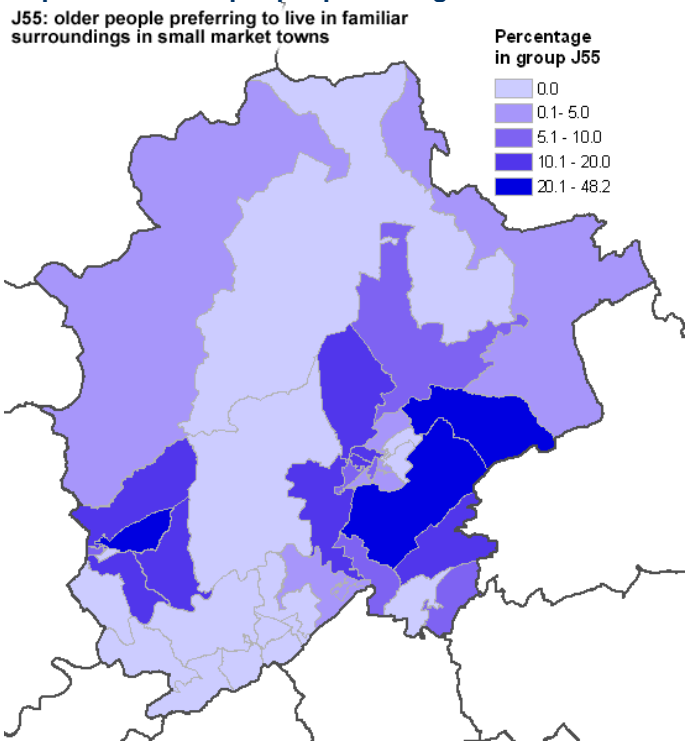
below. Although highlighted as a high risk type in the figure above, J53 was an affluent household type and it was therefore agreed that this meant they were a household type of less risk than the others selected of medium risk. Similarly, type K58 was excluded despite accounting for a large proportion of this population, because they were also a wealthy household type and therefore not considered the most at risk groups.

Table 2: Summary of Mosaic categories and health needs

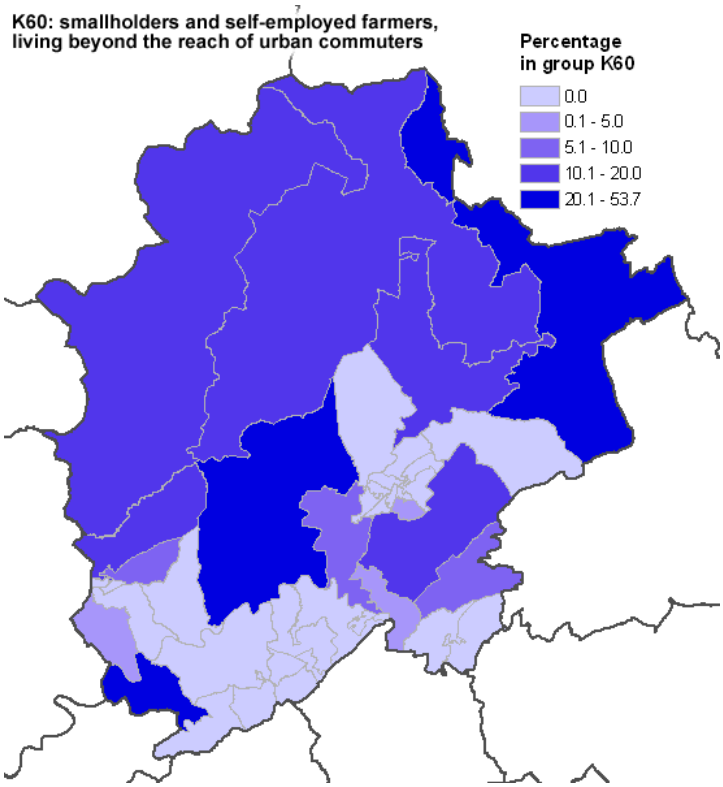
Mosaic sub groups	Health needs
J55 Older people preferring to live in familiar surroundings in small market towns	Good health but likely future need for services
K60 Smallholders and self-employed farmers, living beyond the reach of urban commuters	Good health but potential isolation from services
K61 Low income farmers struggling on thin soils in isolated upland locations	Good health but potential isolation from services

The maps below highlight the concentration of people in the three household types across the district.

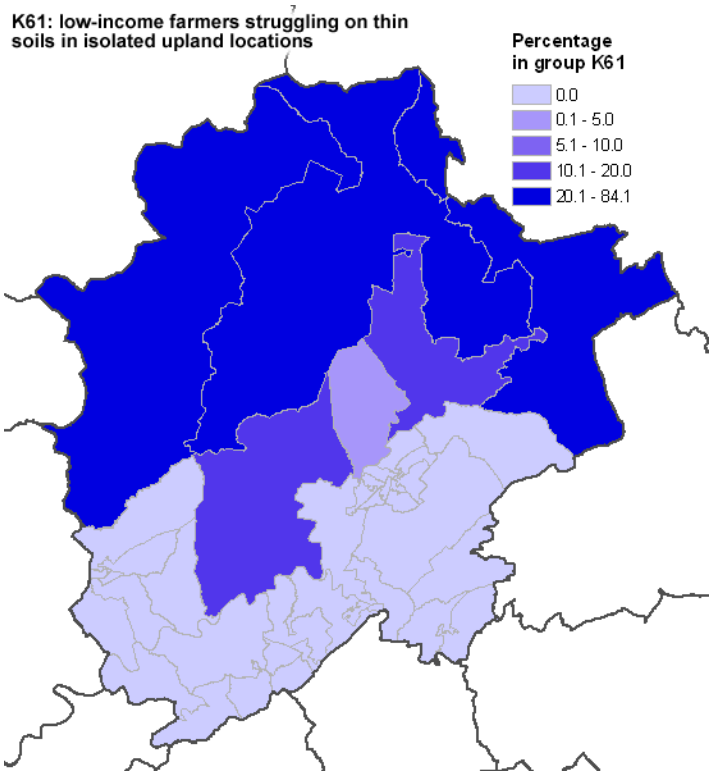
Map 1: J55: older people preferring to live in familiar surroundings in small market towns



Map 2: K60: smallholders and self-employed farmers, living beyond the reach of urban commuters



Map 3: K61: low-income farmers struggling on thin soils in isolated upland locations

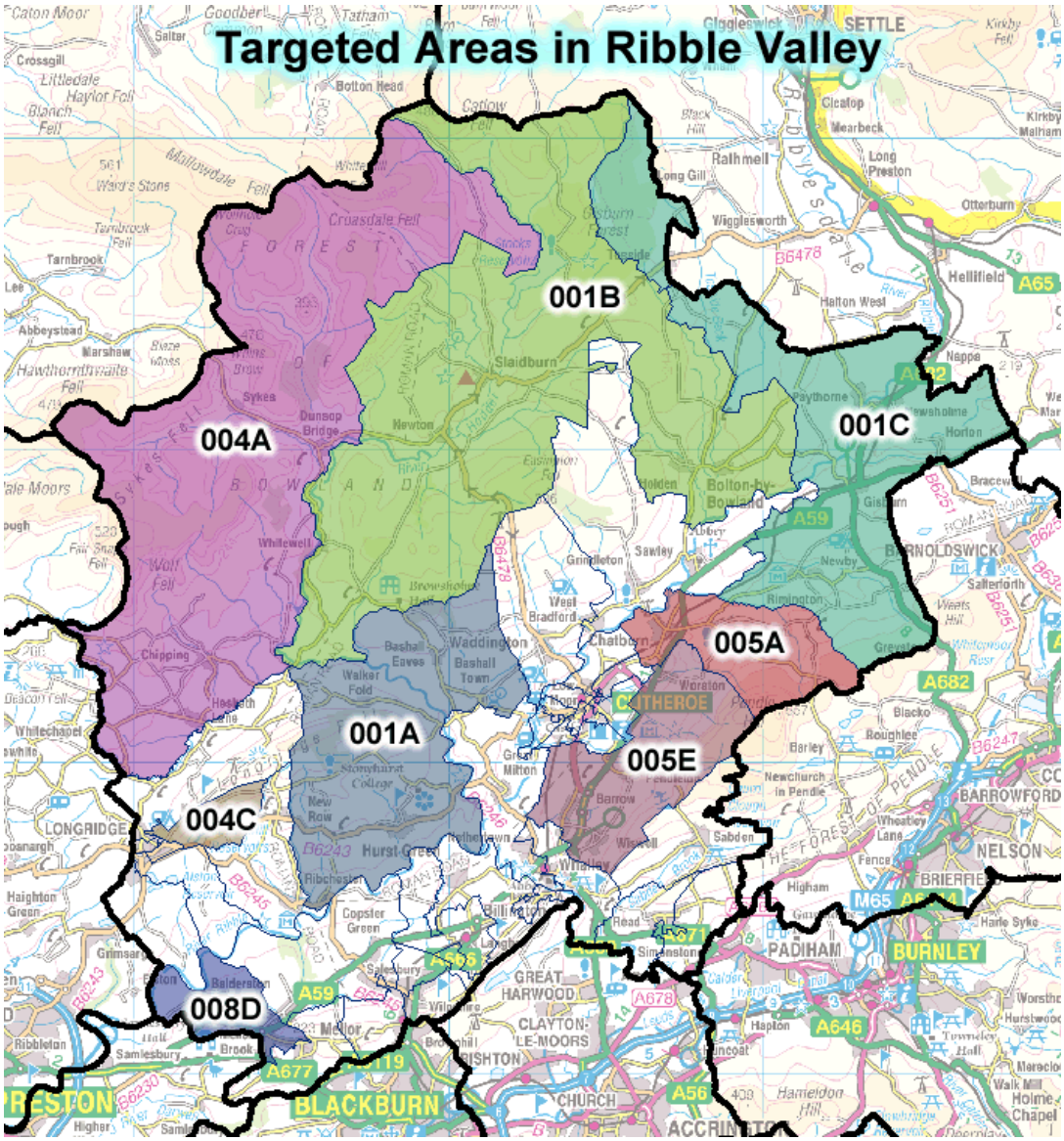


Having identified groups of interest, it is possible to now identify locations of interest. The method used to target the project is on those areas with the highest proportions of the three sub groups – in this case, those with more than a fifth. This approach suggests eight lower super output areas of interest. These are shown in the table below, with the corresponding MSOA, and the map highlighting their position in Ribble Valley. These areas are used for the secondary data analysis in the next chapter.

Table 3: Target LSOA and corresponding MSOAs in Ribble Valley

LSOA	MSOA	MSOA description
Ribble Valley 001A	Ribble Valley 001	Slaidburn, Bolton-by-Bowland, Waddington and Hurst Green
Ribble Valley 001B	Ribble Valley 001	Slaidburn, Bolton-by-Bowland, Waddington and Hurst Green
Ribble Valley 001C	Ribble Valley 001	Slaidburn, Bolton-by-Bowland, Waddington and Hurst Green
Ribble Valley 004A	Ribble Valley 004	Chipping, Dunsop Bridge and Ribchester
Ribble Valley 004C	Ribble Valley 004	Chipping, Dunsop Bridge and Ribchester
Ribble Valley 005A	Ribble Valley 005	Chatburn, Wiswell, Sabden and Read
Ribble Valley 005E	Ribble Valley 005	Chatburn, Wiswell, Sabden and Read
Ribble Valley 008D	Ribble Valley 008	Clayton-le-Dale, Wilpshire and Mellor

Map 4: Target areas in Ribble Valley



Based upon this exercise, villages were chosen by the project team where the primary research to be conducted. The selected villages were:

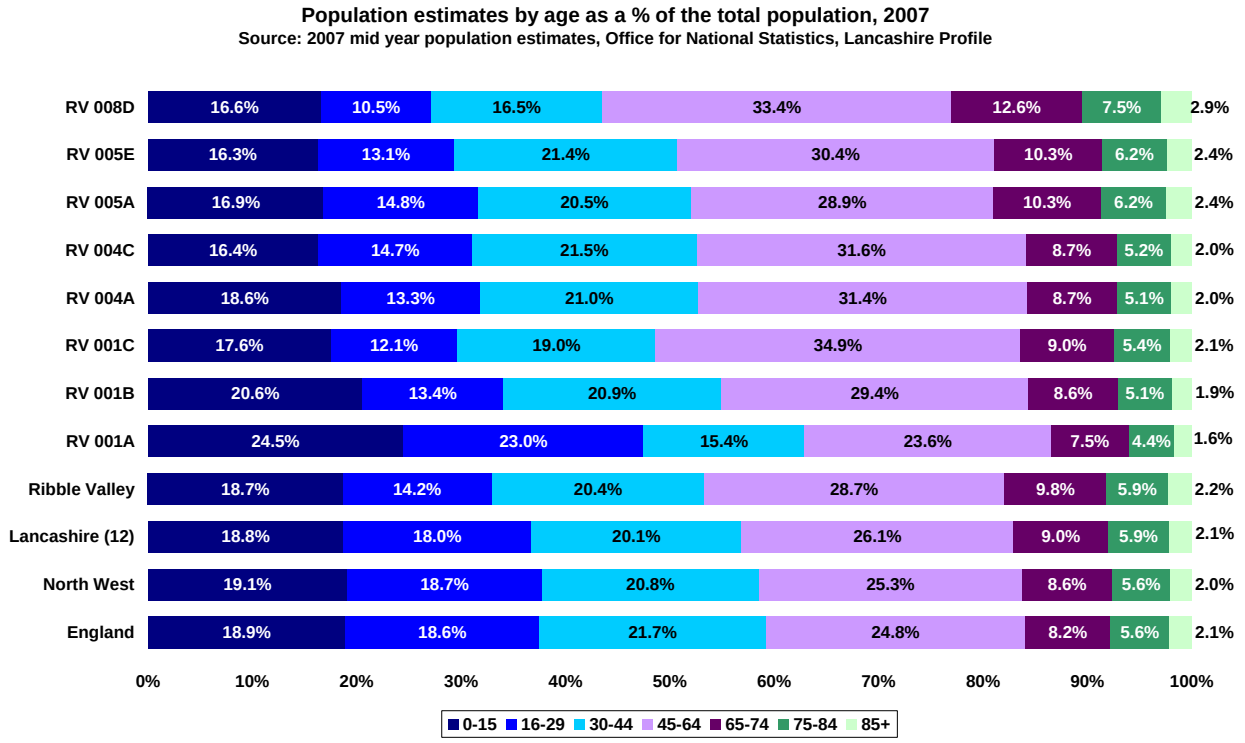
- Waddington
- Ribchester / Hurst Green
- Chipping
- Barrow / Wiswell / Pendleton
- Gisburn
- Downham / Chatburn

- Slaidburn / Newton / Dunsop Bridge
- Balderston / Osbaldeston / Mellor

Demographics of the target area

The chart and table below highlight differing demographics across the target areas. Ribble Valley has an older population than nationally with approximately 45% of the population aged over 45 and almost 18% are aged over 65, compared with 40% and 16%. This trend of an older population is found across all of the target areas with the exception of one LSOA (RV 001A).

Figure 4: Population estimates by age as a % of the total population, 2007



The population estimates suggest that there are 1.935 people aged over 65 living in the target areas, of which 241 are aged over 85 years.

Table 4: 2007 mid year population estimates by age group

	all ages	0-15	16-29	30-44	45-64	65-74	75-84	85+
England	51,094,200	9,673,780	9,487,120	11,106,300	12,670,400	4,196,100	2,864,700	1,095,600
North West	6,879,300	1,313,300	1,284,900	1,428,200	1,738,000	590,000	385,600	139,200
Lancs (12)	1,172,800	219,940	211,060	236,100	306,100	105,700	68,900	25,000
Ribble Valley	58,300	10,900	8,300	11,900	16,727	5,737	3,425	1,311
RV 001A	1,932	473	445	298	456	144	85	32
RV 001B	1,423	293	191	298	418	123	73	27
RV 001C	1,480	260	179	281	517	133	79	30
RV 004A	1,417	263	188	297	446	123	73	28
RV 004C	1,356	222	199	292	429	118	70	27
RV 005A	1,369	231	202	280	396	142	85	33
RV 005E	1,315	214	172	281	400	136	81	31
RV 008D	1,136	189	119	187	379	143	86	33

Source: 2007 mid year population estimates, Office for National Statistics, Lancashire Profile

Health needs analysis

This chapter provides an analysis of routine secondary data sources to establish a picture of needs for the target areas. The analysis is structured around the themes of material deprivation, resilience to inequality and deprivation, health behaviours, accessible, equitable and effective health services, and health outcomes.

Deprivation

Material deprivation is deprivation in physical terms – poor quality housing, a lack of employment opportunities and low incomes are all part of being materially deprived. The links to health are direct and indirect. For example, being cold increases blood pressure and the risk of stroke so reducing fuel poverty through improved houses can have a direct impact. However, there are also indirect impacts. As an example consider a child living in a cold, damp home. Not having anywhere warm to do their homework will have impacts upon the long term achievement of that child and therefore their access to employment. In turn this will affect their life options including health behaviours, which will impact upon their health.

The target areas display low levels of overall deprivation according to the Indices of Deprivation 2010. It is possible that there may be very small pockets of deprivation which are not picked up by the indices and it is of course possible and likely that there will be some people who are experiencing poverty and deprivation that will not be captured. Older people may be more vulnerable to poverty.

One of the indices of deprivation looks at income deprivation affecting older people. This highlights relatively low levels of income deprivation affecting older people in the target areas compared to the rest of England. Ribble Valley 004A is the worst affected of the target LSOAs, with a rank within the worst 40% nationally. As with the overall deprivation measure, it is possible and likely that there are very small pockets of income deprivation with a few older people experiencing relative poverty despite the overall relative affluence of the area.

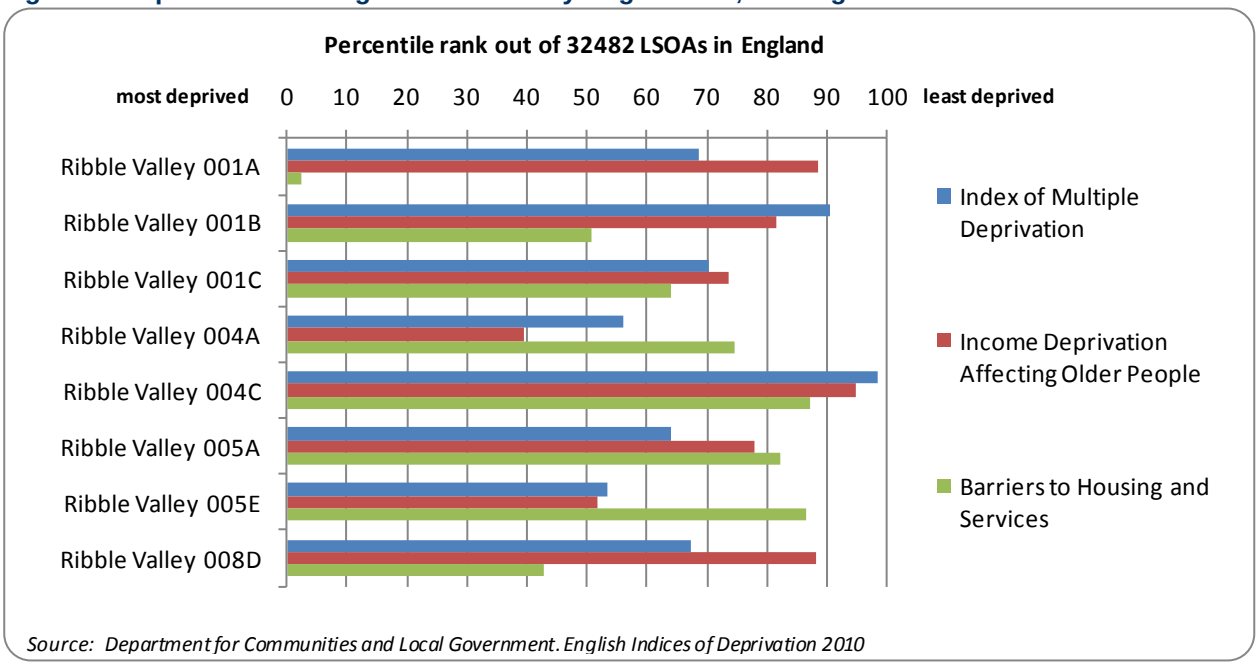
Under the Defra Rural Classification (2009) Ribble Valley is listed as Rural 80 which means: *'districts with at least 80% of their population in rural settlements and larger market towns'.*
http://www.defra.gov.uk/rural/ruralstats/rural-definition.htm

Ribble Valley is a rural area and as such experiences problems related to isolation. Pockets of deprivation which are also rural will experience complex problems.

As a rural area, Ribble Valley experiences greater difficulties in relation to barriers to housing and services, as measured by the Indices of Deprivation 2010. Most of the target areas rank in the least deprived 50% nationally with the exceptions of Ribble Valley 008D which is ranked in the bottom 43% and Ribble Valley 001A ranked in the bottom 2% nationally. People living in the latter area will experience substantial difficulties accessing housing and service. They will probably have to travel a long way to the nearest food store, GP practice, post office and primary school.

The table below shows the relative position of each of the target area LSOAs in terms of the three categories of deprivation previously mentioned. The position is in relation to all LSOAs in England with 100% being the least deprived.

Figure 5: Deprivation ranking of Ribble Valley target areas, ranking out of all LSOAs



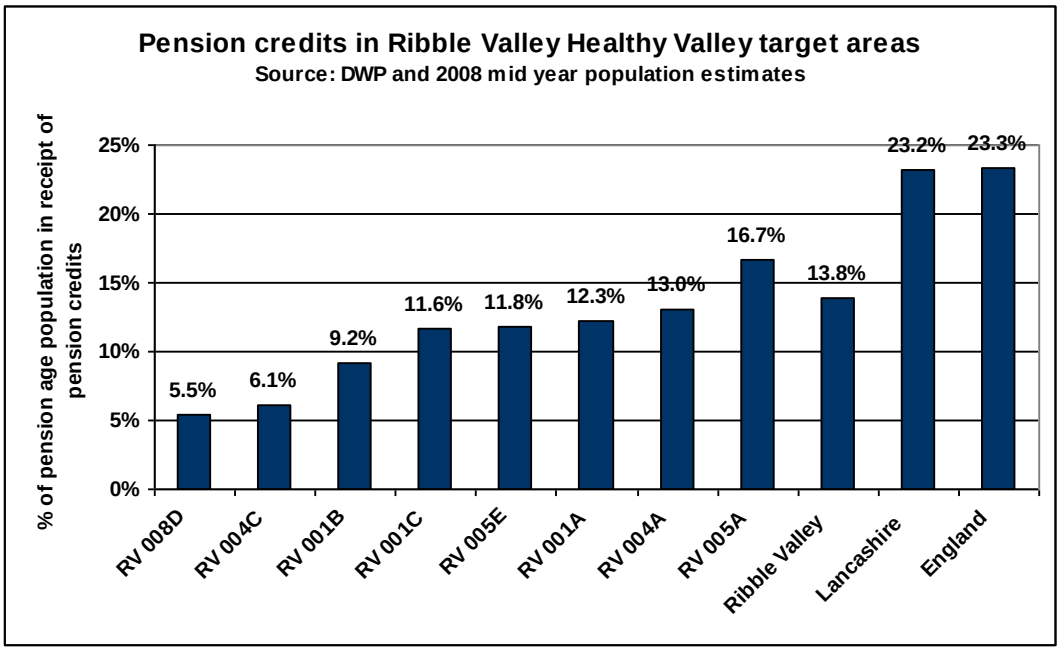
Source: Department for Communities and Local Government. English Indices of Deprivation 2010

Benefits

Pension credits

Less than 14% of Ribble Valley's pension age population are in receipt of pension credits compared with 23% of the county and national populations. This is despite equivalent levels of pension claimants. The uptake of pension credit claimants varies widely from 6.1% to almost 22% of the eligible population across the target area. There may be opportunities to increase the levels of pension credit uptake in several areas of the target areas including RV008D, RV004C, RV001B, RV001C and RV005E as these areas all have levels of take up below the district average.

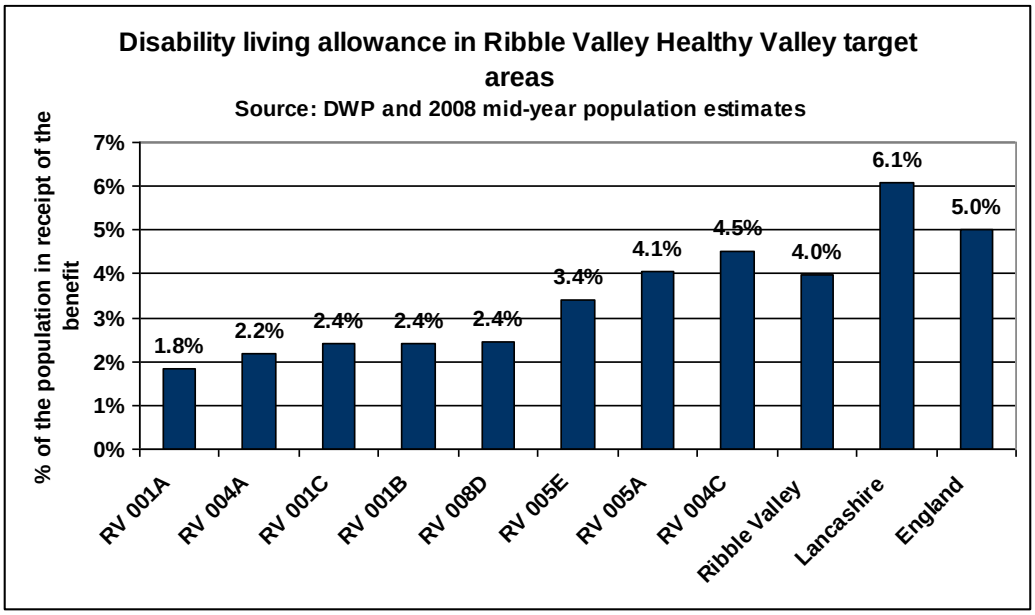
Figure 6: Pension credits in Ribble Valley Healthy Valley target areas



Disability living allowance

Disability living allowance claimant rates in Ribble Valley are lower than the county average (4% versus 6%). Given the older age structure of the Ribble Valley population compared to the Lancashire population we would expect a higher claimant rate and this indicates an opportunity to maximise uptake of this benefit. There are further variations within the target area and only in RV005A and RV004C are DLA claimant rates above the district average. Services may wish to target DLA uptake support in RV001A, RV004A, RV001C, RV001B and RV008D as claimant levels are particular low in these areas.

