ASSESSING NEEDS AND ASSETS IN GLOSSOP

A partnership approach to collection and synthesis of evidence from key informant interviews, community profiling, asset/ service mapping and stakeholder consultation to inform health and well-being improvement in Glossop

Health and Communities Department, Derbyshire County Council

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DERBYSHIRE County Council
Improving life for local people

Preliminaries

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Statement of purpose

This report describes a partnership approach to collection and synthesis of evidence from key informant interviews, community profiling, asset/ service mapping and stakeholder consultation. It aims to identify gaps in current service provision and to provide evidence for prioritising options to improve health and well-being in Glossop (here regarded as synonymous with Glossopdale) and to reduce health inequalities.

Intended audience

This report will be of interest to those with roles in providing or commissioning health and related services for Glossop residents, the users of those services and individuals or organisations with an interest in the improvement of health and well-being in Glossop.

Acknowledgements

The Contributors wish to acknowledge the assistance gratefully received from members of the community in Glossop and other stakeholders who agreed to be interviewed as part of this assessment. The Public Health Intelligence team, Derbyshire County Council, provided support.

Abbreviations/ acronyms used in this report

BC	borough council
CAB	Citizens Advice Bureau
CCG	clinical commissioning group
CC	county council
DC	district council
DCC	Derbyshire County Council
DCHS	Derbyshire Community Health Services NHS Trust
DDDC	Derbyshire Dales District Council
GP	general practice (or practitioner)
HCFT	Healthcare Foundation Trust
HNA	health needs assessment
HPBC	High Peak Borough Council
IMD	Index of Multiple Deprivation
LDD	learning difficulty and/or disability
LSOA	lower layer super output area
MSOA	middle layer super output area
NEET	not in education, employment or training
NHS	National Health Service
PHE	Public Health England
PSHE	personal, social and health education
SEND	special educational needs and disabilities
T&G CCG	Tameside and Glossop Clinical Commissioning Group
TMBC	Tameside Metropolitan Borough Council

Interpretation of this report

Restrictions on scope

In pre-defining the topic scope of this report, our ability to capture health needs outside of our chosen framework for assessing need is constrained.

Limitations of evidence

The data contained in this report are aggregate and may therefore obfuscate some important variations in health indicators between community groups. Where available we have presented ward-level data to help identify inequalities within Glossop; we have deliberately avoided presenting district-level data and data that are very dated. Some indicators, however, have not been directly measured at ward level and therefore only modelled estimates are available, based on larger geographic areas. Practice-level health indicators are taken from the Quality and Outcomes Framework (QOF) database, which was designed for performance management of general practices rather than as an epidemiological profiling tool. QOF is widely considered to under-estimate the community prevalence of ill health. The small number of key informant interviews and stakeholder questionnaires collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Low numbers of events (below 5) are routinely supressed in official statistics; this may account for some missing data.

Implications, options and recommendations

The Steering Group acknowledge the desirability of making 'SMART' recommendations (specific, measurable, assignable/ attainable, relevant, time-bound) based on this report. This report is informational; subsequent work will review options and identify priorities for health improvement in Glossop.

Interpretation of quilt tables

A quilt table is a popular presentation format for health indicator data and is used extensively in this report. The colour coding refers to statistically significant differences and can be interpreted using the following keys:

Worse than England average	Similar to England average	Better than England average	No statistical comparison made

Higher than England average	Similar to England average	Lower than England average	No statistical comparison made

Document control

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Summary

This report describes a partnership approach to collection and synthesis of evidence from key informant interviews, community profiling, asset/ service mapping and stakeholder consultation to inform health and well-being improvement in Glossop.

Geographic scope: Dinting; Whitfield; Old Glossop; Howard Town; Gamesley; Simmondley; Hadfield North; Hadfield South; Tintwistle; Padfield and St. John's.

Topic scope: Where people live (including housing and some aspects of community life and the urban/natural environment); Money to live off (including employment and related personal income); Choice of food (including the availability and affordability of healthy options); Getting about (focussing on transport and general access to services); Learning and training (including measures of educational attainment); Health and health care (including lifestyle and leisure, disability, mental health and well-being, physical health and injury, deaths and life expectancy, and access to public health, primary and secondary health services).

Overarching key messages

The following messages emerged from Chapter 2 ('The people of Glossop') and/ or as a result of looking across the sections of this report:

Wider health determinants: Stakeholders recognise the need to tackle the 'upstream' determinants of health (housing, education, etc.) in order to improve the 'downstream' health of individuals and communities as a whole.

Health status: Health is said to be more than the absence of disease, however, routine statistics focus almost exclusively on the latter so it is very challenging to find information about how 'healthy' the people of Glossop are.

Deprivation and inequality: Overall Glossop is not deprived relative to some districts within Derbyshire or to England; however, there are significant pockets of difference (inequalities) within Glossop itself (see Chapter 2 and quilt tables throughout this report).

Prevention and planning: The 'band' of Glossop residents currently of working age (see population pyramid, Chapter 2) presents opportunities to preserve good health and prevent ill health amongst this cohort, and to begin forecasting the impact of larger numbers entering retirement age on service capacity—while recognising that impacts will be less favourably experienced by those retiring into more deprived communities and/or those living alone.

Transport links: Transport issues have high visibility throughout this assessment, seems critical to accessing existing services and perceived negative impact on well-being—with the potential to affect all age groups.

Asset use: A good number of community-based assets have been identified in most chapters, although this assessment cannot comment on how well utilised or accessible these assets are.

Working together: There is recognition of potential benefits to partnership working between service providers and commissioners, although ability to take this forward may be tempered by limited resources and other barriers implicit within current systems that do not facilitate their doing so.

Key messages concerning where people live

The following messages emerged from Chapter 3 of this report:

Community identification: "Community" within Glossop is not necessarily defined in geographic terms (for example, commuters may have different perspectives on local identity to residents born in Glossop); this implies identification of groups for health improvement intervention may not be as simple as naming particular wards.

Young people's needs: This assessment has identified an adult perspective on the needs of young people in Glossop, but it is not known whether this perspective is shared by young people themselves; further work to identify the needs of younger age groups in Glossop may be indicated.

Housing affordability: Perceptions that the cost of housing is high may be related to personal income level rather than to awareness of cost relative to elsewhere.

Social housing: The borough council have committed to continuing improvements to social housing in Glossop, although there are indications that some council tenants perceive the authority to be less responsive to requests for repairs to council properties than they could be; tension between ambitions to improve the supply of social housing and to repair existing properties in a timely fashion may be anticipated in the face of funding restrictions.

Community safety: There may be a discrepancy between the level of reported crime and the perceived level of crime in Glossop.

Key messages concerning money to live off

The following messages emerged from Chapter 4 of this report:

Getting (to) work: Transport connects people to jobs.

Employment and education: A relationship between occupational group and educational attainment seems evident at ward level, with manual occupations (Table 4.6) corresponding to lack of qualifications or education to lower-level qualifications (Chapter 7, Table 7.3).

Working part time: The proportion of Glossop males in part time work is notability higher (23.5% ward average) than the County average (13.5%); part time work is associated with reduced earnings potential.

Benefit claimants: Variation in proportion of benefit claimants by ward likely reflects demographic differences in part, although more information is needed to comment on possible disparities in access to welfare rights advice and uptake of benefit entitlements in relation to need.

Employment role models: Gamesley stands out for having a high proportion of households where no adult is in employment, which could contribute to the normalisation of this situation among young people on the estate.

Welfare advice: It seems necessary to find more effective ways of increasing community understanding of what community-based welfare/ financial advice services are available, and to reinforce messages that such advice is independent.

Key messages concerning choice of food

The following messages emerged from Chapter 5 of this report:

Facilitating choice: Transport widens choice in terms of healthy eating and price.

Obesity prevalence: The high level of adult obesity recorded by Glossop GP practices is a concern, with complex causes and implications.

Knowledge gaps: More information is required to understand local influences of food choice and its relationships with other determinants of health, such as the 'community' value of local shops and the financial viability of education about 'spending to save' via larger but less frequent shopping trips.

Key messages concerning getting about

The following messages emerged from Chapter 6 of this report:

Proportionate services: Transport provision in Glossop may be mismatched to local requirements to support improved access to employment, health care and other community amenities, food choice, educational opportunities and beneficial lifestyle changes.

Cost barriers: Cost can be a barrier to travel outside of Glossop via public transport and access to information about passes/ concessions may need improving.

Active travel: Glossop is not active travel-friendly (e.g. walking, cycling) and road safety considerations may dictate that alternative forms of physical activity should be more heavily promoted given the anti-obesity and other benefits of regular exercise.

Planning for the future: Transport needs revisiting using a 'whole system' approach. Currently, car ownership seems to be a necessity rather than luxury, and there are no incentivised car sharing schemes in place to maximise existing vehicle use. Volunteer driver eligibility criteria are strict and may inhibit greater utilisation of this resource. Planning needs to take into account proposed cuts to public transport and community transport services in the Glossop area.

Key messages concerning learning and training

The following messages emerged from Chapter 7 of this report:

Younger voices: This assessment identifies the need to better understand what young people think about education and training—particularly young residents of Gamesley, Hadfield North and Whitfield, who may be at higher risk of finishing compulsory education with no qualification.