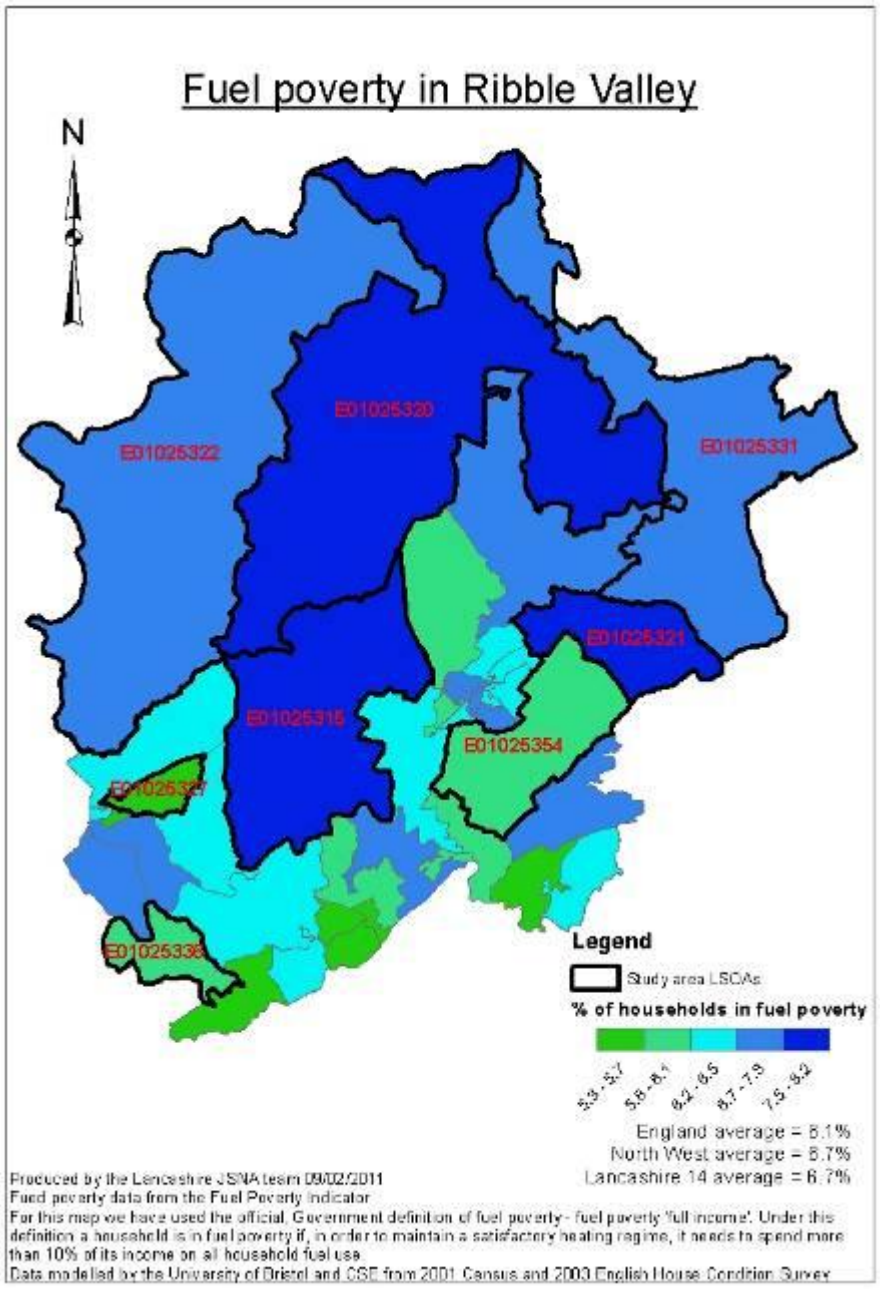
Figure 7: Disability living allowance in Ribble Valley Healthy Valley target areas



Fuel poverty

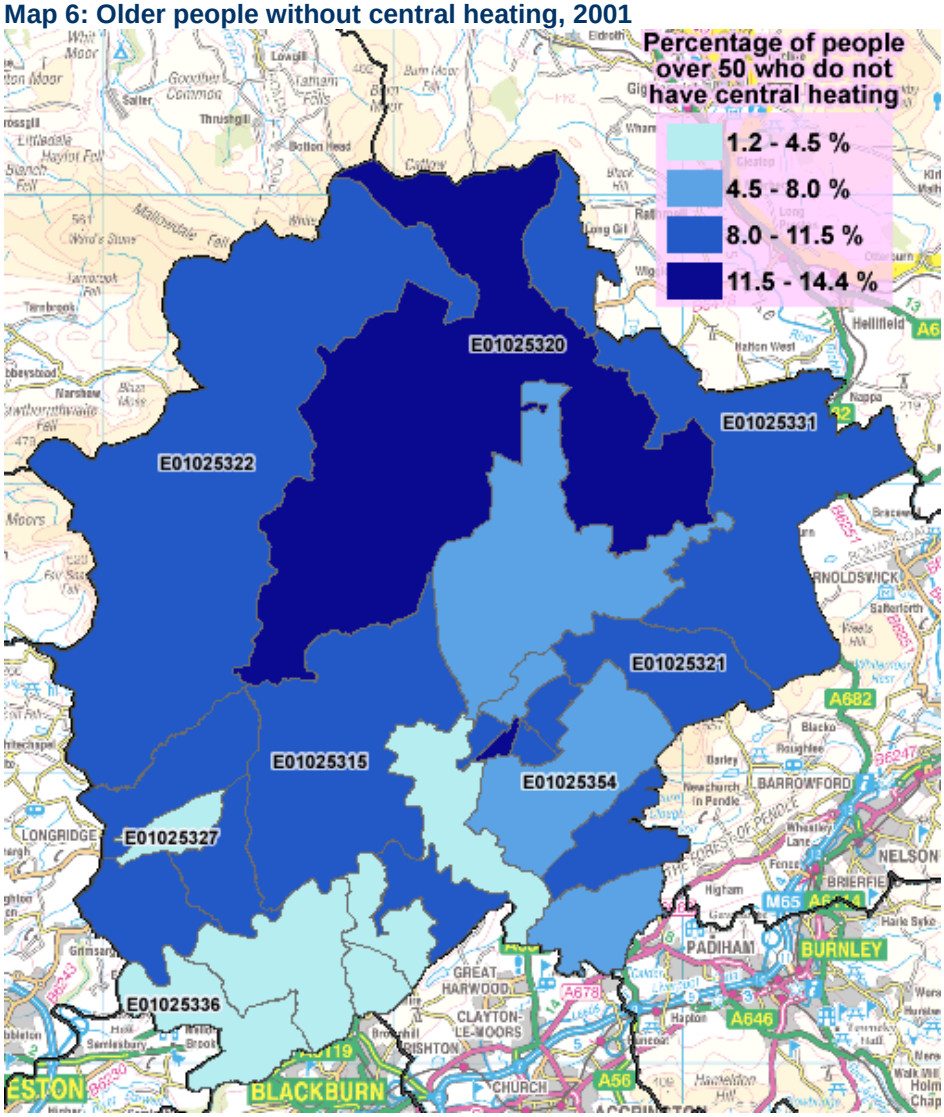
Fuel poverty is defined as the need to spend more than 10% of income on maintaining an acceptable level of heat within a household. According to the 2003 Fuel Poverty Indicator for small areas, there are many areas within the Ribble Valley Healthy Valley target area that experience high levels of fuel poverty, above the national average. Fuel poverty tends to be due to a combination of low income, high fuel prices and under occupancy in homes. Given the significant rises in fuel prices since 2003 it is likely that this has become more, not less, of a problem.

Map 5: Fuel Poverty in Ribble Valley Healthy Valley target areas, 2003



The map highlights relatively high proportions of the population of interest who did not have central heating in their homes at the time of the last Census. Without central heating it is likely that people use single sources of heat such as gas fires. The sudden change in temperature from leaving a hot room and entering a cold one is linked to poor health outcomes related to cardiovascular disease.

Map 6: Older people without central heating, 2001



Source: ONS Census 2001

Resilience to inequality and deprivation

Resilience is an important factor determining health outcomes and health inequalities. It is likely that all people will experience hardship at some point during their lives. Whilst some people are able to deal with the hardships without any impact upon their health and wellbeing, for others difficult times will manifest in reductions in mental wellbeing and physical health. Some people will have greater resilience. The same can be found at a population level. Some communities in severe deprivation will experience poor health whilst some will continue to flourish. Research has suggested that resilience factors play a role in protecting some communities from the health effects of inequality and deprivation.

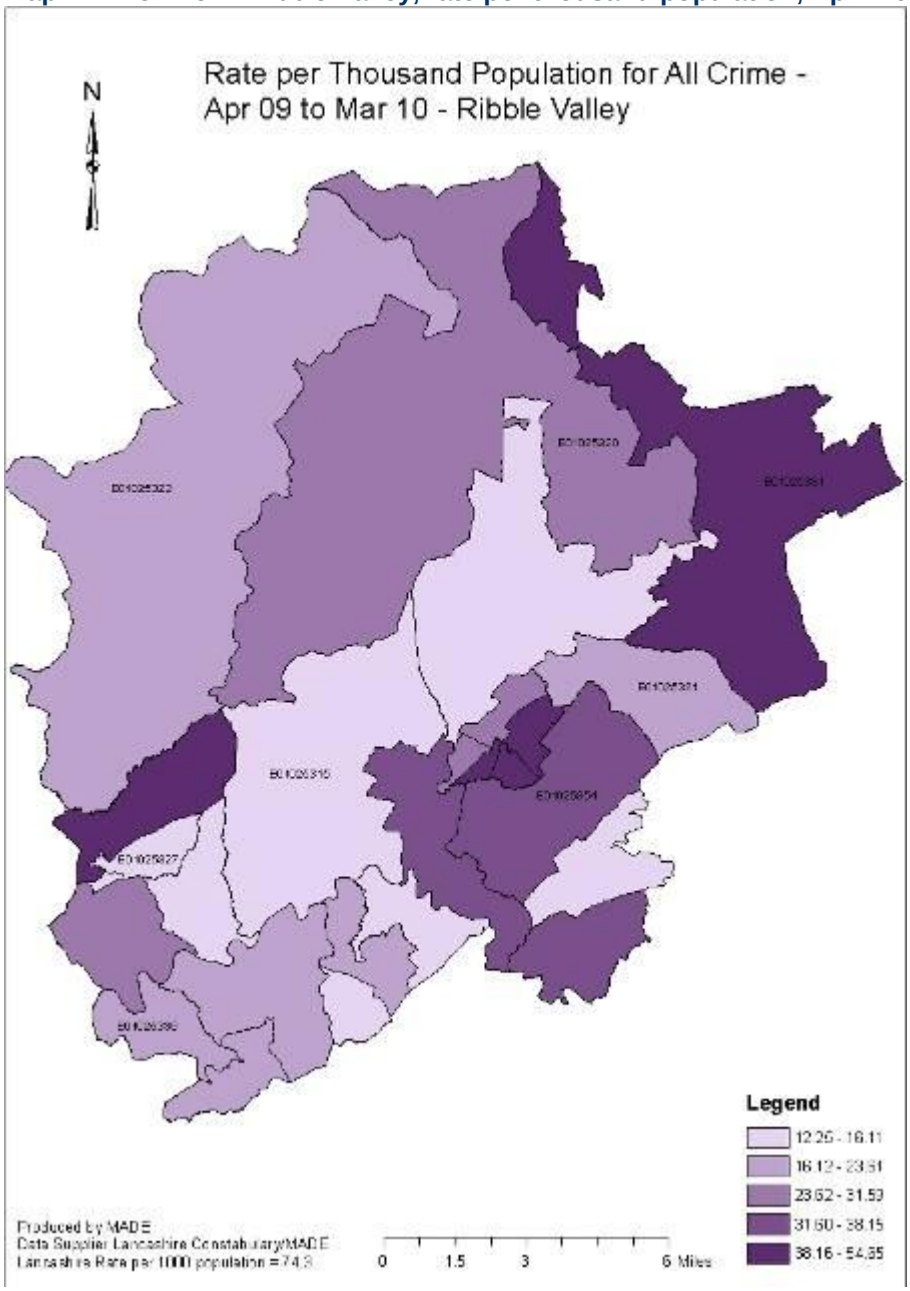
Improved social capital, community cohesion, personal wellbeing, satisfaction with the local area, community safety and personal skills seem to provide this resilience and are all linked to positive health and wellbeing. Areas where there is an active community, where people feel safe, tend to be those where health and wellbeing is highest. This is particularly important as people age as they may be more likely to experience fear of crime and the reduction in employment may be linked to feelings of not being able to contribute and not being valued. Data on social capital is generally unavailable for small areas and therefore none has been presented here.

Community safety

Crime and community safety are important determinants of health. Fear of crime is a particular barrier to physical activity and can prevent people from participating in local community life.

The map below shows the rates of all crime at ward level for the Ribble Valley.

Map 7: All crime in Ribble Valley, rate per thousand population, April 2009 to March 2010

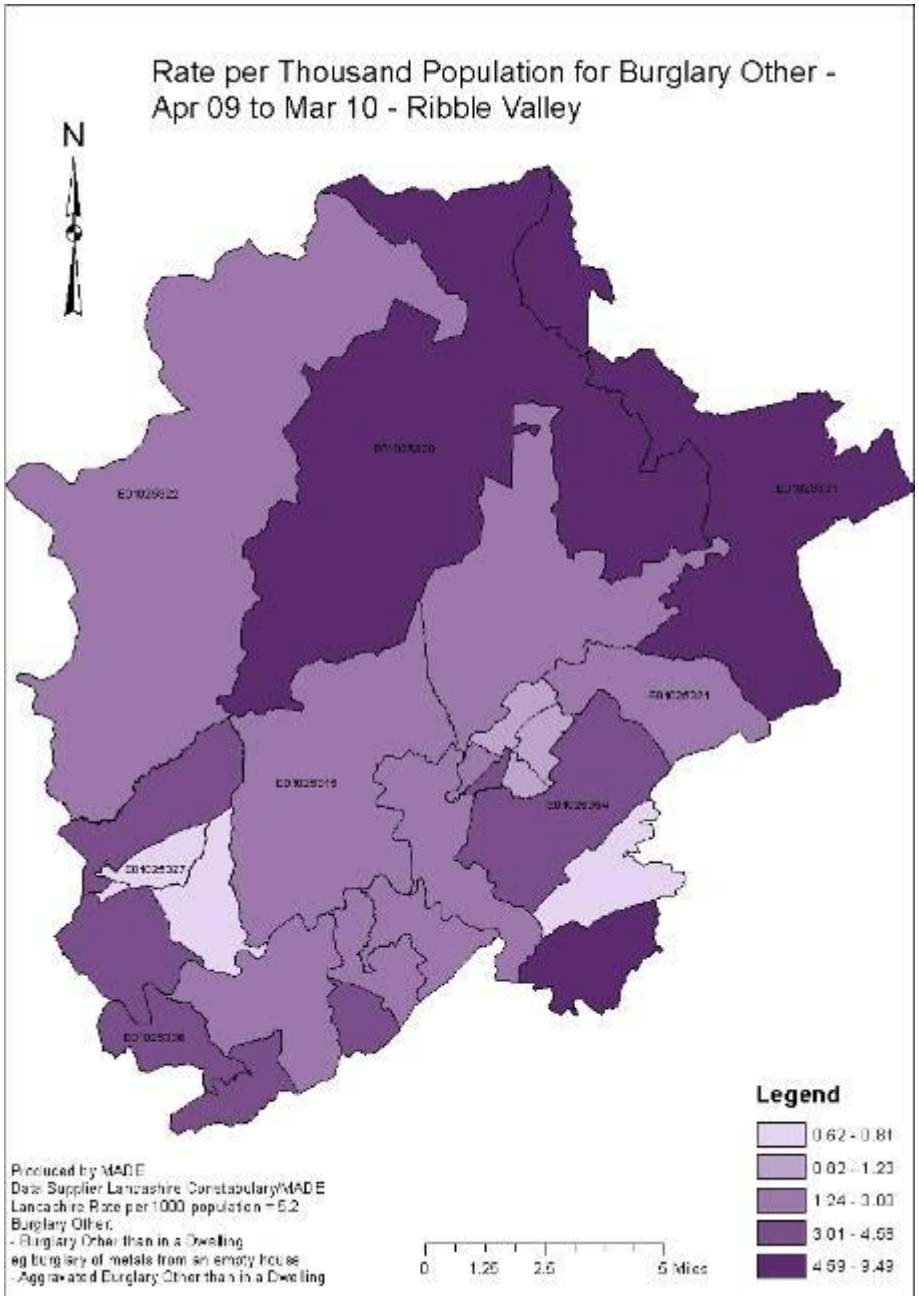


Between April 2009 and March 2010 the top three reported police incidences in Ribble Valley were:

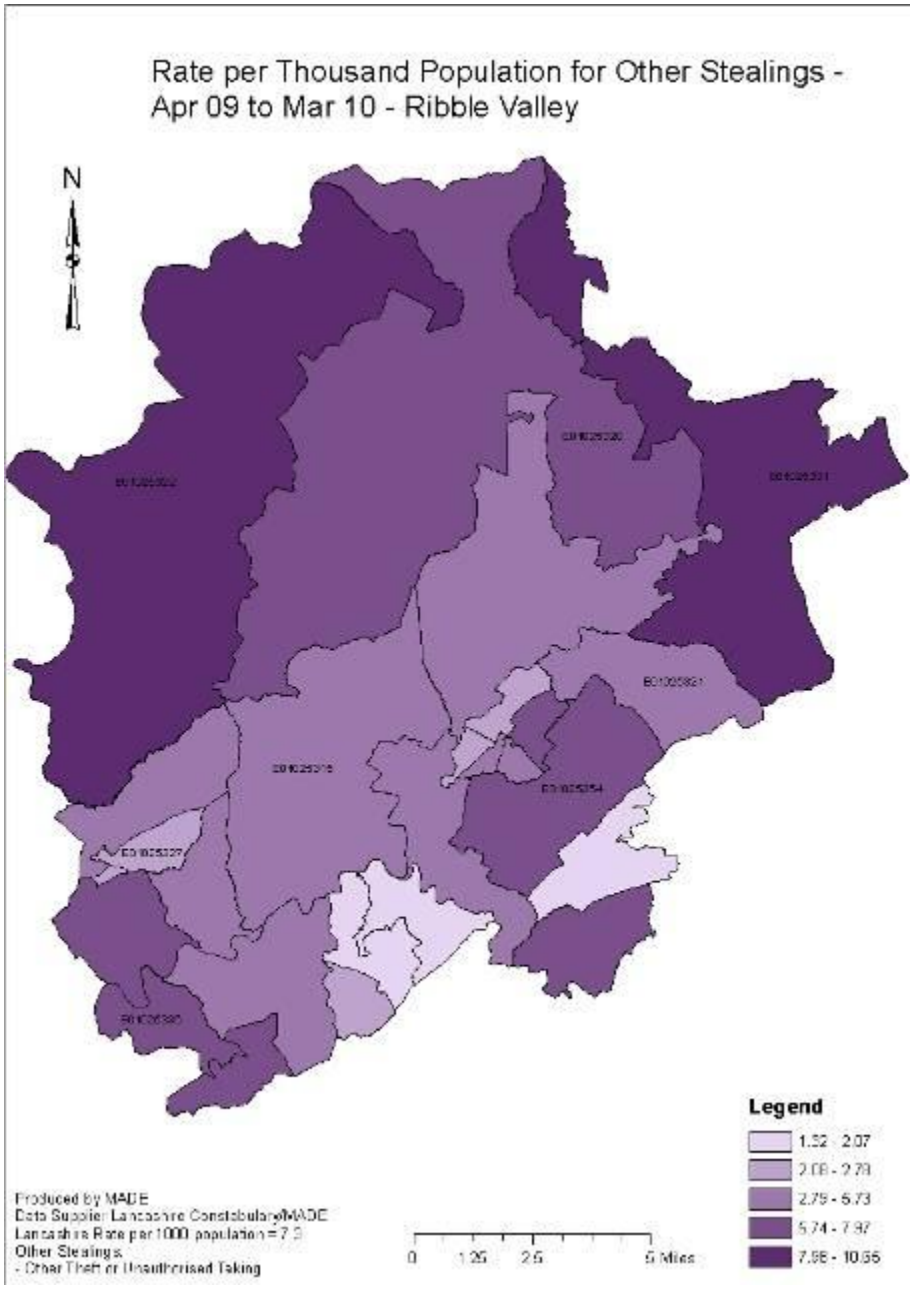
- Burglary other than from a dwelling
- Other stealing
- Assault with less serious injury

The incidence rates of each of these crimes have been mapped below at ward level with the target LSOAs labelled.

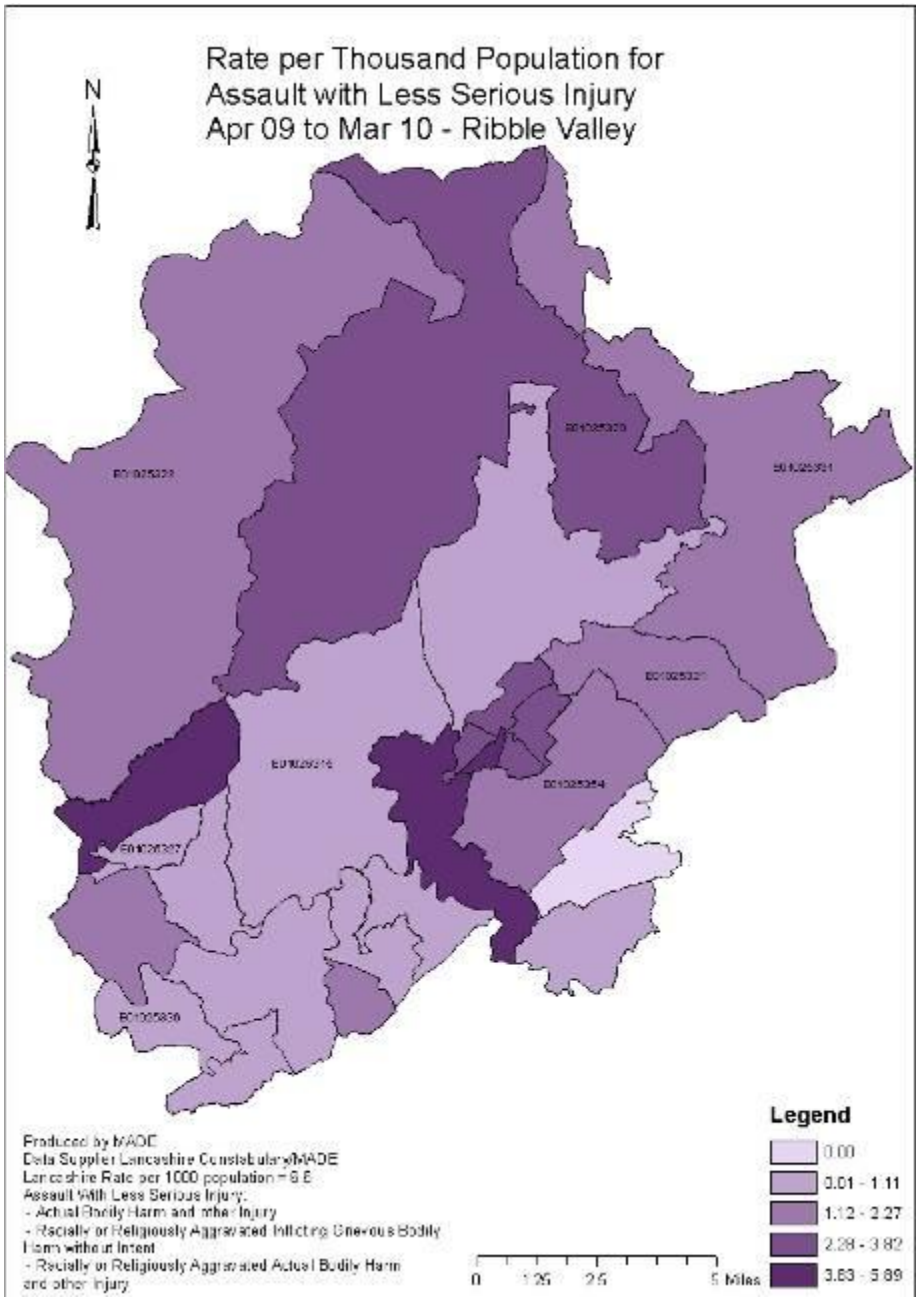
Map 8: Burglary in Ribble Valley, rate per thousand population, April 2009 to March 2010



Map 9: Other stealings in Ribble Valley, rate per thousand population, April 2009 to March 2010



Map 10: Assault with less serious injury in Ribble Valley, rate per thousand population, Apr 09 to Mar 10



- In terms of police incidence rates for the top three crimes in Ribble Valley, the more northerly of the target areas are the worst affected.