Access barriers: A better understanding of local barriers to adult education such as transport and childcare is needed, as is information on resident awareness of existing education-focussed assets in and around Glossop.

Pooling assets: Educator willingness to partner with the community sector has the potential to improve resourcing and utilisation of wider community assets (both people and buildings, such as a network of peer educators teaching life skills outside of classrooms).

Tailored training: Some training may be impeded by small numbers that impact course viability, with the result that meeting demand may be usurped by systems that effectively push people into training that satisfies performance indicators only.

Learning environment: The perception that there may be a fall-off in educational attainment between leaving primary school and leaving secondary school merits further investigation, including the possible role of experiences outside of school in shaping attitudes to education.

Careers advice: There is limited local provision of careers advice (Connexions Derbyshire had offered a restricted service; a National Careers Service access point operates at Glossop Adult Education Centre).

Volunteering benefits: Opportunities to develop the soft skills required for employment (e.g. self-confidence, able to communicating appropriately, work in a team, etc.) should not be overlooked; volunteering offers an opportunity to re-gain or learn these skills.

Key messages concerning health and health care

The following messages emerged from Chapter 8 of this report:

Inequalities: There are geographic inequalities in health and health outcomes within Glossop (as there are inequalities in the determinants of health, noted elsewhere).

Lifestyle data: Measured (rather than estimated or self-reported) information about lifestyle behaviours and their consequences in Glossop is limited in relation to healthy eating, obesity, physical activity, smoking and drug misuse.

Alcohol misuse: Harms related to alcohol misuse are a concern in Glossop, as noted in a recent alcohol and substance misuse needs assessment; excess alcohol is also an important contributor to adult obesity.

Mental health: Information about mental well-being in Glossop is lacking, however, indicators relating to prevalence of depression and self-harm behaviours may suggest the need for initiatives to improve mental health.

Transport and timing: Transport to/ from health-related amenities appears to be an issue for some Glossop residents; this is probably linked in with hours of service availability and/or scheduling of transport options.

Interpretation of variation: Potential reasons for variation in condition prevalence and in health care activity measured at ward and/or practice level require discussion informed by local insights to facilitate a shared understanding between stakeholders regarding what is being measured and what actions may be appropriate.

System complexity: Commissioning and provision of health services is particularly complex in Glossop, with fragmentation resulting from unique cross-border issues.

Enthusiasm and ideas: Stakeholder enthusiasm and innovative thinking to improve health and health services is noted and will require more collaboration between statutory and non-statutory partners, with wider input into service design and delivery leading to innovative models of delivery (e.g. referral of GP patients to community-based lifestyle interventions).

1. Introduction

This chapter introduces health needs assessment (HNA) and explains our purpose in undertaking an assessment of needs and assets in Glossop, as well as the approach we took.

1.1 Background

In April 2013 Derbyshire County Council (DCC) took over responsibility for some public health functions from the National Health Service (NHS). Now part of the Council, the public health team works with other parts of local government to influence matters that affect health in different ways. A key public health role is helping those who provide and commission (plan, buy and manage) health services take account of the needs of the local community. Health needs assessment (HNA) is a tool for doing exactly that, although modern HNAs interpret health rather liberally.

The health of individuals is broadly determined by personal lifestyles choices (e.g. amount of exercise), stress and other impacts on mental well-being, and the things that physically cause illness like genetic problems, wear-and-tear or injuries. At a national level, things like social norms, economics, the environment (both natural and built) and political decisions affect health. Local communities often find the middle ground of 'intermediate' influences on health—sitting between these levels—to be of more relevance. This is because these are things we recognise as having impacts locally and these are the things within our power to influence. Health and social services, while the first thing many might think of, are but one of these intermediate influences on health (often referred to as 'determinants of health'; see Box). Health also depends crucially on things like household income, how far we got in school, whether our homes are free from damp, the availability of suitable transport, and whether we feel in control over our lives and appreciated for the work we do.

Key term: Determinants of health

Broader, population-level influences on health and well-being (as opposed to the causes of ill health, which tend to be visible on an individual basis).

1.2 Aim and objectives of this assessment

The overarching aim of this work is to involve the Glossop community in making decisions about improving the health of people in Glossop, working in partnership with them and other stakeholders to identify issues and plan actions. To achieve this aim, we agreed the following objectives:

- Form a partnership steering group;
- Conduct an assessment of health needs and assets in Glossop (the present document);
- Translate the assessment of need into a plan for action;
- Take action, within available resources.