- Ribble Valley 004C has the amongst the lowest rates of all three crimes

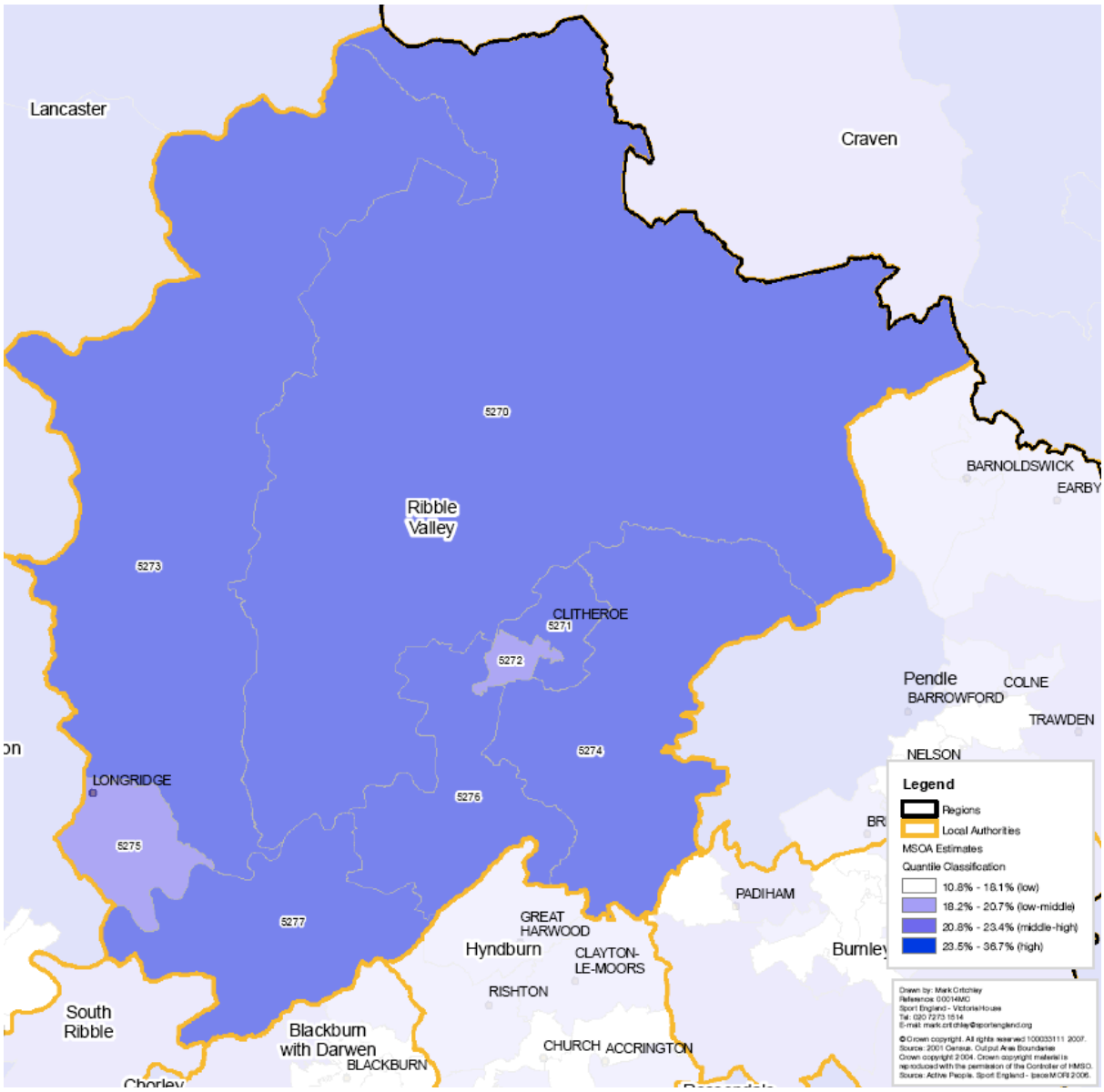
Health behaviour

There is a wealth of evidence to show that individual health behaviours have an impact on a wide range of health outcomes. For example, participating in regular physically activity is known to provide protection from heart disease, stroke and mental health problems. Because of this encouraging healthy behaviour is the basis of both population based interventions such as social marketing campaigns and legislation (e.g. seatbelt, smoke free), and individual support such as stop smoking services and health trainers. Positive health behaviours produce good health, which is not pursued for its own sake but rather because of its use for other things, such as the capability to work, participate in the daily life of society and enjoy leisure time. If these activities are not valued by the population, are not felt to be achievable or if the opportunities to take part in such activities do not exist, the population may decide not to prioritise positive health behaviours despite all the messages they receive about the harms from poor diet, drinking over the recommended limits, smoking and not exercising. Unless people have the full range of opportunities available to them, they may make choices which lead to poor health outcomes. Organisations have responsibilities to make the life chances available which will enable individuals and populations to make healthy choices.

The environment in which people live their lives is known to have a significant impact on the ease with which people can choose healthy behaviours. People who perceive their neighbourhood to be safe and pleasant are significantly more likely to be physically active. Children and young people who live in homes in which adults smoke are more likely to take up smoking themselves. People who live in areas with high concentrations of unhealthy fast food outlets are less likely to eat a healthy diet. Therefore organisations have a responsibility to create environments that make healthy behaviours as easy as possible.

The map below shows the percentage of people doing a minimum of three sessions of moderate physical activity per week at MSOA level, the lighter the colour the least amount of participation.

Map 11: Distribution of participation within sport and physical activity across Ribble Valley



Source: "Sport and Physical Activity in the Ribble Valley", Lancashire Sport Partnership

We can see from the map that most of the areas come into the "middle-high" category, meaning that just over a fifth of people are doing their three 30 minute sessions a week, with the exceptions of the areas surrounding the main towns of Clitheroe and Longridge, where the figures can be as low as 18.2%.

The table below gives the number of operational sports facilities in Ribble Valley, although some of these facilities may be privately run and only available to members of clubs or schools.

Table 5: Sports facilities in Ribble Valley

Type of Facility	Number of facility sites in Ribble Valley
Athletics tracks	1
Golf facilities (includes courses, driving ranges and par 3s)	7
Grass Pitches	140
Health & Fitness Suites	11
Indoor Tennis Centres	1
Ski Slopes	2
Sports Halls	13
Swimming Pools	5
Synthetic Turf Pitches	3

Source: Active Places export (Dec 09), Lancashire Sport Partnership

The chart below shows the most common types of sports clubs in Ribble Valley. Football comes out on top with a total of 15 clubs. As we would expect, equestrian clubs seem to be fairly popular too.

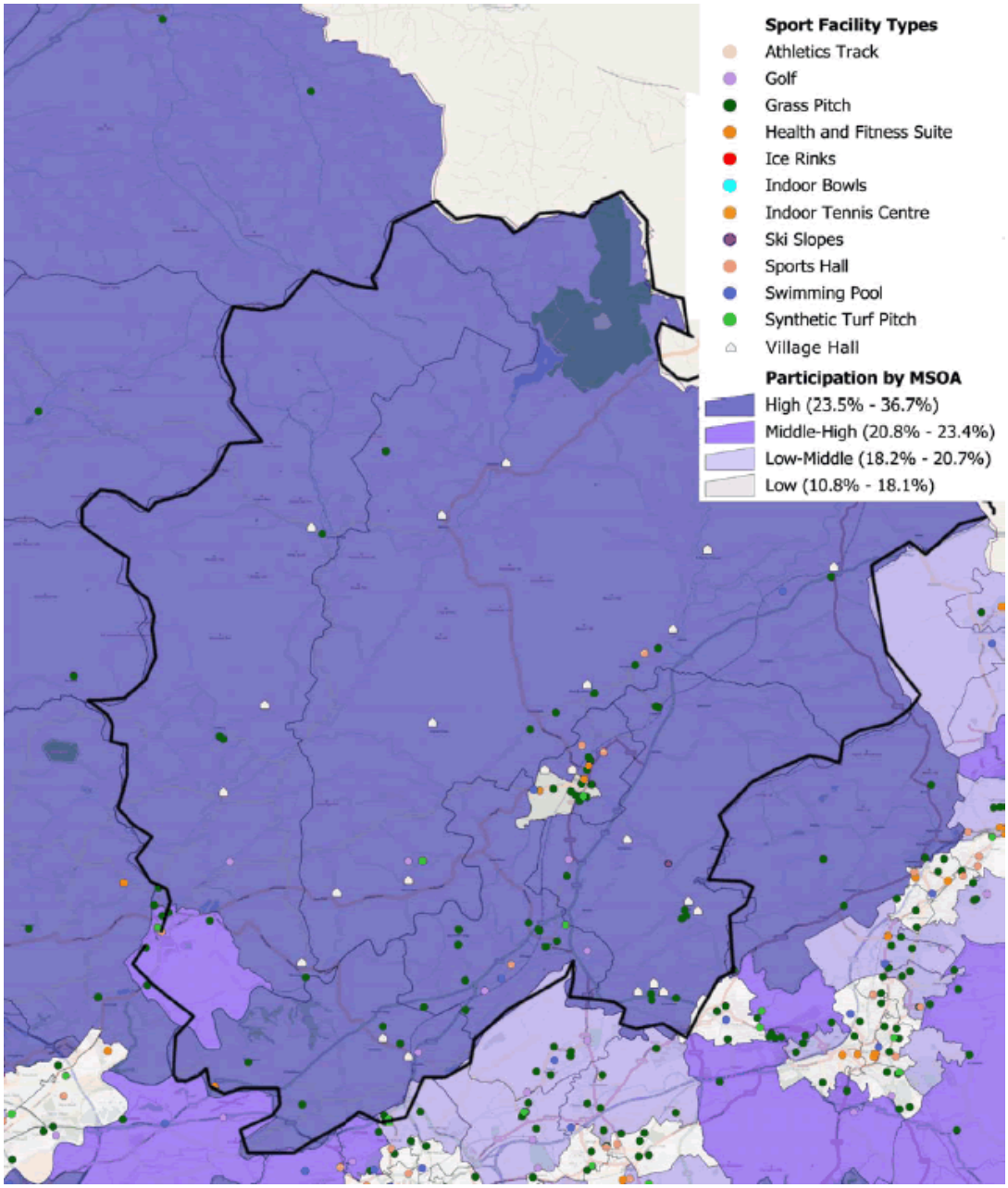
Table 6: Number of sports clubs in Ribble Valley

Rank	Sport	Quantity
1	Football	15
2	Cricket	11
3	Bowls	8
4	Golf	6
5	Tennis	4
6	Equestrian	3
7	Badminton	2
8	Hockey	2

Source: "Sport and Physical Activity in the Ribble Valley", Lancashire Sport Partnership

The map below shows sports facilities in Ribble Valley and their relationship to levels of participation as identified by the Active People Survey 2 (2007-2008).

Map 12: Location of sports facilities and levels of participation within sport and physical activity

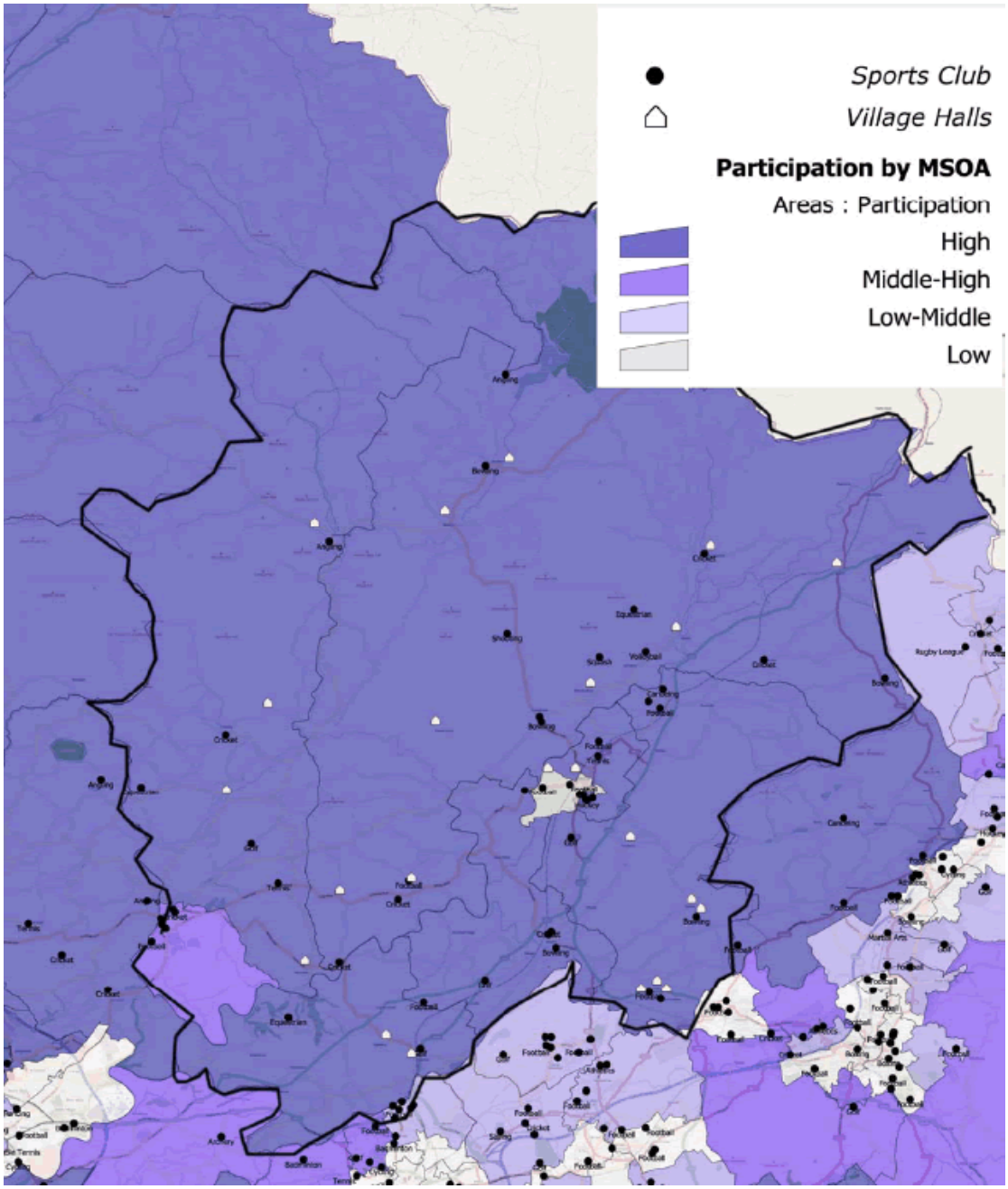


Source: "Sport and Physical Activity in the Ribble Valley", Lancashire Sport Partnership

The most notable thing about the map is that despite the wealth and breadth of sports facilities in and around Clitheroe, participation was low with between 10.8% and 18.1% of people getting their three 30 minute sessions of physical activity per week. This compares to as much as 36.7% of people achieving this target in the more rural areas where less facilities are available.

A similar picture is seen in the map below which shows participation levels and sports clubs. This lack of participation in the towns may be linked to a combination of financial deprivation and high membership or participation fees but the inequity should be investigated further.

Map 13: Location of sports clubs in relation to levels of participation in sport and physical activity



Source: "Sport and Physical Activity in the Ribble Valley", Lancashire Sport Partnership

Accessible, equitable and effective support services

One aspect to reducing health inequalities is to ensure that the services we provide are available, accessible and effective to all of those who need them irrespective of socio-economic status, ethnicity, etc. For example, ensuring that annual asthma checks are completed for all on the GP disease registers will spot potential problems which, if not spotted, could lead to an emergency hospital admission. Similarly, ensuring affordable warmth interventions are available to those who need them most will have impacts, for example by reducing blood pressure and preventing stroke.

Take up of the flu vaccine across East Lancashire is slightly lower than the North West and England average with approximately 28% of the at-risk population not getting vaccinated. This could be due to a number of reasons including poor access to GP practices. This is certainly an area for further investigation and an opportunity exists to increase awareness and promotion of the vaccination programme, perhaps through mobile facilities such as the Services to a Neighbourhood (STAN) bus.

Table 7: Percentage of persons aged 65 and over immunised against influenza, by primary care trust:

PCT Code	PCT Name	Percentage Immunised during October 2007 - January 2008
5CC	Blackburn with Darwen PCT	73
5HP	Blackpool PCT	72
5NF	North Lancashire PCT	76
5NG	Central Lancashire PCT	75
5NH	East Lancashire PCT	72
	North West	74
	England	74

Source: NCHOD

GP practices serving the target area

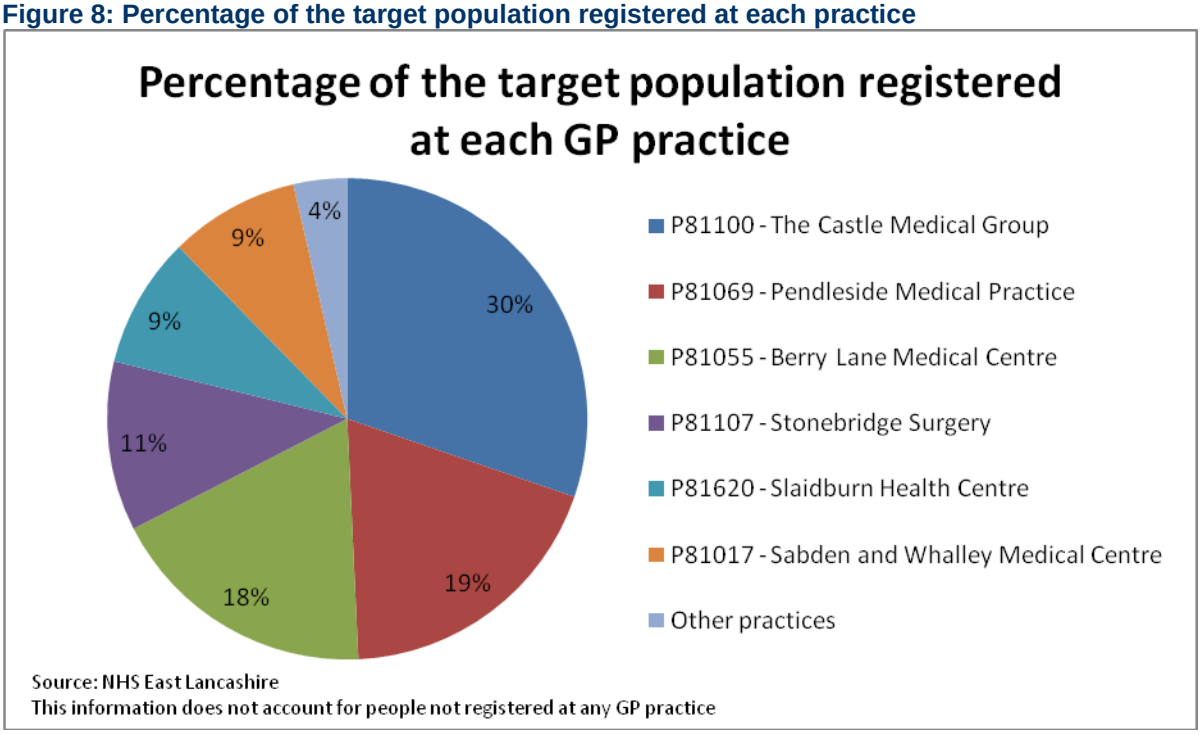
Residents of the eight LSOAs most at risk of isolation are registered at a total of 30 GP practices. Over 95% of these people are registered six particular practices and for that reason the analysis at GP practice level focuses on these as shown in the table below.

Table 8: GP practices of the residents of the target area

Practice code	Practice name	Number of registered patients from the eight LSOAs
P81100	The Castle Medical Group	3024
P81069	Pendleside Medical Practice	1900
P81055	Berry Lane Medical Centre	1819
P81107	Stonebridge Surgery	1138
P81620	Slaidburn Health Centre	880
P81017	Sabden And Whalley Medical Centre	875

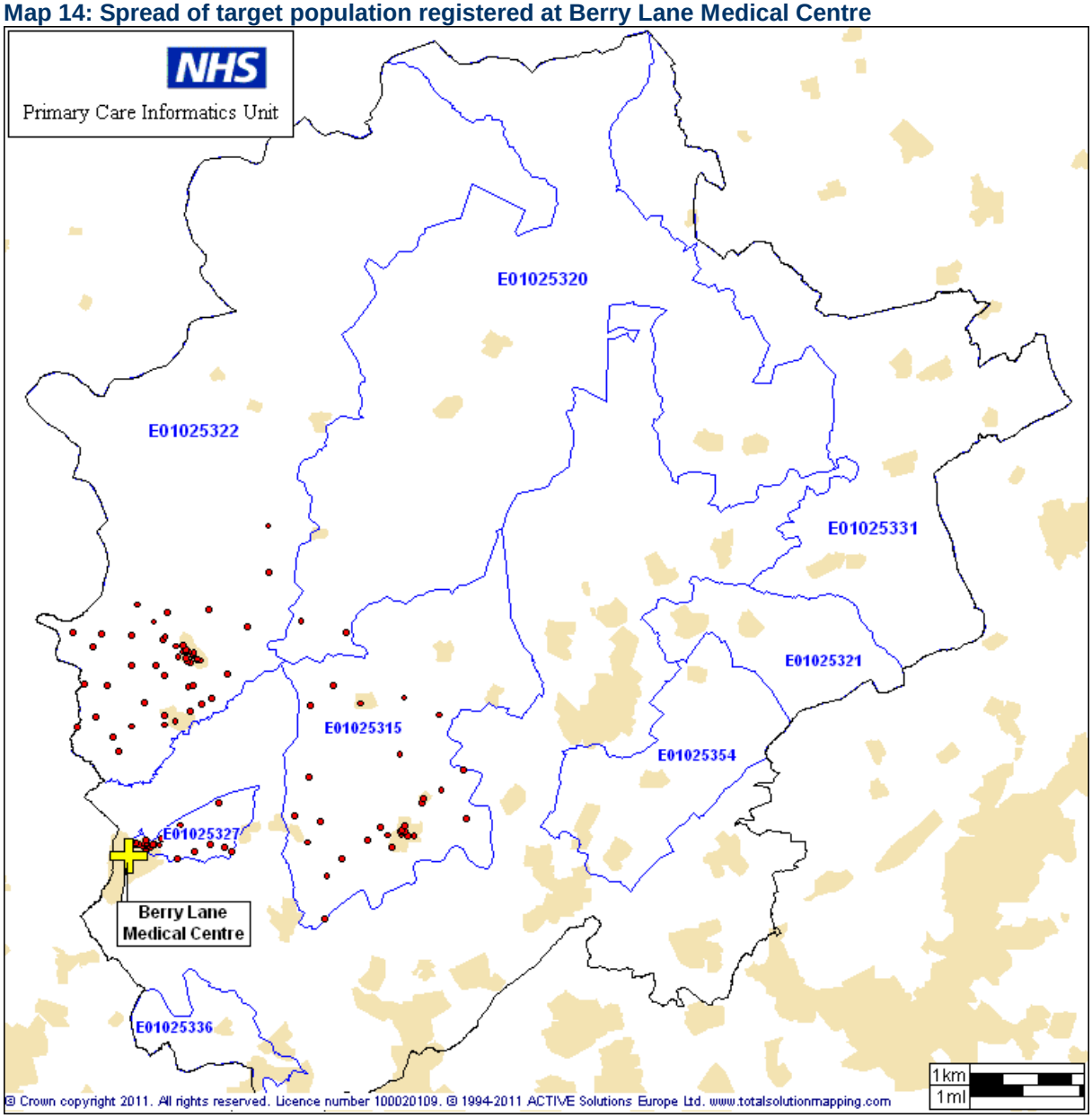
Source: NHS East Lancashire

Figure 8: Percentage of the target population registered at each practice

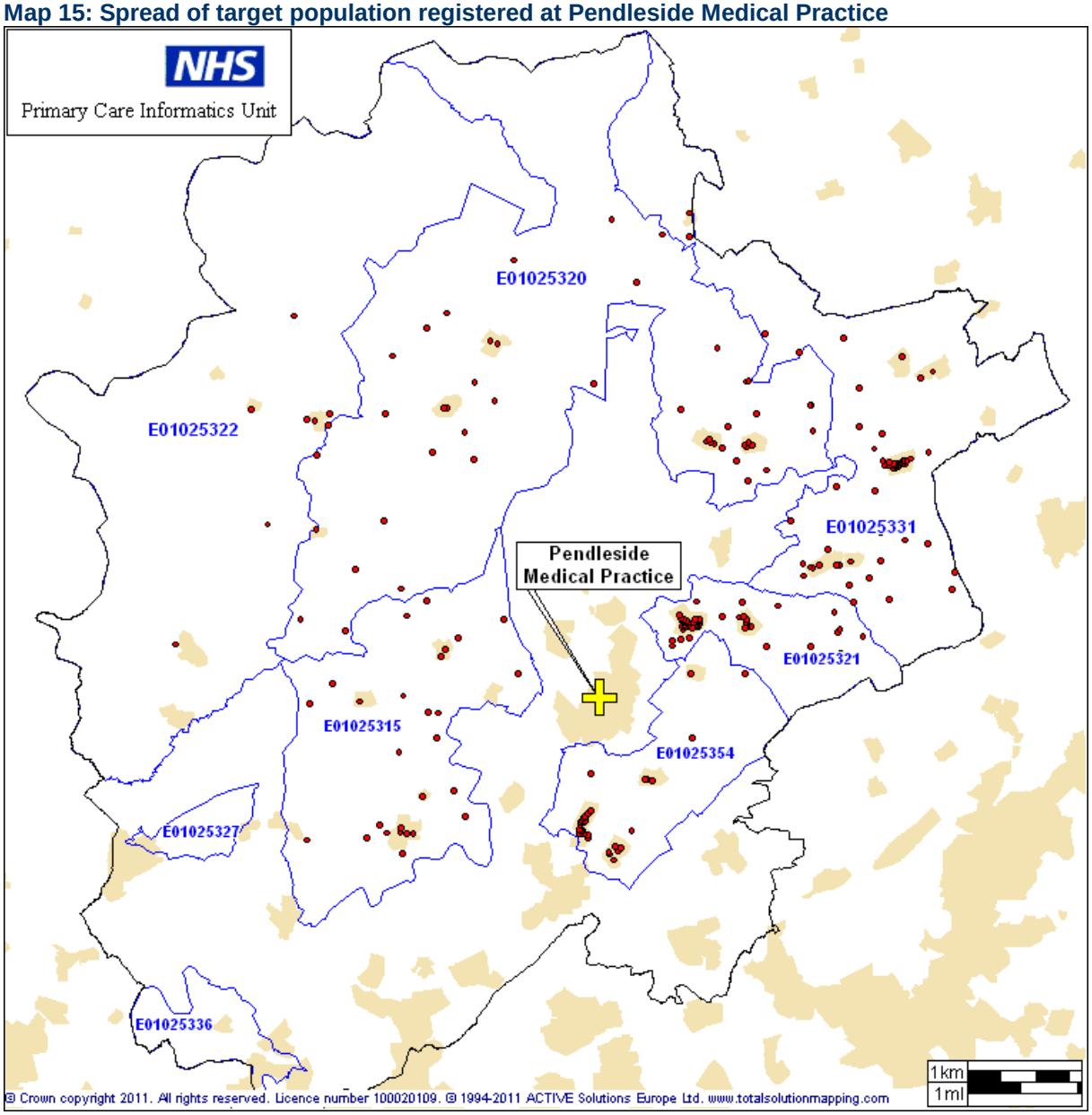


The maps below shows patients registered with each of the six main practices. Each red dot represents a post code centre point in which a patient resides.

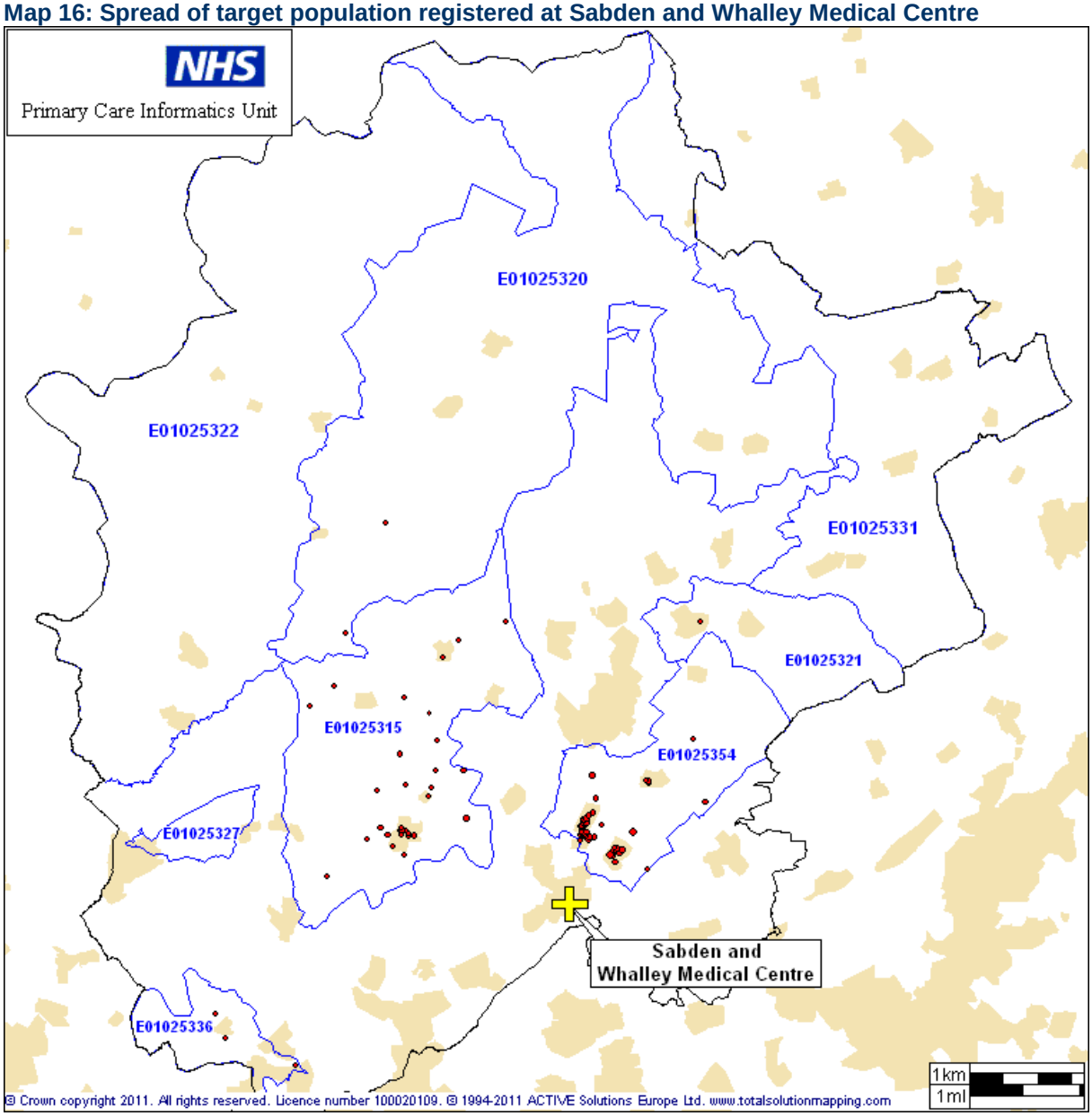
Map 14: Spread of target population registered at Berry Lane Medical Centre



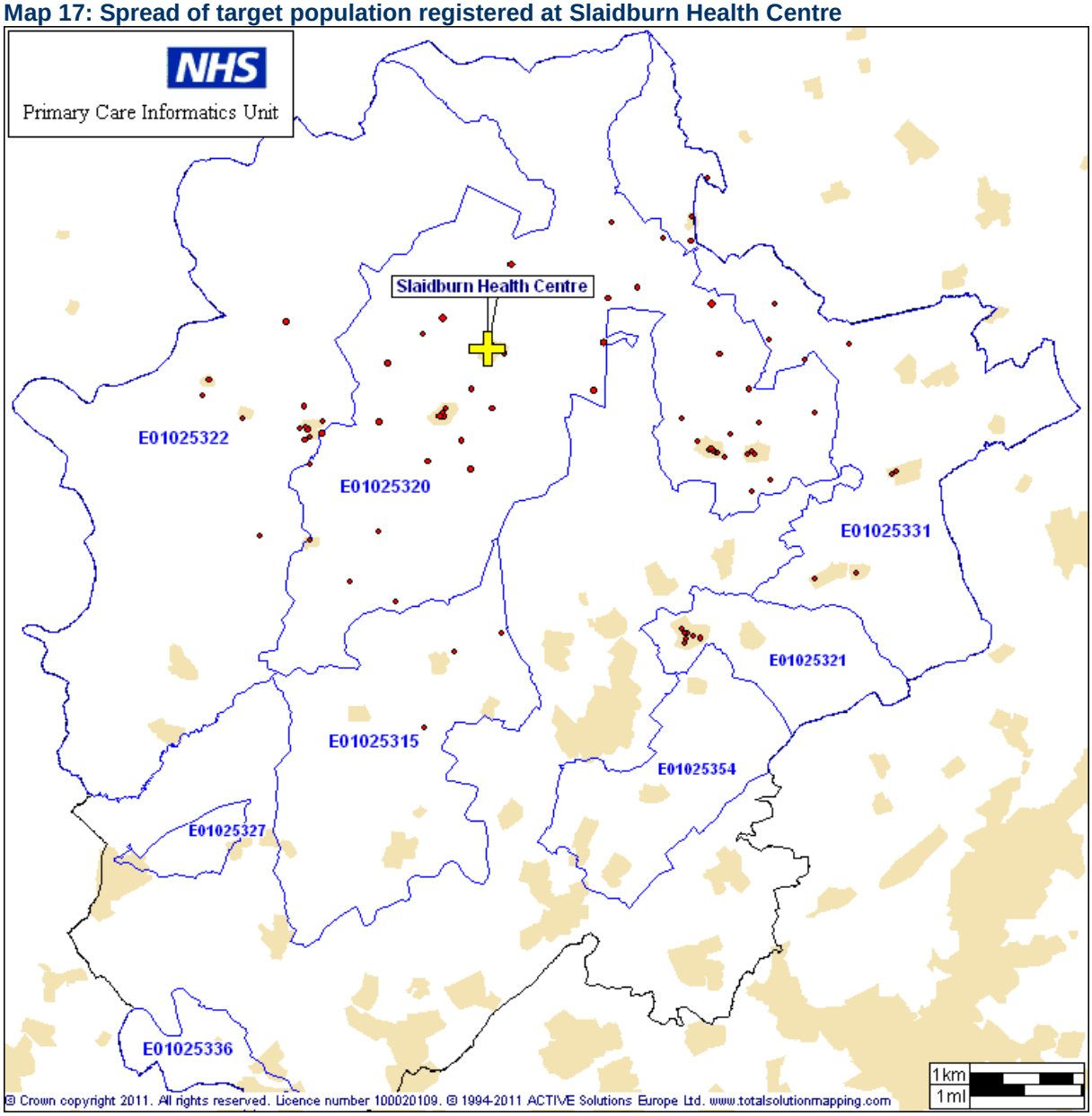
Map 15: Spread of target population registered at Pendleside Medical Practice



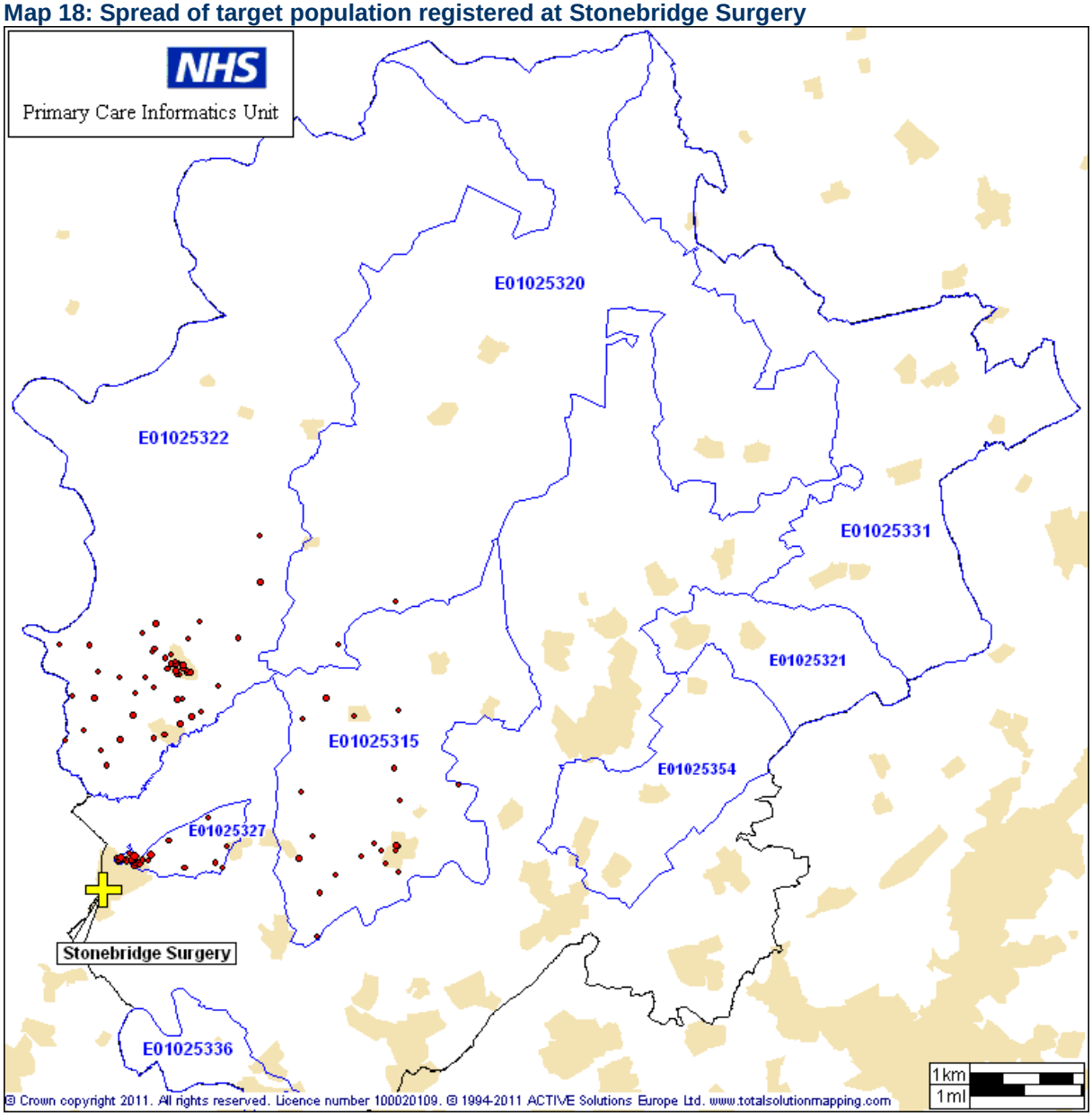
Map 16: Spread of target population registered at Sabden and Whalley Medical Centre



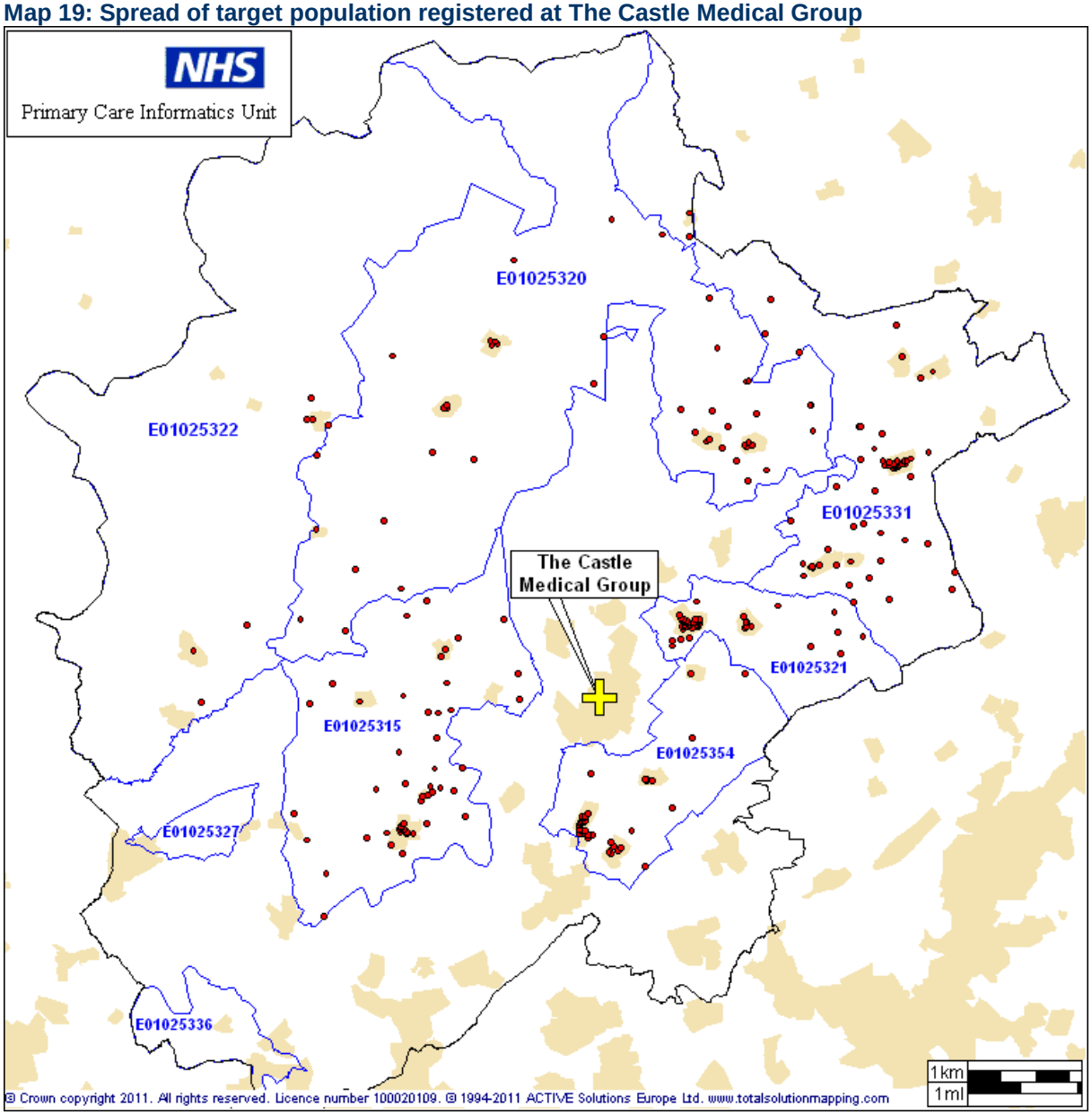
Map 17: Spread of target population registered at Slaidburn Health Centre



Map 18: Spread of target population registered at Stonebridge Surgery



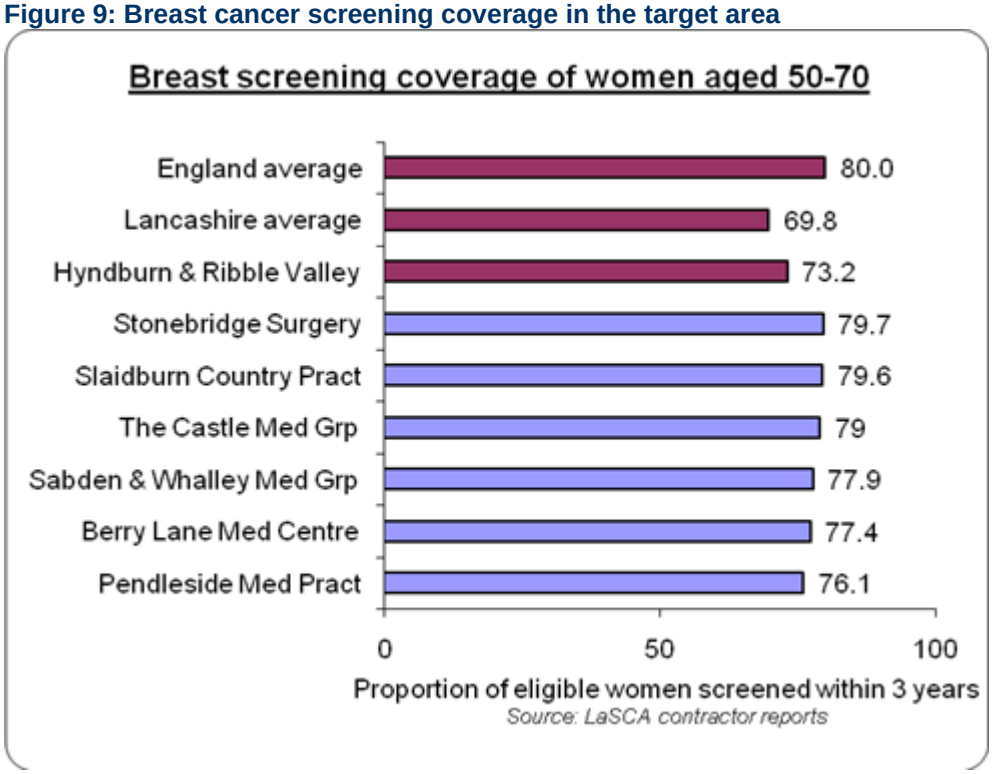
Map 19: Spread of target population registered at The Castle Medical Group



Screening services

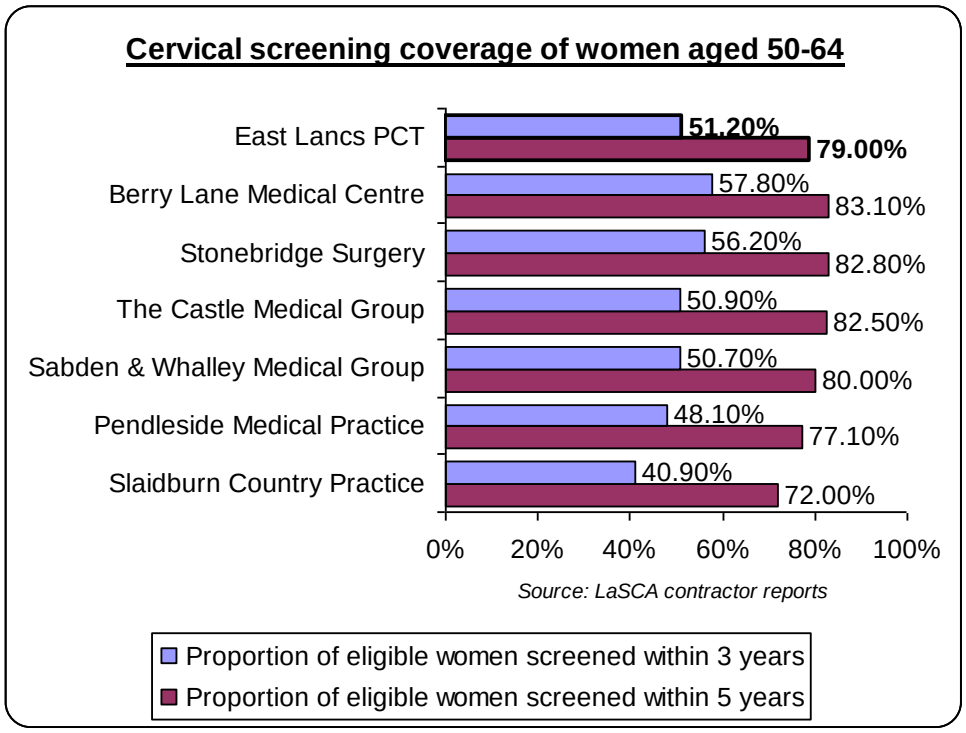
The target areas have fairly good breast screening coverage compared to Lancashire as a whole but these are below the national target of 80%. Pendleside Medical practice comes out worst with 76.1% of those who are eligible recorded as being screened.

Figure 9: Breast cancer screening coverage in the target area



Cervical screening sees a much more varied uptake, especially for those screened within three years where the Slaidburn Country Practice recorded just 40.9% uptake versus Berry Lane with 57.8%. The national target for those screened within 5 years is 80% and whilst several surgeries meet or exceed this target, the rates of eligible women screened are much lower in Pendleside Medical Practice and Slaidburn Country Practice.

Figure 10: Cervical cancer screening coverage in the target area

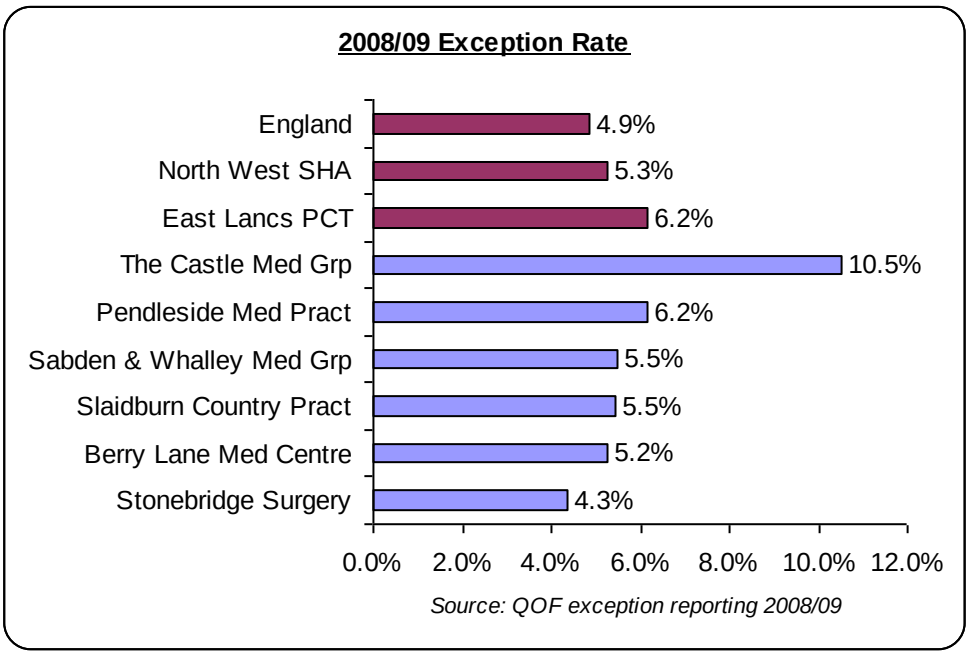


Exception reporting

Exception reporting allows practices to pursue the quality improvement agenda without being penalised if patients do not attend for a review or where a medication cannot be prescribed due to a contraindication or side effect. For the purposes of this report it has been used as a proxy for non-attendance for medical reviews.

We can see from the chart that The Castle Medical Group had a much higher exception rate than the other practices, and wider comparators.

Figure 11: Exception reporting by GPs serving the target population

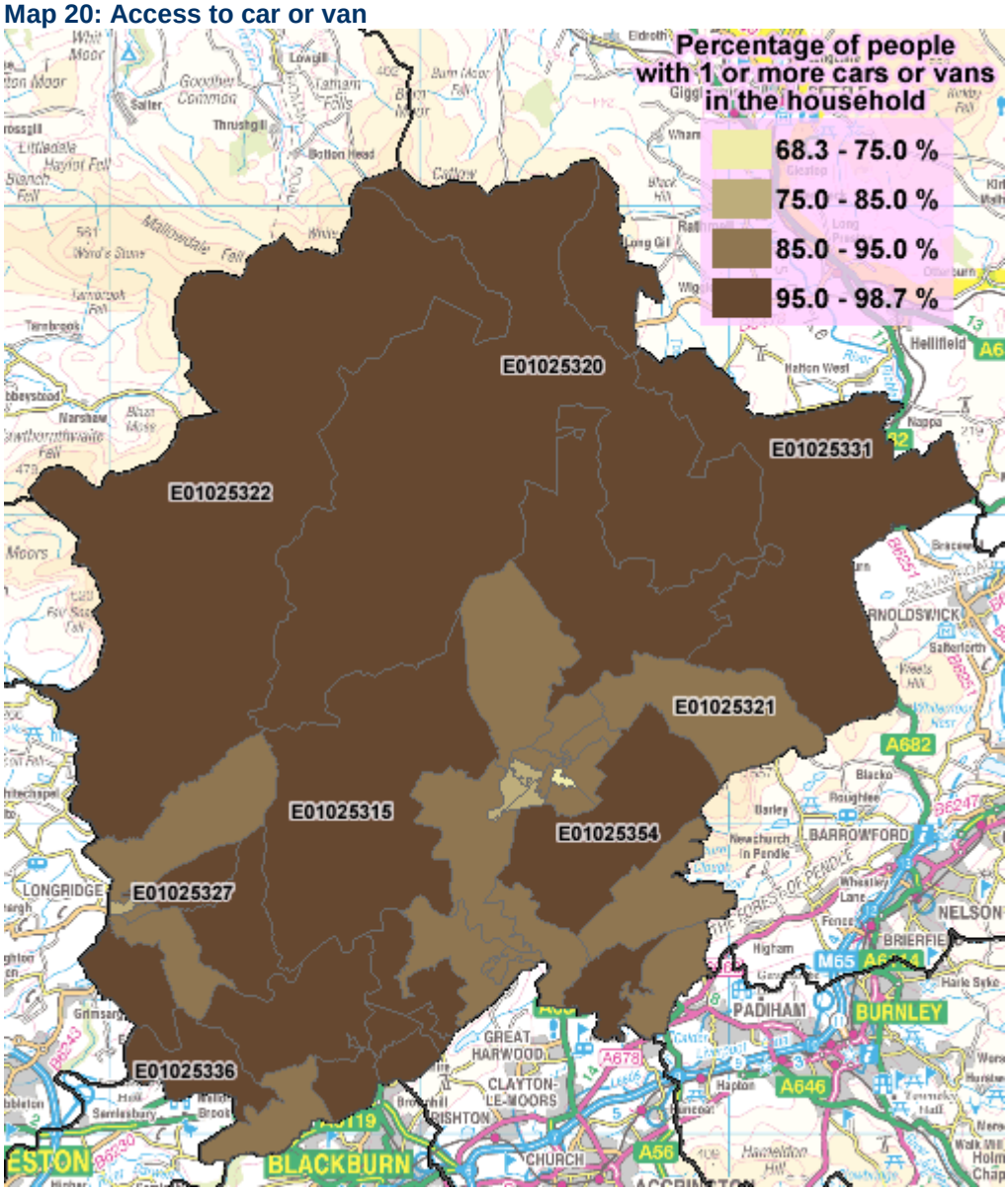


Variations in access to services and exception reporting practices by surgery should be investigated to determine whether they are appropriate.

NHS and social care services are not exclusively relevant here though, physical access to services is important, which links to the quality of public transport services. How people feel about services will affect their level of access. If services are perceived to treat people unfairly uptake of those services will be affected, whether reality matches the perception or not.

The map below shows the percentage of people with access to at least one vehicle. The target areas are labelled.

Map 20: Access to car or van



Source: ONS Census 2001

Ribble Valley 005A has the lowest percentage of household vehicle access out of the target areas with between 5% and 15%of households without access to a car or van. Ensuring these people are supported to access services will help to prevent inequalities and poor health outcomes.

Health outcomes

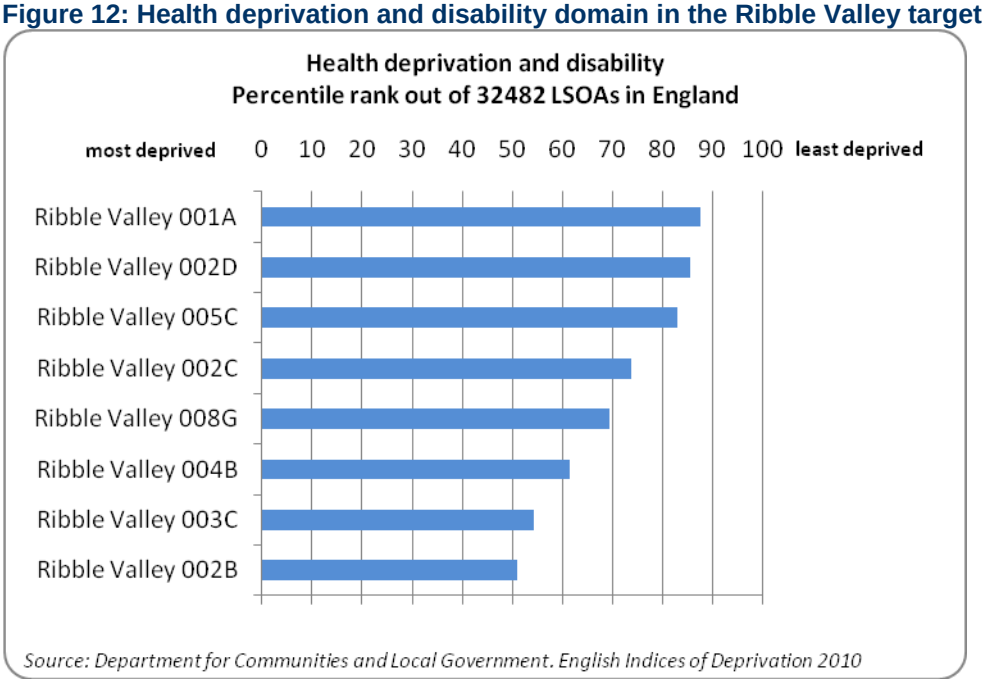
Health deprivation and disability

The health deprivation and disability domain of the Indices of Deprivation looks at the following indicators:

- Years of Potential Life Lost: An age and sex standardised measure of premature death.
- Comparative Illness and Disability Ratio: An age and sex standardised morbidity/disability ratio.
- Acute morbidity: An age and sex standardised rate of emergency admission to hospital.
- Mood and anxiety disorders: The rate of adults suffering from mood and anxiety disorders.

The chart shows that all of the target areas rank in the least deprived 50% for this domain compared to all LSOAs in England as measured by the Indices of Deprivation 2010, although there is a marked variation between the eight super output areas.

Figure 12: Health deprivation and disability domain in the Ribble Valley target area

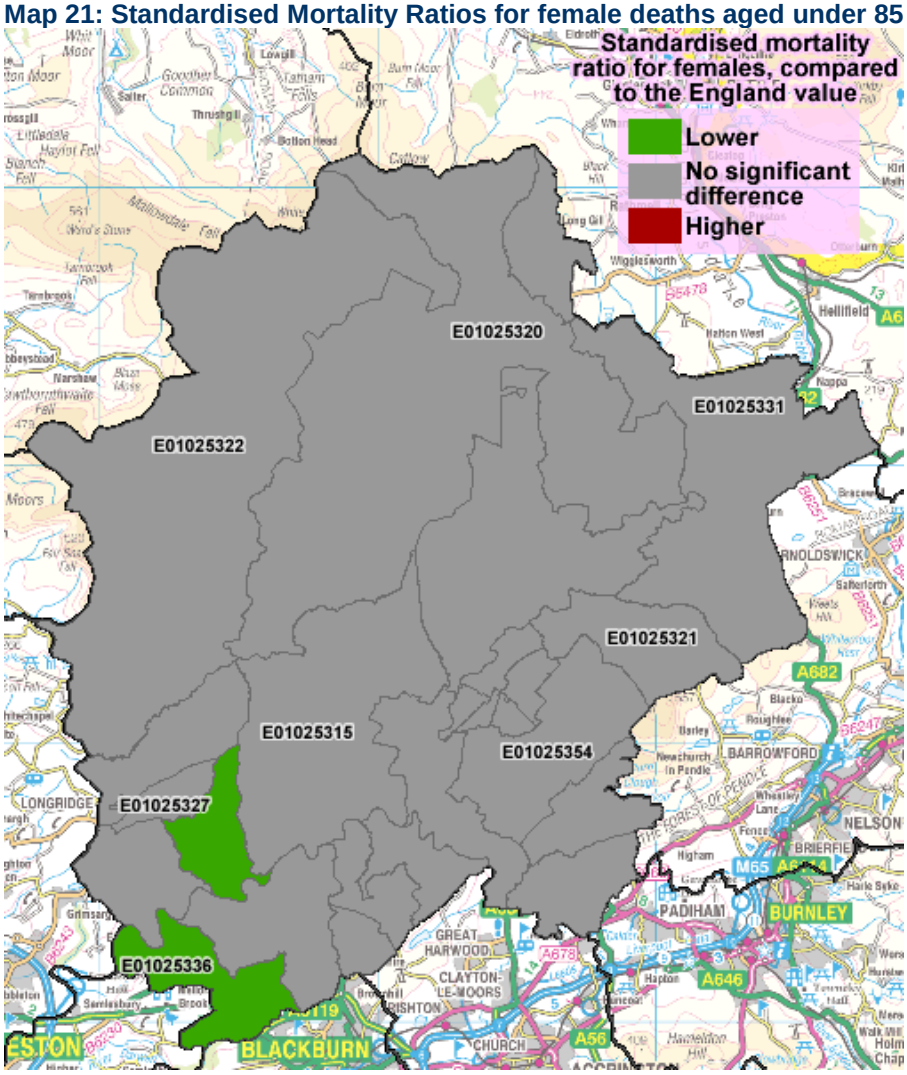


Standardised mortality ratios

The two maps below show the standardised mortality ratio for males and then females in Ribble Valley. As you can see, the target areas fall in line with the rest of England, with the exception of

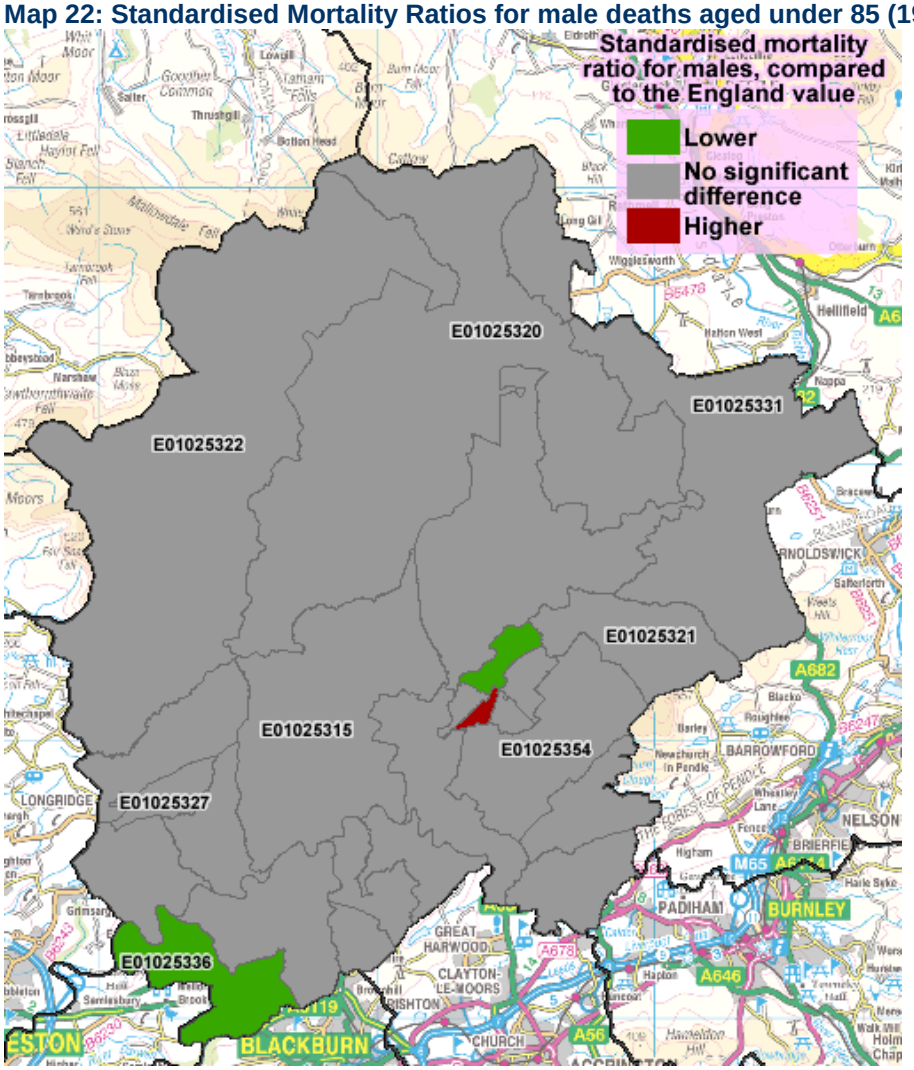
Ribble Valley 008D in which both males and females live longer than their national counterparts when age and gender are equivalised.

Map 21: Standardised Mortality Ratios for female deaths aged under 85 (1999-2003)



Source: ONS

Map 22: Standardised Mortality Ratios for male deaths aged under 85 (1999-2003)



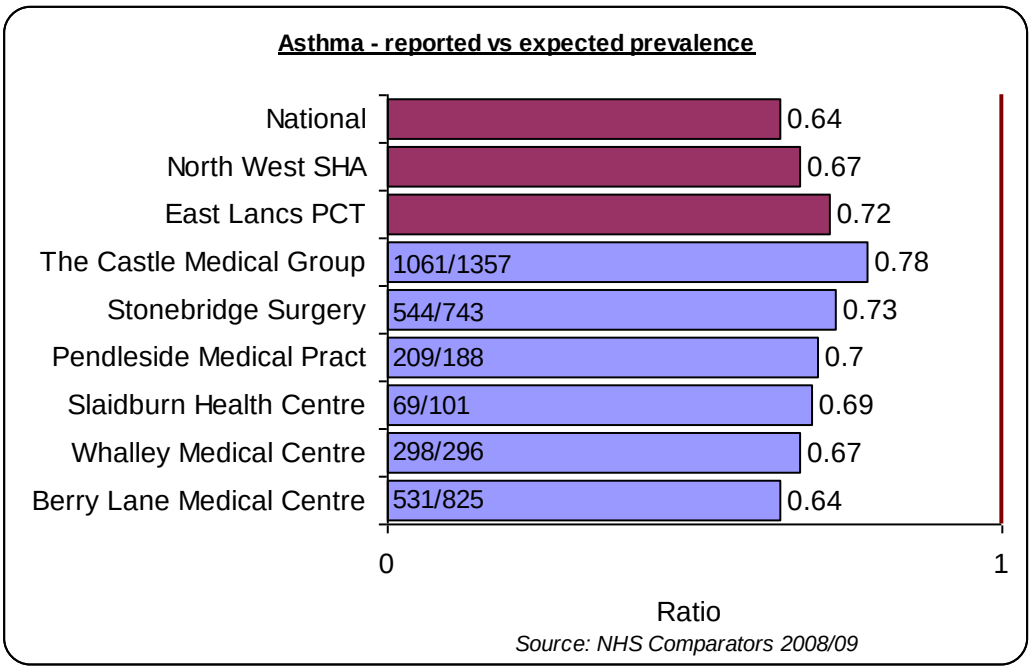
Source: ONS

NHS comparators – reported vs. expected prevalence

NHS Comparators is designed to help NHS organisations improve the quality of care delivered by benchmarking and comparing activity and costs on a local, regional and national level. In the following charts we look at where the 2008-09 ratio of reported versus expected prevalence of certain health conditions varies from the national ratio. A ratio of 1 means the reported prevalence is exactly in line with the expected prevalence for an area, less than 1 indicates a lower than expected prevalence, higher than 1 indicates higher than expected prevalence. What we are most interested in is where a local ratio is considerably different from the national ratio; we would deem this to be out of the ordinary regardless of the ratio figure itself. Understanding the reasons for any variation would require further investigation – it could reflect an actual difference in the burden of disease or may simply reflect differences in reporting or recording.

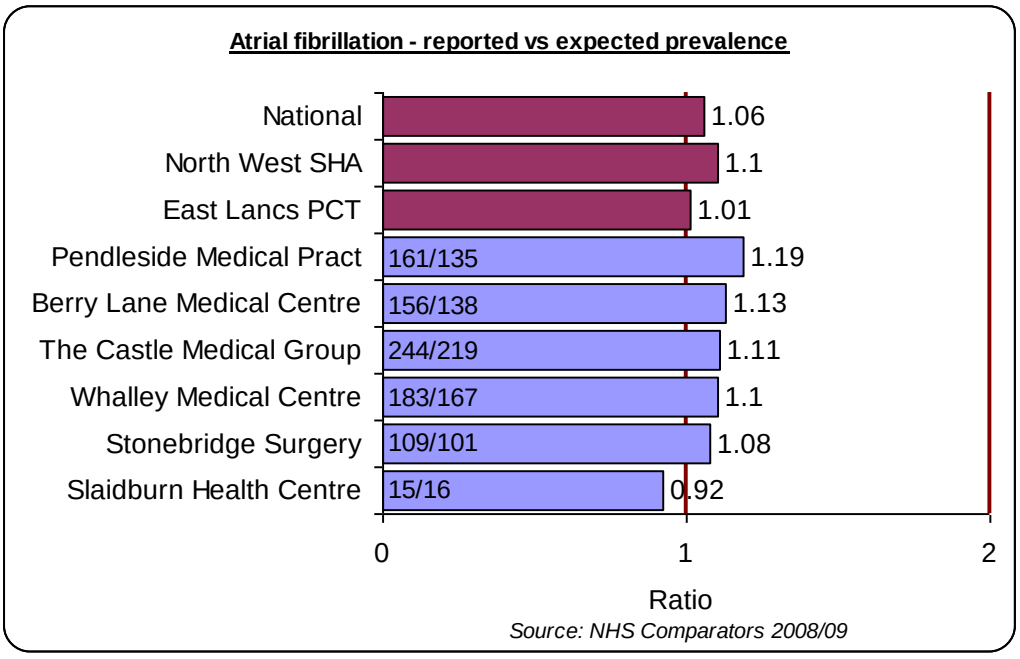
The ratio of reported versus expected prevalence of asthma is the same or higher than the national ratio in all six of our chosen practices. The Castle Medical Group has the highest ratio at 0.78.

Figure 13: Asthma reported vs expected prevalence



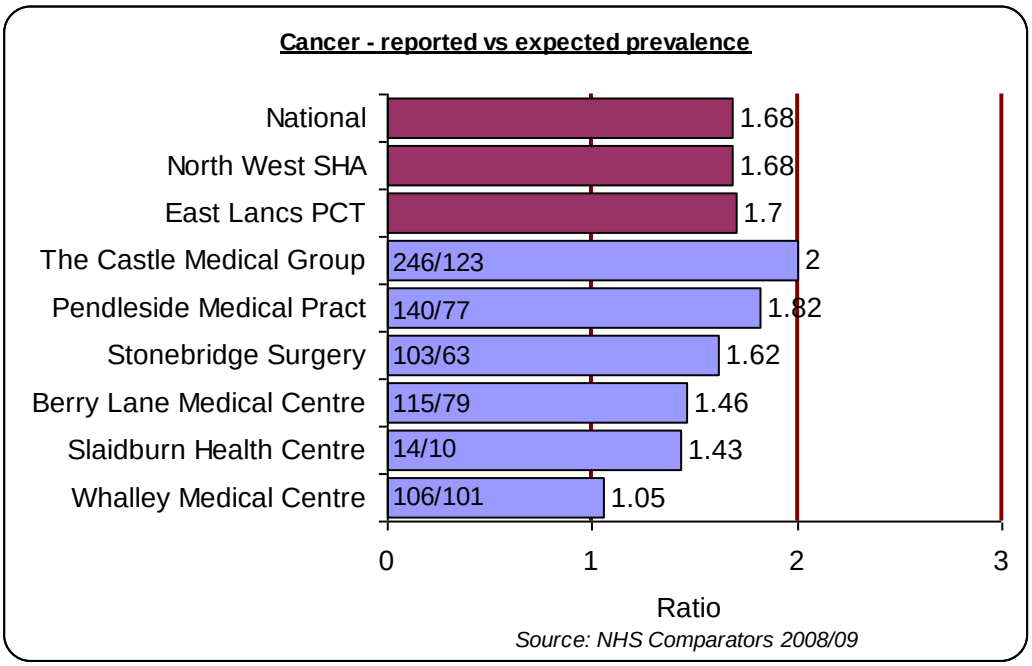
The ratio for atrial fibrillation, which causes a fast and erratic heartbeat, is broadly in line with the national figure in all six practices and varied from 0.92 in Slaidburn Health Centre to 1.19 in Pendleside Medical Practice.

Figure 14: Atrial fibrillation reported vs expected prevalence



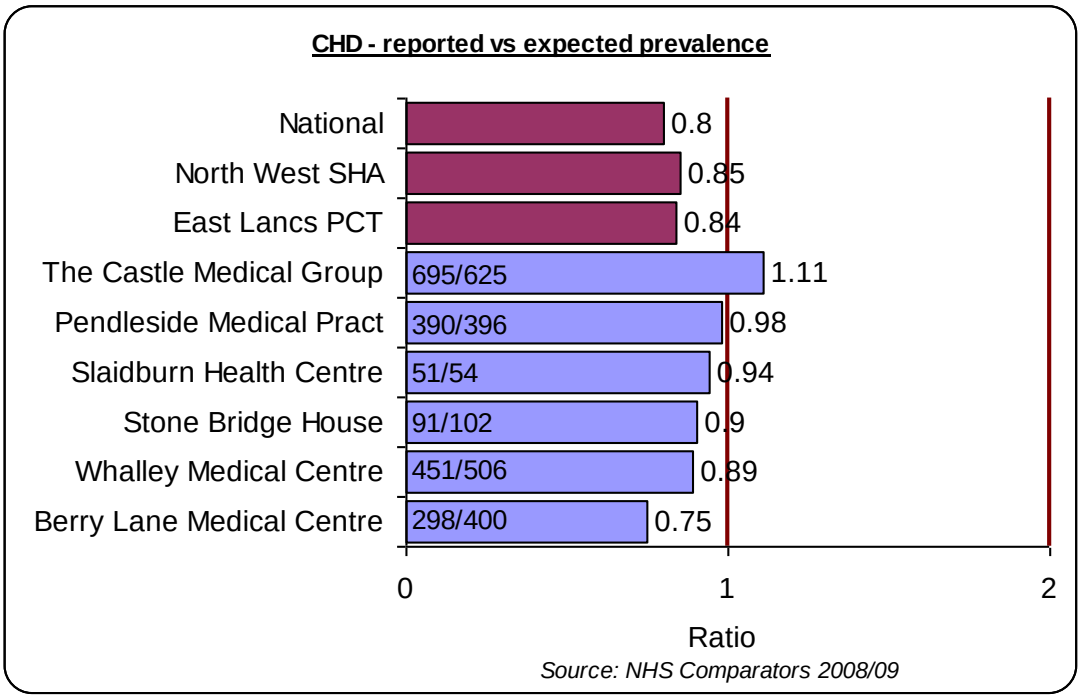
The Castle Medical Group and Pendleside Medical Practice have a higher then national ratio of reported versus expected Cancer prevalence. Whalley Medical Centre has a ratio much lower than that of England as a whole. The ratio for the Castle Medical Group is almost double the ratio for Whalley Medical Centre.

Figure 15: Cancer reported vs expected prevalence



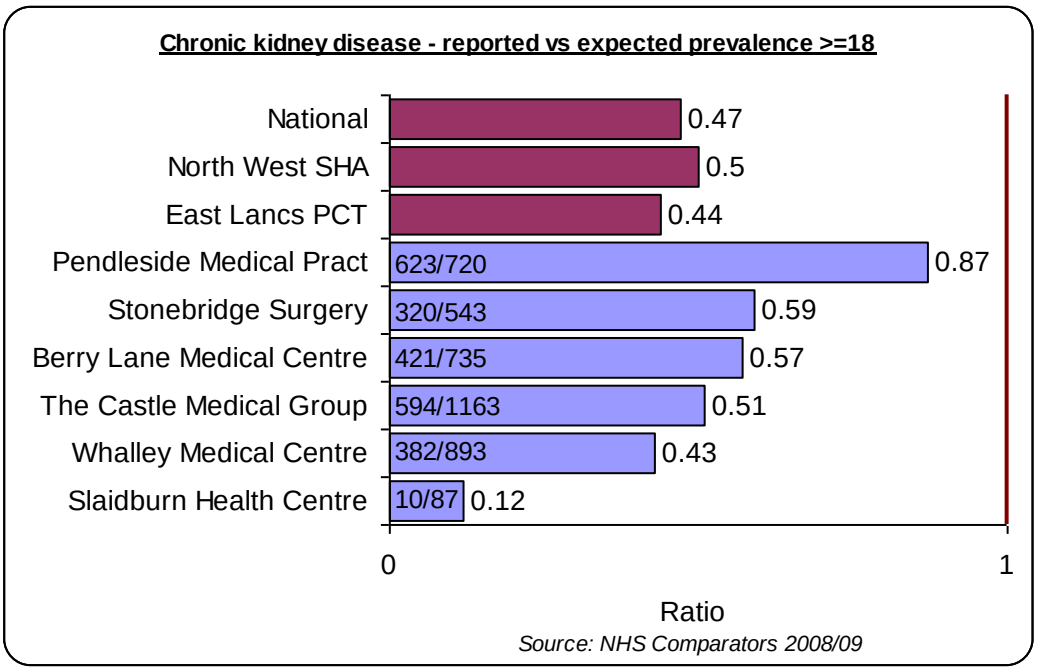
Five out of the six practices had a higher than national ratio of reported versus expected prevalence of coronary heart disease, most notably The Castle Medical group which was the only area with a higher than expected prevalence of CHD. Berry Lane Medical Centre had a lower than national ratio for CHD.

Figure 16: Coronary heart disease reported vs expected prevalence



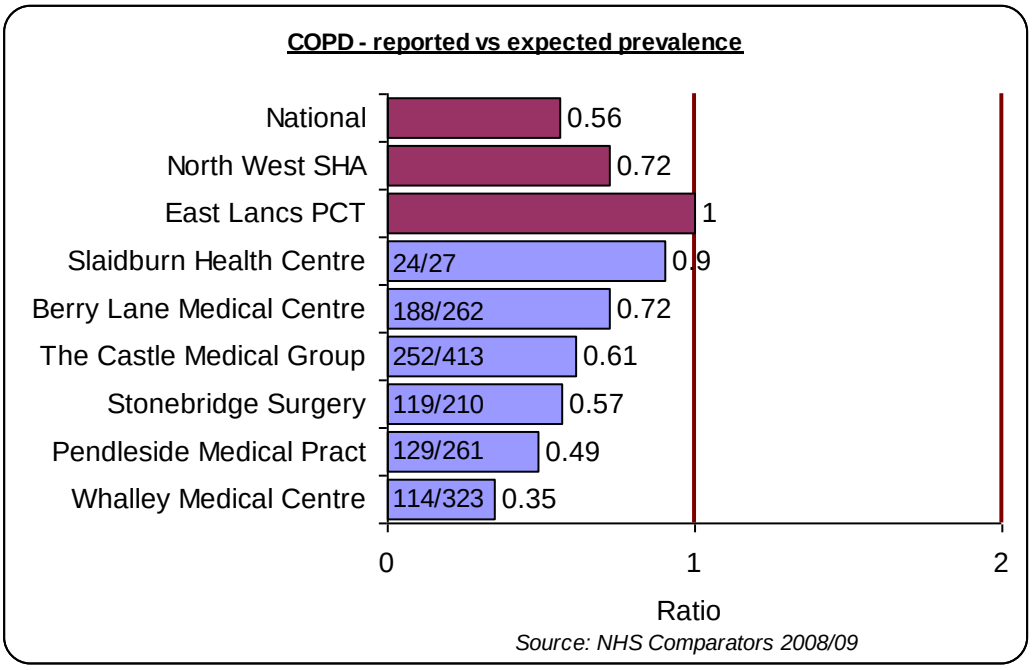
Pendleside Medical Practice and Slaidburn Health Centre were at either end of the scale for chronic kidney disease. In Pendleside the ratio was notably higher than nationally and in Slaidburn it was substantially lower.

Figure 17: Chronic kidney disease reported vs expected prevalence



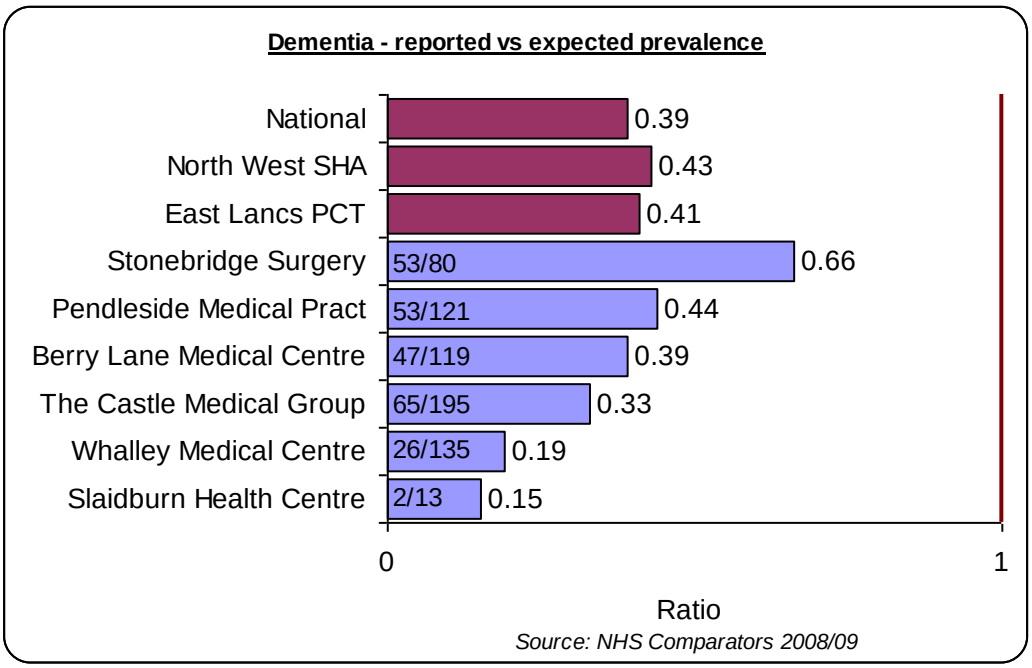
Whalley Medical Centre experienced the lowest ratio of reported versus expected prevalence of chronic obstructive pulmonary disease at just 0.35 compared to the national ratio of 0.56. At the other end of the scale was Slaidburn Health Centre with almost double the national ratio (0.9).

Figure 18: Chronic kidney disease reported vs expected prevalence



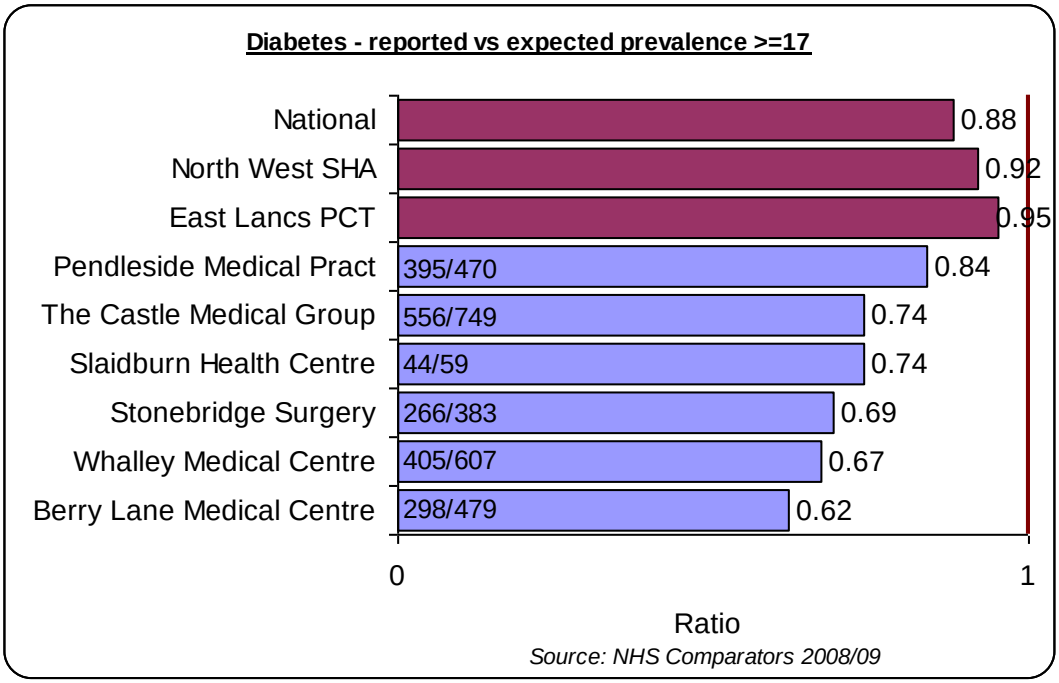
The ratio of reported versus expected prevalence of dementia was only notably higher than the England ratio in Stonebridge Surgery. In Whalley Medical Centre and Slaidburn Health Centre the ratio was much lower than national ratio.

Figure 19: Dementia reported vs expected prevalence



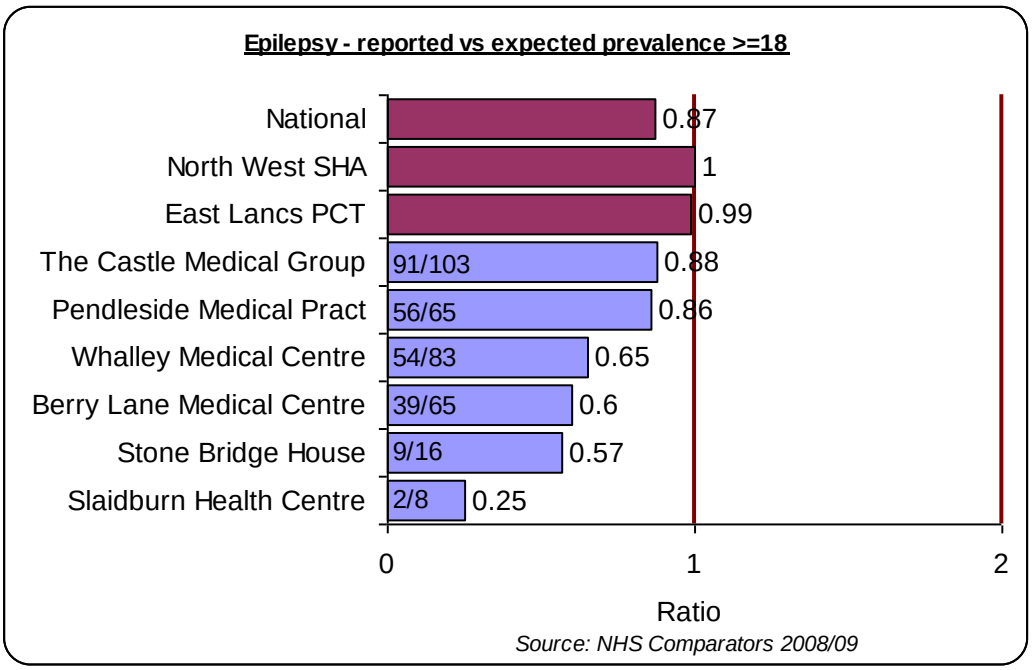
The ratio for diabetes was lower than the national ratio in all six practices, the lowest of which was in Berry Lane Medical Centre.

Figure 20: Diabetes reported vs expected prevalence



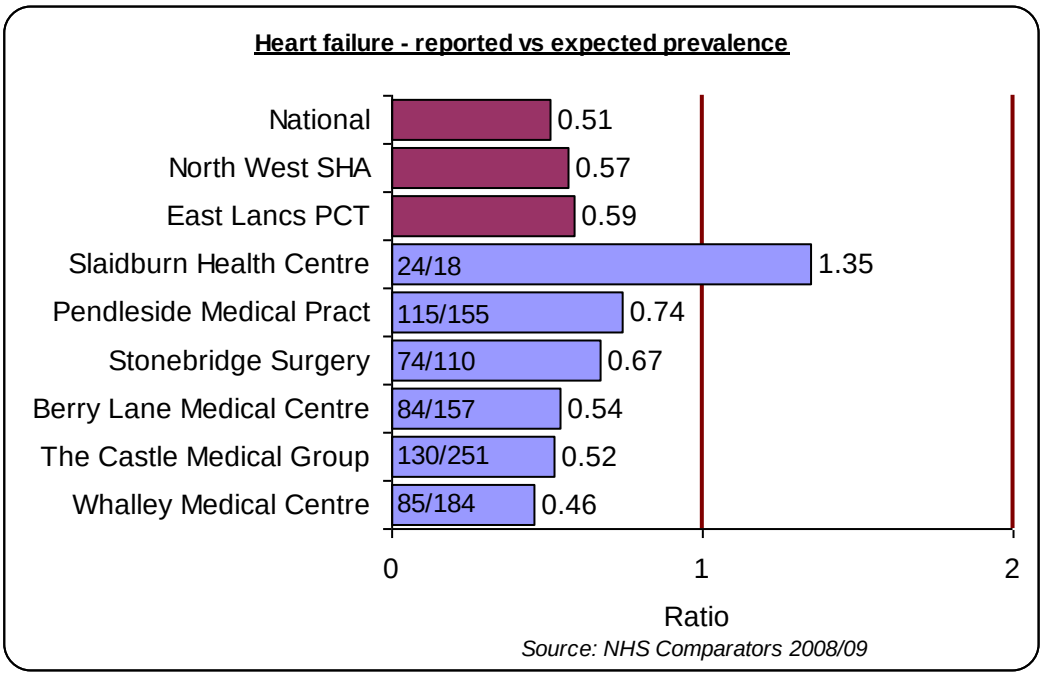
The ratio for epilepsy in The Castle Medical Group and Pendleside Medical Practice is in line with the national ratio. The ratios in Whalley, Berry Lane and Stonebridge were lower than national and the ratio in Slaidburn was much lower than the national ratio.

Figure 21: Epilepsy reported vs expected prevalence



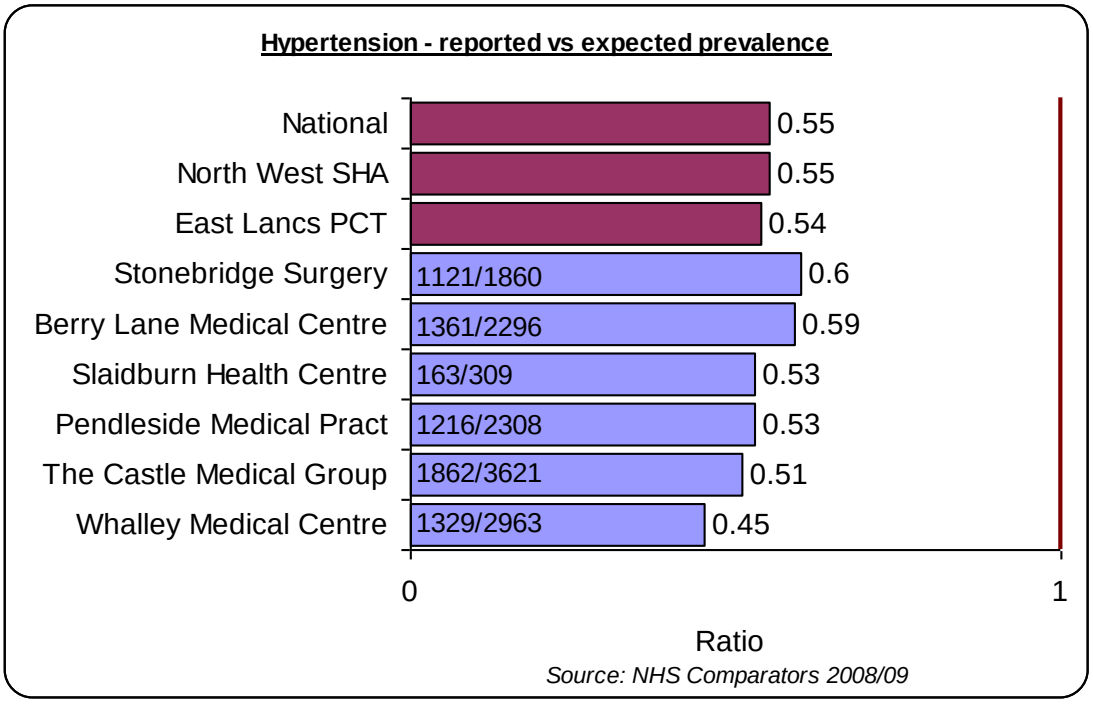
Five of the six practices were broadly in line with the national ratio for heart failure. Pendleside Medical practice was fairly high but Slaidburn Health Centre was well above the national ratio at 1.35 compared to 0.51 in England.

Figure 22: Heart failure reported vs expected prevalence



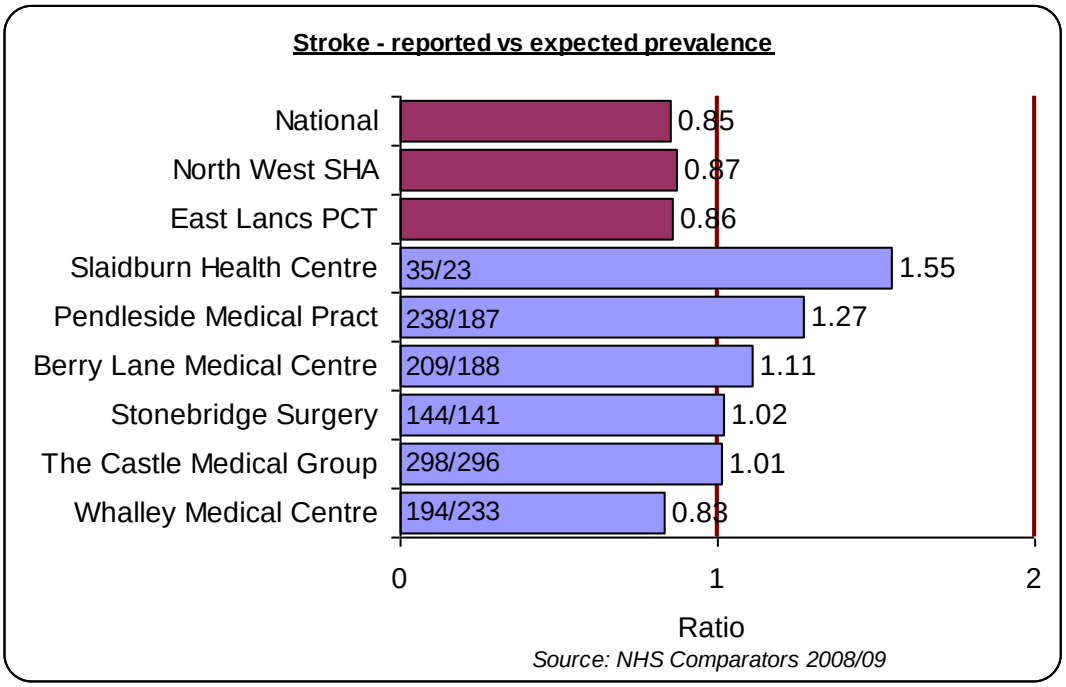
The ratio for hypertension is broadly in line with the national ratio in all six practices ranging from 0.45 in Whalley Medical Centre to 0.6 in Stonebridge Surgery, compared to the national ratio of 0.55.

Figure 23: Hypertension reported vs expected prevalence



With the exception of Whalley Medical Centre, all of the practices have a higher than national ratio of reported versus expected prevalence of stroke. These five practices reported a higher than expected prevalence of stroke, whereas the national trend was to have lower than expected prevalence. Most notably Slaidburn Health Centre had a ratio of 1.55 compared to 0.85 nationally.

Figure 24: Hypertension reported vs expected prevalence



NHS comparators summary

Whalley Medical Centre and Berry Lane Medical Centre have ratios lower than those for England for many conditions. Pendleside Medical Practice, Stonebridge Surgery and The Castle Medical Group have higher than national ratios for many conditions. Conversely, Slaidburn Health Centre stands out from the other practices in its variation from national trends. Whereas the other practices fair generally better or worse overall than the England average, Slaidburn Health Centre varies more widely by condition. For example the ratios for stroke and heart failure are much higher than the national ratio whilst the ratios for epilepsy, dementia and chronic kidney disease are much lower than the national ratio. In short, Slaidburn Health Centre seems to have greater extremes of prevalence than any of the other practices.

Traffic light summary of key health indicators

The traffic light summary of key health indicators at middle layer super output area (MSOA) highlight good levels of general health in the population with the vast majority of indicators below or not significantly different to the national average. Only in one MSOA, Slaidburn, Bolton-by-Bowland, Waddington and Hurst Green, were any health conditions found to be significantly more prevalent than the England average: hospitalised arthroses of the hip and permanent sickness.

Table 9: Traffic light summary of key health conditions (significant differences from England average based upon indirectly standardised ratio)

Indicator	Ribble Valley 001	Ribble Valley 004	Ribble Valley 005	Ribble Valley 008
Accidents Hospitalised Incidence	lower	lower	not sig	lower
Cardiovascular Conditions Hospitalised Incidence	lower	lower	not sig	not sig
Coronary Heart Disease Hospitalised Incidence	not sig	lower	lower	lower
Chronic Lower Respiratory Conditions Hospitalised Incidence	lower	lower	lower	lower
Emergency Admissions Hospitalised Incidence	lower	lower	lower	lower
Falls Hospitalised Incidence	not sig	lower	not sig	lower
Fractured Femur Hospitalised Incidence	not sig	not sig	not sig	not sig
Stroke Hospitalised Incidence	not sig	not sig	lower	lower
Alcohol Specific Conditions Hospitalised Prevalence	lower	lower	lower	lower
Arthroses Hospitalised Prevalence	not sig	not sig	lower	lower
Back Pain Hospitalised Prevalence	lower	lower	lower	lower
Breast Cancer Female Hospitalised Prevalence	not sig	not sig	not sig	not sig
Colorectal Cancer Hospitalised Prevalence	not sig	not sig	lower	not sig
Chronic Obstructive Pulmonary Disease Hospitalised Prevalence	lower	lower	lower	lower
Diabetes Hospitalised Prevalence	lower	lower	lower	lower
Arthroses Of The Hip Hospitalised Prevalence	higher	not sig	not sig	lower
Arthroses Of The Knee Hospitalised Prevalence	lower	not sig	lower	lower
Lung Cancer Hospitalised Prevalence	not sig	not sig	not sig	not sig
Mental Health Conditions Hospitalised Prevalence	lower	not sig	lower	lower

Indicator	Ribble Valley 001	Ribble Valley 004	Ribble Valley 005	Ribble Valley 008
Osteoporosis Hospitalised Prevalence	lower	not sig	not sig	lower
Prostate Cancer Hospitalised Prevalence	not sig	not sig	not sig	not sig
Rheumatoid Arthritis Hospitalised Prevalence	not sig	not sig	not sig	not sig
Cataracts Hospitalised Treatment	not sig	lower	lower	lower
Hip Replacement Hospitalised Treatment	not sig	not sig	not sig	not sig
Knee Replacement Hospitalised Treatment	not sig	not sig	not sig	lower
Prostatectomy Hospitalised Treatment	not sig	not sig	not sig	not sig
Revascularisation Hospitalised Treatment	not sig	not sig	not sig	lower
Circulatory Disease Mortality	lower	not sig	not sig	not sig
All Benefits (CG) Benefit Claimants	lower	lower	lower	lower
Disability Living Allowance (DLA) Benefit Claimants	lower	lower	lower	lower
Disability Living Allowance High Rate for Mobility Component (DLAHR) Benefit Claimants	lower	lower	lower	lower
Incapacity Benefit Severe Disablement Allowance (IBSDA) Benefit Claimants	lower	lower	lower	lower
Mental Health Specific Incapacity Benefit Severe Disablement Allowance (IBSDAMH) Benefit Claimants	lower	lower	lower	lower
Pension Credit (PC) Benefit Claimants	lower	lower	lower	lower
Percentage of Unpaid Carers Census Data	lower	lower	lower	lower
Long Term Illness Census Data	lower	lower	lower	lower
Not Good Health Census Data	lower	lower	lower	lower
Permanent Sickness Census Data	higher	lower	lower	not sig
All Age All Cause Mortality Males ONS	lower	not sig	lower	lower
All Age All Cause Mortality Females ONS	lower	lower	not sig	not sig

Source: NWPHO Health Profiler Tool

Healthy Valley Survey

Respondent profile

Age and gender

The following table summarises the unweighted respondent age and gender profile. Men were underrepresented (of the 50+ population) as was the youngest of the three age groups. By weighting the data against the Ribble Valley population, this helps to address this imbalance.

Table 10: Gender and age breakdown

	Unweighted	Weighted
Male	35%	46%
Female	65%	54%
50-64	34%	54%
65-79	46%	34%
80+	20%	12%

Source: Healthy Valley 2010 (Q14 n=385 and Q15 n=385)

Location

Sixteen villages were targeted throughout the Borough. Chipping saw the highest response, accounting for nearly a third of all completed surveys. No surveys were completed in Ribchester/ Hurst Green. Amongst the remaining villages listed below, there is a good mix of responses.

Table 11: Share of total responses

	Number	%
Waddington	28	9%
Ribchester/ Hurst Green	0	0%
Chipping	102	31%
Barrow/ Wiswell/ Pendleton	26	8%
Gisburn	14	4%
Downham/ Chatburn	42	13%
Slaidburn/ Newton/ Dunsop Bridge	60	19%
Balderston/ Osbaldeston/ Mellor	52	16%

Source: Healthy Valley 2010 (Q19, n=324)

Survey findings

Health and well being

72% rate their general health as either good or very good. As you would expect, health is negatively correlated with age (i.e. as you get older, perception of health deteriorates). However, the interesting finding here is that only 4% rate their health as bad or very bad. Given the target audience (residents aged 50+), this is surprisingly low and perhaps suggests one or more causal factors:

- Awareness/ understanding of health issues
- Conscious/ subconscious denial
- Relative self diagnosis (i.e. compared to my friends I'm doing pretty well)

It is also surprisingly low when at fig 3.2 below, 17% state that a long standing health problem/ disability means that they have difficulty doing day to day activities (note that for those aged 80+, 47% have difficulties).

Table 12: How would you describe your general health?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Very good	25%	26.40%	23.10%	31.70%	19.50%	7.30%	42.30%	32.70%	39.10%	19.30%	13.80%	28.80%	15.40%
Good	47%	44.80%	48.80%	47.10%	50.50%	36.70%	33.90%	49.30%	48.30%	26.90%	44.90%	51.30%	38.80%
Fair	24%	25.50%	22.40%	17.00%	26.10%	48.30%	19.00%	12.70%	3.20%	53.80%	39.90%	19.10%	36.90%
Bad	3%	2.70%	4.10%	2.90%	3.10%	6.60%	0%	3.00%	7.50%	0%	1.40%	0.80%	9.00%
Very bad	1%	0.60%	1.50%	1.30%	0.80%	1.10%	4.80%	2.30%	1.90%	0%	0%	0%	0%

Source: Healthy Valley 2010 (Q1, n=384)

Table 13: Does a long-standing health problem/ disability mean you have difficulties doing day to day activities?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Yes	17%	16.10%	18.50%	10.80%	17.70%	46.70%	25.60%	12.00%	9.50%	6.90%	14.50%	10.70%	38.80%
No	83%	83.90%	81.50%	89.20%	82.30%	53.30%	74.40%	88.00%	90.50%	93.10%	85.50%	89.30%	61.20%

Source: Healthy Valley 2010 (Q2, n=373)

89% are satisfied with their life as a whole. Again, satisfaction with life seems to be negatively correlated with age (i.e. the older you get, the less satisfied you become with life) and health will be one of the causal factors to this level of satisfaction. So as an elderly resident in Ribble Valley's rural villages, life is pretty good at the moment.

Table 14: How satisfied are you with your life as a whole?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Very satisfied	50%	46.60%	52.80%	51.90%	53.40%	31.30%	70.50%	55.50%	66.20%	17.60%	46.50%	52.20%	36.90%
Slightly satisfied	39%	41.40%	36.90%	38.00%	35.80%	52.30%	29.50%	36.20%	25.60%	78.20%	42.50%	42.00%	41.70%
Neither	7%	7.30%	6.40%	6.70%	5.40%	11.10%	0%	5.50%	3.10%	4.20%	9.50%	1.60%	13.00%
Slightly dissatisfied	4%	4.70%	3.60%	3.40%	4.90%	5.30%	0%	2.70%	5.00%	0%	1.40%	4.10%	8.30%
Very dissatisfied	0%	0%	0.3%	0%	0.5%	0%	0%	0%	0%	0%	0%	0%	0%

Source: Healthy Valley 2010 (Q3, n=384)

Your local area and its amenities

96% are satisfied with their local area as a place to live. This is a staggering finding and reinforces similarly positive findings from the Place Survey in 2008.

Table 15: In general, how satisfied or dissatisfied are you with your local area as a place to live?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Very satisfied	67%	68.10%	65.50%	66.80%	68.10%	62.30%	71.80%	68.40%	68.80%	30.30%	66.80%	69.90%	63.00%
Slightly satisfied	29%	29.70%	28.60%	29.00%	28.40%	31.70%	26.50%	28.10%	29.30%	60.40%	25.40%	30.10%	31.10%
Neither	3%	2.20%	3.80%	2.90%	2.60%	4.90%	1.80%	1.00%	1.90%	9.20%	6.40%	0%	4.80%
Slightly dissatisfied	1%	0%	0.90%	0.60%	0%	1.10%	0%	1.30%	0%	0%	0%	0%	0%
Very dissatisfied	1%	0%	1.20%	0.60%	0.90%	0%	0%	1.30%	0%	0%	1.40%	0%	1.20%

Source: Healthy Valley 2010 (Q4, n=384)

The most difficult to access local service is that of leisure facilities. This is particularly so for residents living in Gisburn. You may hypothesise that the difficulty in accessing the leisure services is due to distance/ transport links. But the findings don't support this. Slaidburn is equally as far away from Clitheroe and arguably residents living in Slaidburn have a more difficult task in getting to Clitheroe (as Gisburn benefits from sitting on the A59). Similarly, it seems that access is more difficult for the younger age group (50–64), who in all likelihood will still have access to their own transport. So what is the difficulty?

Table 16: If you need access to any of the following services or amenities, how difficult do you find this?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Leisure facilities	29%	27.50%	30.90%	32.50%	24.80%	27.20%	14.00%	42.80%	16.40%	63.90%	21.80%	11.80%	43.80%
Bank/ cash point	25%	30.90%	19.90%	26.00%	21.00%	32.00%	8.40%	39.40%	10.20%	69.50%	18.90%	19.90%	24.20%
Dentist	23%	21.70%	23.40%	24.30%	20.70%	20.10%	10.40%	29.80%	8.80%	61.20%	26.50%	18.60%	21.20%
Post office	22%	25.40%	19.10%	22.60%	21.80%	19.50%	10.70%	46.00%	15.70%	88.20%	3.20%	10.80%	6.00%
Work opportunities	19%	21.40%	16.20%	23.70%	13.50%	6.20%	8.10%	37.80%	13.50%	28.50%	18.30%	7.60%	15.30%
Supermarket	18%	17.90%	17.80%	12.10%	21.90%	33.20%	13.40%	17.40%	10.00%	9.60%	4.70%	18.90%	36.60%
Learning opportunities	16%	16.20%	15.00%	17.30%	14.30%	10.00%	24.20%	27.20%	2.10%	32.70%	12.30%	6.50%	9.40%
Library	12%	17.50%	7.40%	12.70%	11.20%	11.90%	5.70%	24.40%	3.20%	31.10%	0.00%	11.90%	2.40%
Petrol station	12%	13.10%	10.60%	13.00%	11.00%	7.70%	3.80%	28.20%	16.40%	0.00%	0.00%	8.90%	7.80%
Gas supply	12%	11.40%	12.20%	17.60%	4.90%	4.50%	0.00%	22.00%	0.00%	70.90%	2.00%	20.00%	0.00%
Chemist	11%	9.20%	11.80%	10.20%	10.70%	12.10%	5.50%	20.90%	0.00%	31.90%	8.80%	5.90%	4.00%
Hairdresser	11%	14.90%	7.40%	8.80%	12.80%	14.20%	6.70%	28.50%	6.10%	0.00%	2.00%	1.70%	3.60%
GP	10%	9.40%	10.70%	9.10%	11.60%	10.80%	5.40%	27.60%	1.90%	3.40%	0.00%	3.30%	5.70%
Shop/ newsagent	10%	10.40%	9.20%	7.30%	10.20%	20.50%	26.50%	2.90%	21.30%	16.90%	3.20%	6.20%	3.90%
Bus stop	6%	6.10%	5.00%	1.40%	9.80%	12.70%	1.80%	3.60%	12.90%	8.40%	1.40%	4.10%	7.60%
Internet access	6%	5.00%	6.60%	6.80%	4.10%	5.80%	1.90%	3.90%	13.60%	28.90%	9.60%	3.80%	1.30%
Green space	5%	5.30%	3.70%	3.60%	4.80%	8.10%	1.90%	3.70%	19.60%	0.00%	1.50%	0.00%	10.90%
Pub	4%	4.30%	4.00%	4.10%	4.30%	3.80%	16.70%	1.00%	0.00%	3.40%	3.20%	8.70%	3.60%
Religious facilities	3%	2.10%	3.20%	0.70%	3.20%	10.50%	4.80%	0.00%	6.40%	12.70%	0.00%	1.70%	4.70%
Community facilities	3%	3.40%	2.90%	0.70%	5.10%	9.00%	1.80%	1.00%	3.20%	3.40%	3.60%	1.70%	4.60%
Mains water	2%	2.30%	1.50%	1.80%	1.30%	4.40%	0.00%	0.00%	0.00%	0.00%	1.90%	7.10%	0.00%
Mains sewerage	2%	3.00%	1.50%	1.70%	2.60%	3.30%	0.00%	3.20%	0.00%	4.30%	2.00%	3.30%	0.00%

Source: Healthy Valley 2010 (Q5, n=375)

It seems that the main reason for the difficulty in accessing the above services is due to access to a vehicle. Please note – the question below WAS NOT asked in the context of each service above and so the answers provided at fig 3.6 below may well cover a variety of services that residents have difficulty in accessing. It may not be the case that transport is the main problem in accessing leisure services as this question was not directly asked. It would be advisable that if Ribble Valley are wanting to understand the reasons as to why leisure services are difficult to access, then analysis of alternative datasets and/or qualitative work with users and non users will be the only way of truly understanding the difficulties facing residents. It should be noted that 13% of respondents listed the cost of fuel as a reason why they cannot access services. Given the recent rises in fuel costs this is likely to have become an even greater problem.

Table 17: If you find that it is "fairly difficult" or "very difficult" to access for any of the above services or amenities, please can you identify the reasons why?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Limited access to a vehicle	24%	24.50%	23.90%	15.80%	34.80%	46.50%	29.40%	20.60%	22.80%	4.70%	39.30%	15.00%	22.90%
Cost of fuel	13%	13.70%	12.60%	12.00%	17.40%	5.10%	0%	13.80%	13.20%	4.70%	31.00%	12.50%	10.20%
No public transport	14%	10.80%	16.00%	8.90%	24.80%	11.30%	0%	13.20%	23.90%	9.40%	25.50%	3.90%	21.10%
Inconvenient opening times	15%	14.20%	15.40%	18.10%	10.30%	8.20%	0%	28.00%	0%	0%	20.70%	13.80%	11.70%
Can't get an appointment	15%	15.80%	14.50%	15.80%	16.00%	6.20%	0%	32.60%	0%	17.00%	9.10%	8.60%	2.20%
Service not available	64%	64.00%	63.20%	66.80%	59.60%	53.50%	87.90%	62.60%	48.00%	78.30%	29.80%	87.50%	54.30%

Source: Healthy Valley 2010 (Q6, n=185)

But note that leisure facilities are actually the least important service currently received. The level of importance increases slightly in the future but not to a level that allows it to compete with the key services. The single most important service both now and in the future is that of health services (and hence the importance health plays in quality of life). The GP service and chemist service are vital services for this population and access to these services needs to be easy and convenient for quality of life to remain at the currently high level in fig 3.3 above.

Table 18: For the same list of services, which 5 are most important to you now and which 5 do you feel will be most important to you in the future?

	Now	Future
Post office	87%	64%
GP	85%	82%
Chemist	85%	70%
Mains water	84%	64%
Mains sewerage	81%	56%
Supermarket	80%	64%
Petrol station	79%	42%
Internet access	77%	50%
Green space	76%	37%
Pub	75%	39%
Dentist	74%	65%
Bank/ cash point	73%	61%
Central heating	73%	62%
Religious facilities	72%	39%
Library	71%	56%
Hairdresser	68%	35%
Shop/ newsagent	68%	77%
Community facilities	67%	63%
Gas supply	61%	39%
Bus stop	56%	73%
Work opportunities	45%	15%
Learning opportunities	43%	18%
Leisure facilities	34%	40%

Source: Healthy Valley 2010 (Q7, n=343)

It's quite clear from this survey that social interaction and independence are two very important factors in determining quality of life (along with health care provision). Residents state in fig 3.8 below that a local shop and/ or post office would benefit them and the local area. In essence, this meets 2 very important needs:

1. The ability for elderly residents to get their own shopping or to pay their own bills

2. The need for interaction – be it with fellow villages and also the staff who would run the shops

Obviously, in the current climate, this would normally require private investment of some sort but perhaps it is worth exploring the possibility of a community run enterprise, providing a service that would meet the specific needs of its villagers whilst at the same time not being reliant on the economic climate and having to attract private investment into what may not be a profitable enough opportunity?

Table 19: Is there anything missing from your local area?

	Total
Newsagent/ shop	23%
Post office	21%
Gas supply	12%
Better bus services	9%
Greater police presence	7%

Source: Healthy Valley 2010 (Q8, n=140)

79% chat or socialise with friends/ family at least 2-3 times a week. This is particularly high for women, perhaps highlighting a greater social need.

Table 20: How often do you have a chat or socialise with any friends or family who live in the local area?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Daily	46%	41.60%	50.40%	43.00%	53.20%	42.40%	50.30%	50.20%	44.40%	50.40%	52.20%	34.10%	44.60%
2-3 times a week	33%	30.60%	35.40%	36.70%	28.00%	32.30%	44.90%	33.60%	33.10%	45.40%	35.40%	41.30%	26.90%
Weekly	14%	19.60%	10.10%	12.90%	14.70%	20.60%	4.80%	13.60%	1.90%	4.20%	9.70%	22.90%	20.00%
Fortnightly or monthly	2%	3.50%	0.20%	1.10%	3.10%	1.10%	0%	0%	3.90%	0%	1.20%	1.70%	2.00%
Less often	2%	2.20%	1.30%	2.30%	0%	3.60%	0%	1.30%	3.10%	0%	0%	0%	2.60%
Never	1%	1.20%	1.60%	2.30%	0.50%	0%	0%	1.30%	0%	0%	1.50%	0%	2.60%
N/A	1%	1.20%	0.90%	1.70%	0.50%	0%	0%	0%	13.6%	0%	0%	0%	1.20%

Source: Healthy Valley 2010 (Q9, n=380)

Similarly, 76% chat or socialise with neighbours at least 2-3 times a week. This level of interaction seems quite high and is perhaps reflective of the typical demographic composition of a Ribble Valley rural village.

Table 21: How often do you have a chat or socialise with any of your neighbours?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Daily	34%	32.20%	35.60%	28.00%	43.70%	33.50%	52.90%	31.00%	21.90%	36.20%	41.90%	19.80%	43.50%
2-3 times a week	42%	36.50%	47.00%	46.40%	36.80%	38.60%	33.90%	40.40%	39.60%	63.80%	44.10%	60.70%	38.90%
Weekly	15%	19.30%	10.50%	14.70%	13.80%	15.90%	13.20%	16.60%	15.20%	0%	5.90%	13.70%	12.60%
Fortnightly or monthly	4%	4.60%	2.70%	3.40%	4.10%	2.80%	0%	6.50%	3.80%	0%	0%	3.60%	1.20%
Less often	2%	2.20%	2.70%	3.00%	0.50%	5.60%	0%	2.60%	3.10%	0%	5.10%	2.20%	2.20%
Never	2%	2.90%	1.30%	3.40%	0%	1.70%	0%	1.30%	8.30%	0%	3.10%	0%	1.60%
N/A	1%	2.30%	0.30%	1.10%	1.20%	1.70%	0%	1.60%	8.30%	0%	0%	0%	0%

Source: Healthy Valley 2010 (Q10, n=380)

Despite seemingly high levels of contact with family, friends and neighbours, 22% state they occasionally or often feel lonely (and this is higher for women at 27% and also those aged 80+ at 35%). So there is a need for greater and wider social interaction. For those who can get out and about, a local shop, a community village hall etc would help to provide a central focal point for their daily interaction. However, for those unable to get out and about, thought needs to be given to how interaction can be brought to them. Adult care services will be able to provide a limited role (and perhaps even more limited moving forward as funding is further reduced) but perhaps this is an opportunity to unleash the Big Society concept in its finest form. Having a local 'care and share' scheme, whereby residents with the time, experience and qualities sign up to spending half an hour or so 2-3 times a week with some of the villages eldest residents. This gives the elderly resident access to company and conversation and an outlet to share concerns/ problems/ issues that can be dealt with via a formal, central reporting service. It also gives the volunteer the opportunity to really make a difference in their village and help those who need it most.

Table 22: Do you ever feel lonely?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Never	52%	62.80%	42.50%	51.00%	55.70%	44.00%	67.10%	53.50%	69.90%	19.20%	60.20%	43.60%	46.40%
Rarely	26%	20.80%	30.90%	28.00%	25.20%	20.80%	13.00%	29.80%	8.10%	53.00%	23.40%	34.60%	22.90%
Occasionally	19%	14.00%	22.90%	19.40%	14.80%	29.10%	14.80%	16.70%	11.90%	23.50%	13.90%	20.20%	27.50%
Often	3%	2.40%	3.60%	1.70%	4.30%	6.20%	0%	10.10%	4.30%	2.60%	1.60%	3.20%	10.10%

Source: Healthy Valley 2010 (Q11, n=376)

Figure 3.12 below further highlights that local friendships are extremely important. However, only 66% state that if they needed advice they could go to someone in their local area. This highlights an apparent gap in service – for the other 34%, where do they go if they need help and advice? Setting up some form of community enterprise, be it a not for profit village shop, opening up the village hall every other morning for tea/

coffee etc, would go a long way to providing residents with a central focal point in the village for meeting and socialising. This in turn would provide a platform for discussing the good, the bad and the ugly.

Table 23: How much do you agree with the following statements about your local area?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
I feel like I belong to the local area	84%	80.80%	87.4%	82.9%	86.2%	85.6%	87%	83.4%	91.90%	100%	90.7%	80.4%	83.1%
The friendships and associations I have with other people in my local area mean a lot to me	86%	81.20%	89.70%	85.30%	87.30%	83.10%	89.90%	88.50%	79.90%	84.90%	90.00%	83.80%	84.50%
If I need advice I could go to someone in my local area	66%	58.40%	72.30%	62.70%	73.60%	58.70%	71.10%	64.00%	91.90%	40.40%	76.70%	59.20%	56.00%
I borrow and exchange things with my neighbours	50%	52.30%	48.60%	52.40%	51.70%	35.10%	60.70%	52.20%	35.70%	4.20%	61.20%	68.60%	36.80%
I plan to remain a resident of the local area for a number of years	87%	83.80%	89.00%	83.60%	91.50%	87.10%	91.10%	82.00%	96.30%	57.20%	85.60%	95.60%	94.90%
I like to think of myself as similar to the people who live in the local area	76%	70.90%	80.60%	70.10%	84.40%	81.20%	76.00%	64.50%	90.20%	95.80%	81.20%	70.00%	81.60%
I regularly stop and talk with people in the local area	85%	80.30%	88.50%	85.00%	87.20%	74.60%	93.10%	85.90%	83.00%	84.90%	80.50%	84.90%	91.40%
I would be willing to work, together with other local people, towards improving my local area	73%	73.10%	72.70%	82.00%	67.80%	39.80%	81.80%	85.50%	75.70%	96.60%	67.40%	69.60%	58.90%

Source: Healthy Valley 2010 (Q12, n=376)

We've already touched upon the role that volunteers could provide in addressing some of the issues that have been raised in this survey. However, the table below highlights the sort of skills that the community possess. For example, 30% have experience of working with vulnerable people, which would be an excellent pre-requisite for the 'care and share' highlighted above. Furthermore, 45% have good admin and people skills, making them adequately equipped for helping to run and staff a local community enterprise. The need is there and the skills are there. It simply needs a facilitator to make it happen.

Table 24: If you felt that you could offer some help towards improving your local area, please can you tell us what type of skills you possess?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Administration skills	45%	44.40%	45.60%	52.50%	30.70%	33.20%	37.70%	47.80%	66.80%	63.60%	44.00%	37.30%	47.30%
Manual skills (gardening etc)	39%	58.20%	21.50%	38.00%	40.50%	39.60%	16.10%	39.60%	44.60%	25.00%	28.40%	66.10%	18.60%
Experience of working with children or vulnerable people	30%	16.90%	42.00%	35.20%	21.80%	14.10%	34.80%	32.70%	38.10%	43.10%	22.90%	15.10%	30.70%
Domestic skills	26%	8.20%	42.00%	28.10%	23.30%	14.10%	20.70%	26.40%	12.60%	23.80%	33.20%	40.10%	16.30%
People skills (conversation, reading aloud etc)	45%	29.40%	59.00%	50.00%	35.60%	34.60%	60.00%	37.90%	42.30%	43.10%	41.20%	31.40%	52.80%
Physical skills (eg sports coaching)	5%	8.60%	1.90%	6.60%	2.50%	0%	10.60%	3.80%	0%	20.40%	8.40%	6.80%	3.40%
Arts and crafts skills	14%	5.50%	21.10%	12.10%	16.20%	20.50%	22.30%	13.50%	7.70%	10.30%	2.30%	20.70%	15.30%

Source: Healthy Valley 2010 (Q13, n=261)

About you and your household

The weighted responses below highlight what the responses would have been if the respondents reflected more closely the Ribble Valley population.

Table 25: What gender are you?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Male	46%	100%	0%	44.70%	48.50%	44.90%	27.90%	51.40%	61.90%	30.20%	45.10%	53.90%	35.40%
Female	54%	0%	100%	55.30%	51.50%	55.10%	72.10%	48.60%	38.10%	69.80%	54.90%	46.10%	64.60%

Source: Healthy Valley 2010 (Q14, n=385)

Table 26: What is your age?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
50 - 64	54%	52.50%	55.30%	100%	0%	0%	60.20%	60.70%	58.30%	76.40%	56.60%	69.10%	26.90%
65 - 79	34%	35.80%	32.40%	0%	100%	0%	25.10%	34.10%	31.90%	16.80%	36.60%	25.50%	52.30%
80+	12%	11.70%	12.30%	0%	0%	100%	14.60%	5.20%	9.90%	6.90%	6.80%	5.40%	20.70%

Source: Healthy Valley 2010 (Q15, n=385)

Table 27: What is your current employment status?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Working full time	18%	28.20%	9.70%	31.40%	3.10%	0%	0%	24.70%	16.50%	48.70%	14.40%	19.70%	2.60%
Working part time	12%	7.30%	15.30%	19.20%	3.40%	0%	17.30%	11.60%	10.10%	27.70%	8.20%	15.60%	5.20%
Unemployed and looking for a job	1%	0%	1.30%	1.30%	0%	0%	0%	1.30%	0%	0%	0%	2.20%	0%
Unable to work due to illness or disability	3%	4.30%	2.20%	5.00%	1.20%	0%	4.80%	1.00%	0%	0%	8.20%	3.60%	6.80%
Retired	64%	60.30%	67.40%	40.00%	91.30%	98.90%	77.90%	58.90%	73.40%	19.40%	66.10%	53.50%	85.50%
Student	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Full time carer	0%	0%	0.30%	0%	0.50%	0%	0%	0%	0%	4.20%	0%	0%	0%
Not looking for paid employment	2%	0%	3.10%	2.50%	0.50%	1.10%	0%	1.30%	0%	0%	3.10%	5.40%	0%
Working as a volunteer	0%	0%	0.60%	0.60%	0%	0%	0%	1.30%	0%	0%	0%	0%	0%

Source: Healthy Valley 2010 (Q16, n=380)

Table 28: If you are retired, at what age did you retire?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Before the age of 50	4%	0.80%	6.20%	4.80%	3.10%	4.00%	8.40%	0%	0%	21.60%	9.00%	4.10%	4.50%
50 to 64	76%	73.00%	77.70%	90.50%	69.00%	65.70%	82.30%	85.90%	69.90%	60.80%	70.10%	73.40%	65.60%
65 plus	17%	23.50%	11.20%	0%	23.90%	28.10%	3.70%	12.30%	7.70%	17.60%	20.90%	21.00%	24.00%
Not applicable	4%	2.80%	4.90%	4.80%	4.10%	2.20%	5.60%	1.80%	22.30%	0%	0%	1.50%	5.90%

Source: Healthy Valley 2010 (Q17, n=245)

Table 29: If you are not retired, in how many years do you expect to retire?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Within 12 months	3%	4.60%	1.90%	2.90%	6.90%	0%	0%	1.80%	0%	0%	0%	8.30%	0%
1 to 4 years	23%	29.90%	15.00%	29.90%	3.40%	0%	41.80%	26.60%	35.80%	0%	45.70%	24.80%	0%
5 to 9 years	11%	9.60%	13.20%	14.70%	0%	0%	0%	7.10%	16.10%	19.80%	0%	5.10%	22.60%
10 to 14 years	15%	14.40%	15.00%	19.30%	0%	0%	0%	20.10%	0%	36.30%	8.70%	21.60%	0%
15 years plus	6%	4.80%	7.50%	7.90%	0%	0%	0%	2.40%	0%	44.00%	0%	5.10%	0%
Don't know / Not applicable	41%	36.70%	47.30%	25.40%	89.70%	100.00%	58.20%	42.20%	48.10%	0%	45.60%	35.10%	77.40%

Source: Healthy Valley 2010 (Q18, n=160)

The largest proportion of residents who took part in this survey were from Chipping. That said, a total of 7 villages/ village clusters were covered by the fieldwork and helped to ensure a reasonable geographic mix.

Table 30: Which village do you live in?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Waddington	9%	5.10%	11.50%	9.10%	6.30%	13.50%	100%	0%	0%	0%	0%	0%	0%
Chipping	31%	34.80%	28.50%	33.60%	31.50%	17.90%	0%	100%	0%	0%	0%	0%	0%
Barrow/ Pendleton/ Wiswell	8%	10.70%	5.70%	8.30%	7.50%	8.60%	0%	0%	100%	0%	0%	0%	0%
Gisburn	4%	2.90%	5.70%	5.90%	2.20%	3.30%	0%	0%	0%	100%	0%	0%	0%
Downham/ Chatburn	13%	12.70%	13.40%	13.00%	14.00%	9.70%	0%	0%	0%	0%	100%	0%	0%
Slaidburn/ Newton/ Dunsop Bridge	19%	21.50%	15.90%	22.50%	13.80%	10.90%	0%	0%	0%	0%	0%	100%	0%
Balderston/ Osbaldeston/ Mellor	16%	12.30%	19.30%	7.60%	24.70%	36.20%	0%	0%	0%	0%	0%	0%	100%

Source: Healthy Valley 2010 (Q19, n=325)

Unsurprisingly, given the high levels of satisfaction with the local area, residents tend to live in their village for considerable periods of time. This must be a conscious decision and so village life clearly has its benefits and attractions. But that is not to say that all needs are being met. Far from it, and we have already alluded to possible solutions above.

Table 31: How long have you lived in the village?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Less than 12 months	2%	0.60%	3.20%	2.60%	1.70%	0%	9.50%	0%	5.00%	0%	6.90%	0%	0%
1 to 9 years	21%	21.90%	20.20%	22.60%	20.40%	14.60%	16.50%	27.10%	41.60%	0%	17.50%	12.80%	25.80%
10 to 19 years	20%	21.00%	19.20%	24.30%	15.50%	13.10%	4.80%	26.60%	26.50%	13.40%	1.40%	23.50%	19.60%
20 to 29 years	19%	20.20%	18.30%	19.70%	20.00%	14.20%	20.20%	13.80%	11.10%	74.80%	9.50%	18.50%	23.10%
30 years plus	38%	36.30%	39.10%	30.80%	42.40%	58.10%	49.00%	32.50%	15.70%	11.80%	64.70%	45.20%	31.50%

Source: Healthy Valley 2010 (Q20, n=373)

Table 32: Is the accommodation within which you live...

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Owned outright by you or your family	67%	73.10%	61.60%	61.60%	73.60%	72.50%	84.40%	65.60%	79.90%	81.50%	59.60%	60.90%	78.30%
Being bought with a mortgage or loan by you or your family	13%	12.00%	14.00%	21.30%	4.40%	0%	3.70%	19.60%	6.70%	18.50%	16.50%	8.50%	5.20%
Rented from a housing association	11%	5.20%	16.80%	7.70%	13.40%	22.40%	11.80%	12.80%	2.50%	0%	19.40%	0.90%	13.20%
Rented from a private landlord	8%	9.20%	7.00%	9.40%	7.20%	4.00%	0%	1.90%	11.00%	0%	4.50%	29.70%	0%
Rented free as it is tied to the employment of one of the occupiers	0%	0%	0.30%	0%	0%	1.10%	0%	0%	0%	0%	0%	0%	0%
Part rented and part being bought with a mortgage (ie shared ownership)	0%	0.60%	0.30%	0%	1.30%	0%	0%	0%	0%	0%	0%	0%	3.30%

Source: Healthy Valley 2010 (Q21, n=365)

The majority of households surveyed were either single occupancy or double occupancy. Children have likely flown the nest by this stage of life and ultimately the next change in household composition will more likely be from double occupancy to single occupancy as age takes its toll. It is these single occupancy households who are the most vulnerable and most in need of local support services.

Table 33: How many people live in your property (including yourself) in each of these age categories?

	0	1	2	3	4	5
Under 19	50%	30%	19%	1%	0%	0%
20 to 64	5%	29%	58%	5%	3%	1%
65 and over	11%	45%	44%	0%	0%	1%

Source: Healthy Valley 2010 (Q22, n=224)

93% are satisfied with their home as a place to live. In a similar vein to accessing leisure services, Gisburn has the lowest level of satisfaction with the home at 87% (and only 35% very satisfied). This perhaps makes the village of Gisburn worthy of specific focus, to understand what the issues might be and what steps could be taken to increase satisfaction and ease of accessing services.

Table 34: How satisfied or dissatisfied are you with your home as a place to live?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Very satisfied	67%	68.60%	66.20%	62.30%	75.90%	66.10%	73.20%	76.30%	82.70%	35.30%	64.50%	56.10%	72.20%
Fairly satisfied	26%	25.50%	26.60%	30.70%	18.60%	26.30%	21.90%	18.70%	10.40%	52.00%	26.70%	40.70%	25.10%
Neither	6%	5.40%	5.60%	6.40%	3.30%	7.60%	4.90%	3.40%	1.90%	12.70%	6.00%	3.30%	2.70%
Fairly dissatisfied	1%	0%	1.60%	0.60%	1.40%	0%	0%	0.60%	5.00%	0%	2.90%	0%	0%
Very dissatisfied	0%	0.60%	0%	0%	0.80%	0%	0%	1.00%	0%	0%	0%	0%	0%

Source: Healthy Valley 2010 (Q23, n=377)

Of the 7% who are not satisfied with their home, the size of the property and the size of the accompanying outside space is the main problem. It seems that people are seeking that extra bedroom or that outside garage as a means to improving their home (despite the fact that maintaining the home is one of the biggest challenges facing this population).

Table 35: If you are dissatisfied with your home as a place to live, why is this?

	Total
Size of property/ land	40%
Location (main roads, traffic etc)	28%

Source: Healthy Valley 2010 (Q24, n=13)

Interestingly, 9% receive care from a friend, relative or neighbour due to a long standing illness or disability (higher for women and considerably higher for those aged 80+). Yet, 17% state that they suffer with a long standing illness or disability (see fig 3.2 above). So this could suggest:

- Of the 8% not receiving care, that they are able to cope without additional support
- Of the 8% not receiving care, that their life would be made considerably better by accessing the support services

Table 36: Do you receive care from a friend, relative, or neighbour because you have a long-standing illness or disability?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Yes	9%	6.50%	11.10%	4.30%	8.60%	32.30%	11.90%	6.50%	3.90%	6.90%	8.20%	3.40%	22.90%
No	91%	93.50%	88.90%	95.70%	91.40%	67.70%	88.10%	93.50%	96.10%	93.10%	91.80%	96.60%	77.10%

Source: Healthy Valley 2010 (Q25, n=367)

The support services that residents are currently making greatest use of include help with food shopping, help with the garden or home maintenance and help getting out and about.

Table 37: Do you currently receive any of the following types of help, and if so who provides that help?

	Yes, provided by friend, neighbour or relative	Yes, provided by NHS	Yes, provided by the Council	Yes, provided by other	No, but I might like this help	No, and I don't currently need this help
Aids and adaptations	1%	3%	1%	1%	2%	92%
Help with food shopping	6%	0%	1%	3%	2%	88%
Help with garden or home maintenance	7%	0%	0%	8%	8%	77%
Help with household chores	4%	0%	0%	6%	5%	85%
Help in caring for yourself	2%	0%	0%	1%	2%	95%
Help with living with an illness or disability	4%	0%	0%	2%	3%	91%
Help with emotional health	3%	0%	0%	0%	3%	94%
Help getting out and about	5%	1%	1%	2%	3%	89%
Help to visit neighbours, friends or family	4%	0%	0%	2%	3%	91%
Help to access leisure or learning opportunities	2%	0%	0%	0%	2%	96%
Help with financial affairs	3%	0%	0%	0%	4%	92%
Help feeling safe at home	2%	0%	0%	2%	4%	92%
Help with feeling safe in the local area	2%	0%	1%	1%	4%	92%
Other	1%	0%	0%	1%	0%	98%

Source: Healthy Valley 2010 (Q26, n=344)

When residents were asked to consider which were the most important for the future, family/ neighbour support, help getting out and about and more money topped the list. So clearly there is an awareness that reliance on other people will increase over the coming years. For those who don't have family (and even for those who do and cannot access them regularly enough) there needs to be a local support mechanism for residents to share difficulties and help each other.

Table 38: How high a priority are each of the following in allowing you to remain happy and healthy as you become older?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Aids and adaptations	21%	11.10%	29.40%	20.50%	19.40%	29.20%	14.80%	23.00%	24.20%	25.10%	20.90%	17.70%	16.30%
Help with food shopping	24%	12.70%	33.70%	23.50%	23.00%	31.90%	23.20%	20.30%	33.30%	64.70%	20.10%	22.10%	14.70%
Help with garden or home maintenance	25%	20.70%	47.40%	33.70%	33.70%	45.70%	33.30%	34.20%	18.80%	81.30%	34.80%	26.10%	39.40%
Help with household chores	25%	17.50%	32.40%	26.10%	23.00%	28.90%	21.30%	26.70%	27.90%	71.90%	16.70%	25.20%	16.60%
Help in caring for yourself	20%	14.60%	25.40%	22.20%	18.60%	14.60%	13.30%	23.60%	33.30%	22.00%	16.00%	17.90%	10.20%
Help with living with an illness or disability	25%	19.70%	29.50%	26.10%	23.30%	22.00%	16.10%	30.20%	41.70%	26.50%	23.60%	17.10%	16.60%
Help with emotional health	15%	9.90%	18.60%	17.80%	10.30%	8.20%	8.40%	17.50%	22.80%	5.50%	6.90%	13.60%	9.40%
Help getting out and about	31%	20.50%	39.70%	31.00%	27.60%	39.10%	18.70%	32.20%	28.60%	81.20%	25.00%	25.60%	22.90%
Help to visit neighbours, friends or family	25%	17.80%	31.00%	26.70%	22.20%	21.70%	18.40%	24.60%	28.60%	69.80%	21.60%	25.00%	13.40%
Help to access leisure or learning opportunities	15%	11.20%	16.90%	17.80%	10.30%	5.10%	6.20%	21.30%	18.20%	18.80%	5.50%	7.90%	8.90%
Help with financial affairs	16%	11.70%	19.60%	17.20%	14.90%	11.90%	10.30%	19.80%	16.20%	35.70%	9.00%	15.30%	8.00%
Help feeling safe at home	25%	19.60%	30.00%	27.30%	22.40%	21.60%	8.10%	22.00%	29.80%	55.30%	22.30%	28.80%	18.60%
Help with feeling safe in the local area	24%	18.90%	29.80%	27.20%	20.20%	23.60%	6.00%	22.10%	30.50%	60.90%	25.60%	26.90%	15.40%
More money	27%	23.80%	29.40%	32.60%	19.40%	16.80%	4.10%	29.10%	28.50%	70.20%	37.80%	20.30%	19.00%
Support from neighbours	32%	26.90%	35.80%	34.60%	28.80%	21.20%	22.30%	39.60%	27.90%	58.70%	25.30%	34.00%	12.80%
Support from relatives	39%	32.50%	44.80%	40.10%	37.60%	37.50%	22.30%	44.10%	32.00%	63.70%	34.60%	38.80%	26.70%
Other	3%	1.90%	4.40%	2.50%	4.20%	0.00%	0.00%	4.20%	0.00%	37.90%	6.10%	0.00%	0.00%

Source: Healthy Valley 2010 (Q27, n=336)

The most interesting finding in the table below is that relating to transport services and social services. Both of these see a tremendous leap in importance when looking at the future. Residents clearly have a need for independence, and the local transport services will help them to remain independent for as long as possible. At the same time, social services will have a vital role to play. But how will these two services be affected by the cuts that will take place over the coming years?

Table 39: Which of the following services, if any: a) are important to you now? b) will be important to you in the future?

	Now	Future	Not important	Don't know
Health Services	79%	74%	1%	2%
Transport Services	48%	71%	9%	5%
Community Safety Services	43%	56%	21%	11%
Leisure Services	40%	42%	33%	13%
Social Services	28%	59%	22%	10%
Housing Services	18%	23%	57%	15%
Employment services	13%	19%	63%	11%
Education Services	11%	13%	74%	10%
Other services	2%	21%	19%	65%

Source: Healthy Valley 2010 (Q28, n=356)

9% regularly care for someone with a long standing illness or disability. It would likely be very welcoming for this 9% of the population if there were additional support mechanisms to help them – i.e. somebody else to call round to say hello, help in getting the person to a morning coffee club etc. These additional support mechanisms don't have to be costly and they don't have to be provided by a public service. But they do need to be provided by volunteers and public service providers need to be on hand to facilitate the early stages and eventually let go once the service is sufficiently well established and self supporting.

Table 40: Do you regularly care for someone with a long-standing illness or disability – other than as part of your job?

	Total	Men	Women	50-64	65-79	80+	Wadd	Chip	Barrow	Gisburn	Down	Slaid	Bald
Yes	9%	9.60%	9.20%	8.20%	14.10%	1.20%	21.50%	6.20%	14.80%	5.10%	6.60%	3.30%	15.10%
No	91%	90.40%	90.80%	91.80%	85.90%	98.80%	78.50%	93.80%	85.20%	94.90%	93.40%	96.70%	84.90%

Source: Healthy Valley 2010 (Q29, n=368)

Summary

The survey has identified a number of areas that may be worthy of further investigation. These include:

- Perceptions of health versus actual health.
- The ability to maintain freedom (transport services and adult care services).
- Providing access to a regular, high quality social circle.
- Apparent levels of higher dissatisfaction in Gisburn compared to any other village.

Conclusions and recommendations

Keep the momentum going

The Healthy Valley survey has simply scratched the surface and highlighted areas where action may need to be taken. But much greater understanding needs to be obtained in order to take things forward in a way that meets the needs of the village and also the needs of the service provider. Keeping decision makers and residents involved and informed along the way will be a crucial, but also difficult, process.

Utilise the willingness to get involved

From a service providers perspective, it is vital that for some services to continue (or new ones to be implemented), responsibility has to be taken up by the voluntary sector. The survey clearly highlights that there is the desire out there to help people and to give something to the community. With the assistance of the Ribble Valley CVS, this could be the start of a fruitful partnership and the beginning of delegated services to the local community. By working together initially, this will help to build relations, confidence and understanding and ultimately allow the public sector to take a step back once the service is up and running and all volunteers comfortable and happy with the set up. Example projects might include:

- Not for profit community shop – providing basic fundamentals (bread, milk etc), the opportunity to meet and interact with others and the opportunity for younger residents to get some work experience and commercial knowledge
- Village hall coffee mornings – providing a regular, consistent meeting point in a warm safe environment
- Care and share scheme – providing vulnerable residents with access to the community, someone to talk to and to share their concerns with. This scheme would also provide volunteers with the opportunity to help the most vulnerable and give something back to their village

But the important thing here is not to be seen to be ‘passing the buck’. This will not be a quick fix and will take months if not years to fully establish - without the dedication of all parties it will be unlikely to succeed.

A series of specific recommendations have been identified by the project team:

- Partner organisations should identify opportunities to deal with the needs identified in the secondary analysis, for example, tackling fuel poverty.
- The variations in practice and prevalence by GPs serving the areas should be investigated to consider whether it is appropriate.
- The survey highlighted some service gaps, real or perceived, in terms of the post office and dentists. These should be investigated.
- The survey identified willingness for people to lend their skills in support of improving their local area. Opportunities to use local skills should be explored on a village by village basis. Timebanks may be a practical way for people to provide their time but also receive back.
- The results of this health needs assessment, particularly on the findings around community spirit and the positive village mentality, should be reported back to:
    - The sponsoring organisations, Lancashire County Council, NHS East Lancashire and Ribble Valley District Council.
    - The Ribble Valley Health Improvement Group
    - The Ribble Valley Seniors Forum
- The results of this needs assessment should be presented to the Parish Councils as this will foster engagement with villages. Villages should be supported to use the intelligence to develop their own solutions to needs. This could be used as an opportunity to identify village enablers.

Final word

Positive outcomes of the survey

Help Direct members of staff assisted in delivering the survey and they really benefitted from the exercise. A Help Direct leaflet was delivered alongside the survey asking residents if they required any assistance. Around 100 specific requests for help and signposting were received and dealt with.

The piece of work is now being used as a background for village meetings and encouraging opportunities for parish councils to talk more to communities.

The work is already being used by Ribble Valley Borough Council's Community Development team as evidence in a funding bid. The Big Lottery Fund has introduced a new funding programme called Reaching Communities, which aims to improve the lives of communities, particularly those in need. It is available to voluntary or community organisations or not for profit organisations and has both revenue and capital funding components. The application requires evidence of needs and the Healthy Valley Survey has provided very useful data about satisfaction levels with current opportunities in the area and areas of need which are not currently being met.

Lessons learnt

Undertaking the survey and analysing the results has served to enforce the message of the benefits of having a village enabler, a local villager.

The door to door method of undertaking the survey was the best method to utilise to ensure a good response rate, despite being the most resource intensive. The method was only successful, however, if arrangements were made to pick the completed surveys up as people tended not to stick to arrangements to drop off a completed survey (say through someone's letter box).

We have also learnt that it is absolutely crucial, when undertaking a door to door survey, to use the right people for the job. The reliability of people is paramount to ensure the survey is undertaken successfully in all areas.

Although take up of the survey was quite good, volunteers met with some reluctance to complete the survey as they were unsure about what use it would be put to/ its authenticity. If we were to repeat the survey more publicity may be required to ensure people are aware that it is authentic – for example, notices could be put on Parish notice-boards.

There is a willingness to use the methodology to target other villages, specifically the Ribchester area which was missed in this exercise.

It has been suggested that it would be useful to repeat the survey in 2-3 years time to track any changes.

Finally, it has been recognised that the cooperation of all partners was essential to the success of the Healthy Valley survey project.

Appendix A: Verbatim responses to Q8

Do you feel that there is anything missing from your local area?

No amenities
Newsagents/Corner shop
Yes a post office
Community spirit missing
Swimming pool
No maybe more police
Post office
Sunshine
More actitvies for children and older people
Bowling green bus to clitheroe and brownhill
Traffic calimg measure
Dentist
Pediatrician
Dont see much of the police
Coffee/ tea/cafe shop and cash machine
Only a bus service that goes directly to Blackburn or preston from mellor
Bus stop
Social activities
Bus service evening/sundays/ bank holiday. no speed limit or move further down
Public transport evenings sundays and bank holidays
Bus service on sundays and bank holidays
A chip shop
Marks and Spencers / bus to Manchester
More safe cycle paths more buses through the village on A59 etc
Bus stop, Post office
Gritting in winter - housebound in winter
Post office
Our granddaughter lives with us aged 17. Returning from college on a bus on the days that she finishes at 8pm is impossible.
Nothing for young adults
A corner shop, a butcher and a confectioner
Swimming pool
A better bus service

A reduction of village shops
Very rarely see a local police presence
A weekly exercise class to help with mobility together with a cuppa and a chat
Recreational facilities for teenagers
A direct bus route to Blackburn, Clitheroe and Preston
Local shop
Better public services - buses
Corner shop/ bakery
Swimming pool
A closer bank
A shop
A village pub
Affordable housing for local people
Car parking
Affordable housing for local people
Cinema
Post office/ shop
Faster broadband
Proper locals
Gas supply
Local shop required
Gas
Local shop
Local shop/ post office
A local shop
Adequate car parking
The Petre recycling centre when it closes in Oct.
Local shop
A shop
A bus more than once a week.
A Marks and Spencers store
A bakery
A bakery
Post office
Post office
GP, dentist, chemist, post office
A fish and chip shop

Work
Post office
A food store to deliver to the disabled
More regular policing
Shop/ newsagent. Village community hall. Evening/ Sunday bus service.
Local shop
A local shop
A small shop
Post office and shop. Village hall for daytime use.
A social club
Post office and local shop
A true village pub in the sense of belonging and being welcome. This is particularly important for older people too.
Village hall, local shop, post office, cash point
A good village shop
Time to enjoy life
A village hall/ tea shop
Corner shop with a post office
Corner shop/ post office
Post office and local shop
Shop and post office
Village hall
Visible police
Shops
GP surgery
GP surgery
Co-ordinated bus/ rail links to Clitheroe
Jobs
No gas supply
Post office
Post office, gas supply
Post office
Swimming and leisure facilities
A good village shop
Gas supply to the village
Foot paths - roads are unsafe as traffic is too fast.
Footpaths and a by pass

Post office, open all week
Post office
Low cost housing, more employment opportunities. Interesting retail outlets and eating places.
Care home/ nursing home/ warden accomodation
A full time post office
GP and post office
More affordable houses
Permanent PO and a petrol station
Leisure facilities and learning opportunities
More transport (buses etc), super market
Village store
Pub
Free cash point, more dog poo bins
Community spirit - too many expensive houses don't contribute to the community
Post office
Policemen
Gas
Industry
Mains gas supply
Larger shops
Gas supply
Gas supply
Post office and corner shop
Evening transport
Post office
A gas supply and a post office
A gas supply
Road maintenance
Petrol
Employment
Post office
Post office, shop
More police presence
Chemist/ pharmacy
More police presence
Chemist
Police

Positive police presence

Police presence

Chemist

Police

Appendix B: Verbatim responses to Q24

If you are dissatisfied with your home as a place to live why is this?

Would like a second bedroom

Bathroom downstairs

The main road has parking and traffic issues - cars travel too fast and people park on both sides.

Renovation being undertaken

Insufficient space and no garage/ parking space

I'm finding keeping the property in good repair quite difficult.

Very small, has no garden.

Noise, heavy traffic and pollution

Noise, traffic disruption, damage to property

Home improvements required

no garden or garage

Speed of passing traffic

Prefer a bungalow

Appendix C: Verbatim responses to Q30

What one message would you pass on to promote and protect the well being of older people?

Aim to avoid loneliness. Undertake stimulating activities. Get involved in community projects.
Any benefits and services provided to facilitate the health and happiness of older people should not be means tested. Developing a stronger community spirit is essential. I am certain that many residents would be happy to work together to support their neighbours
Be disciplined, don't become lazy, make yourself good meals. If you belong to a church or group, you will find friendships and help. Enjoy your leisure time whilst you can.
Be happy
Be polite and considerate stay part of community
Be thankful you're alive
Being financially viable enables older people to have a choice, i.e. to choose to use buses or taxis, buy from the internet vs get to the shops etc. They should not need to 'go without' in order to keep warm or eat well - a proper pension is the way forward
Bus services must be maintained. Help should be given to keep small shops/ post offices to be able to survive in villages.
Care for your friends and neighbours
Communication is an important thing - always to be there to give assistance to those who are in need. Take interest in the young as well as the old. Do as much charity work as possible.
Community spirit, look after your neighbours
Contact people if you need help don't struggle
Do anything that gets you out and about.
Do not cut costs
Don't be judgemental of others get along with everyone
Don't get rid of local services e.g. post offfice, bus service local bobby etc
Don't just sit there get out and about and meet people socialise
Don't sit about - get out and work out every day.
Don't suffer in silence - get out and ask if you need help
Eat better and good diet
Eat healthy
Eat well, keep warm, socialise as much as possible and enjoy the lovely surroundings. It is a privilege that is not appreciated as much as it should be. Many people live in less pleasant surroundings and would be very envious of the residents of Barrow.
Encourage voluntary work

Enjoy and look after the countryside not to be taken for granted
Enjoy the ribble valley, it is a beautiful place
Every generation 'owes' the previous generation for our freedoms. For our generation, this is particularly important. Older people fought for us in the world war. We need to make sure they are safe, well cared for and enjoy the best quality of life.
Family orientated, members live longer
Family support and good neighbourliness
For the community bus to keep running, as it helps me to do my shopping each week (I cannot carry all my shopping home with me from the shops)
Friendship
Get involved in the community
Get involved in things!
Get out and about go to church socialize community spirit
Get out and about walk as much as possible meet people
Get out and enjoy other people's company
Get out and enjoy yourself and mix
Get to know your neighbours and make friends with them because you will need their help at some point in the future
Get up and get going don't sit and let life pass you by
Give them a better old age pension
Go out and meet people
Health is wealth
Health services locally (i.e. no further than Clitheroe). I worry about the future when my health will deteriorate. In my husband's last illness, I was grateful for the home support. I hope it will be available for me.
I have filled in this form but I feel Councils do not take any notice. You ask and then do what you want.
If the answers to this survey are readily available for other residents, that would be all I could ask for.
Instead of just sending older people into care homes, provide more home care to enable old people to stay in their home for as long as possible. Also, make more staff available with care homes and with higher pay, for the service they are providing to humanity.
It would be nice to know that there was somebody you could rely on, a trustworthy person you could speak to about your problems and who wants to listen. That would be a huge relief.
Join in as many events as you can. Socialise via church and over 60s groups. Volunteer where you can to be of help in modest ways.

Join things such as out of house activities. If you need help, ask. It will be better than being housebound.
Just been in the area for 18 months. I moved here because I work in Clitheroe. My family are throughout the UK as are my friends. I do have working friends that I see now and then. Been divorced for 3 years and feel a bit lonely at times. Just recovering from prostate cancer.
Just put yourself in our place. As my husband said to me "it's your turn next". Most older people are independant and like to remain so, i.e. don't want to be a burden to the rest of society. Indeed we can be an asset to them as we have 'gone through it' so to speak.
Keep active, stay interested and don't moan.
Keep all important housing, health and social services intact. Improve transport links. Ensure effective community policing so that the village remains a safe and happy place for older people to live in and prevent isolation.
Keep amenities as they are, Good bus service etc
Keep an eye on your neighbours and be prepared to help them
Keep as active as possible and value friendships
Keep as active as possible in mind and body
Keep as active as you can
Keep as fit as possible, maintain contact with family and friends, learn new hobbies as old ones no longer become possible
Keep busy and consider other people.
Keep fit and active and enjoy the day that you are in. It is often easy to fill a year with cares and concerns when eventualities wouldn't fill a day.
Keep going never sit back and say I can't do it
Keep in contact with your neighbours
Keep in regular touch with your neighbours
Keep in touch with friends, family and neighbours
Keep involved in the community life.
Keep it rural and therefore new housing development to a minimum.
Keep local services
Keep moving and get outside if possible
Keep our Post office
Keep our rural village protected by keeping shops, footpaths and policing accessible to all.
Keep standards of community awareness high, especially in the villages
Keep walking
Keep walking
Keep warm in winter, be young at heart, try not to fall
Keep your hands and minds occupied. Belong to village organisations

Keep your mind active and join local clubs
Knowing what is available
Look after each other
Look after them, prioritise them as they deserve it. Do not penalise them in order to prioritise others who have not contributed to the system.
Look after yourself
Look after yourselves and each other
Look out for others
Looking after each other - community spirit
Make the most of everyday
More involvement with older communities
More visits/ check ups on house bound people. Days out/ shopping trips for those without transport. Local post office and shops. Foot paths on country roads. Traffic calming through the village - 30mph is too fast.
Mostly people in the village are friendly. Just smile and pass the time of day.
Need friendship, ask for Crossroads service if needed.
Nice and peaceful village to live in
None. This is an excellent area in which we live
Not to get yourself isolated.
Nurture the community. It's what we are here for.
Opportunity to take part in adult education to help maintain physical and mental health
Perhaps provide access through a local monthly news sheet with good contacts and problem solving issues.
Please keep social services and welfare services simple to understand. The elderly can't cope with red tape and bureaucracy!!
Positive attitude - make the most of what you have not what you might like!
Protect village life, we need things like a local pub, shop or post office to stay in touch with each other
Provide and promote fitness courses during the day and evenings
Provide sheltered housing in the village so older people stay longer in the community.
Really important not to be treated as an older person just as a person. dont underline negatives promote the positives.
Really pleasant area to live in with fantastic neighbours
Regular community get togethers (i.e. at the village hall and trips out and about)
Resources into Alzheimer's
Sell your home and rent a sheltered accommodation - stress free and worry free
Socializing

Stay active
Stay active
Stay active
Stay active and as healthy as possible for as long as you can and push yourself to do things. Remember - use it or lose it!
Support your local pub and drink good ale.
That there are people who wish to care for them, be aware of their needs and do their best to fulfil these needs in order for them to still have an active and fulfilling life with peace of mind as a priority.
The ability to keep active both physically and mentally, helping to keep illness and disability in perspective.
The continuation of elderly people meeting, socializing and exercising to keep them sharp in mind and body.
The village of Chipping is not people and pedestrian friendly, being dominated by the needs of car communities and heavy goods vehicles. It is time to readdress the balance!
Those older people living alone would benefit hugely from vists from either volunteers or family. Loneliness is a big problem and can make day to day living much more difficult.
To be aware of the people around you
To get out and about in your local area, walking, keeping fit, looking out for others, keeping in touch with family, meeting other people in the village and taking part in as much as possible.
To get out and about where possible and socialising with other people in the area.
To look out for the elderly
To maintain medical services nearby and avoid travelling. To retain post office and library. we have lived with dog problems for almost 2 years. Our neighbours have perpetuated this continual problem.
To make the most of living in a beautiful area
To provide a type of sheltered accommodation allowing older people to stay in the village.
To treat them with dignity
Try and become involved in any social groups in the area and get to know what's going on in the village
Try new things - never put up with loneliness.
Try sky diving - it gives you a new perspective on life
Try to ensure that people in outlying areas are not isolated from services
Try to help yourself - eat properly, exercise regularly, take an interest in people and progress. Think positive, stop 'whingeing'. Make every day count and help others when ever you are able.
Try to walk and eat healthily and regularly
Walk get out and about

Walking facilities

We need a nice park for children to go on, which grandparents can visit, this would need benches for people to be able to sit down whilst the children play. We also need a swimming pool and gym so that we don't have to travel all the way to Clitheroe, this would also keep children and teenagers out of trouble as they would have something to do.

When older people can no longer look after themselves, LCC should provide care homes in the villages where the older people live

When you are older and become a widow it is even harder to cope if you are also a disabled person.

Appendix D: Living in East Lancashire survey comparisons

To help contextualise the findings of the Healthy Valley survey, comparative data has been extracted from the Living and Working in East Lancashire survey that was completed in 2008. All the tables below have been filtered so that the responses include only those living in Ribble Valley over the age of 45. This enables a much closer comparison to the responses of the Healthy Valley survey.

Table 41: Comparative data for Table 13

Do you have any long standing illness, disability or infirmity which limits your activities in any way?	2008 (n=548)
Yes	27%
No	73%

Source: LIEL 2008 and 2006

Table 42: Comparative data for Table 27

Which of these activities best describes your current situation?	2008 (n=548)
Employee in full time job	20%
Employee in part time job	11%
Self employed	12%
On a government supported training programme	0%
Full time education	0%
Unemployed and available for work	1%
Permanently sick or disabled	4%
Wholly retired from work	49%
Looking after the home	2%
Looking after family members	1%
Doing something else	1%

Source: LIEL 2008 and 2006

Tables 43: Comparative data for Table 31

How long have you lived in East Lancashire??	2008 (n=541)
Under 12 months	0%
1 to 5 years	3%
6 to 10 years	6%
Over 10 years	46%
Always lived in East Lancashire	45%

Source: LIEL 2008 and 2006

Table 44: Comparative data for Table 34

How satisfied or dissatisfied are you with your current property?	2008 (n=548)
Very satisfied	66%
Fairly satisfied	27%
Neither	4%
Fairly dissatisfied	2%
Very dissatisfied	2%

Source: LIEL 2008 and 2006