1.3 Scope of this assessment

The geographic scope of this assessment comprises eleven electoral wards: Dinting; Whitfield; Old Glossop; Howard Town; Gamesley; Simmondley; Hadfield North; Hadfield South; Tintwistle; Padfield and St. John's (see Fig. 1.1).

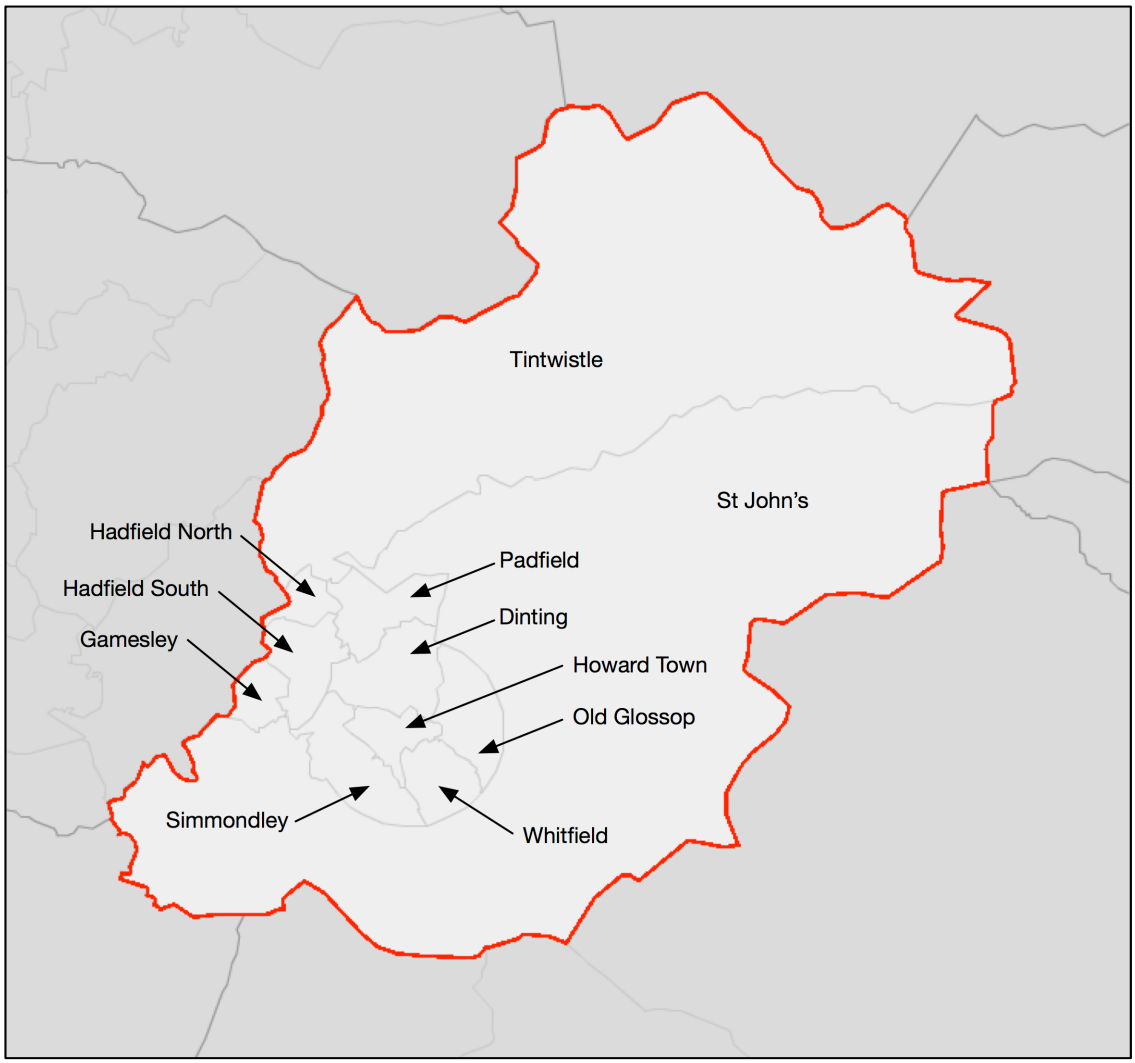

Fig. 1.1: Map showing the eleven wards comprising Glossop

Six broad areas define the topic scope of this assessment (see Fig. 1.2):

- Where people live, including housing and some aspects of community life and the urban/natural environment;
- Money to live off, including employment and related personal income;
- Choice of food, including the availability and affordability of healthy options;
- Getting about, focussing on transport and general access to services;
- Learning and training, including measures of educational attainment;
- Health and health care, including lifestyle and leisure, disability, mental health and well-being, physical health and injury, deaths and life expectancy, and access to public health, primary (e.g. GP) and secondary (hospital) health services.

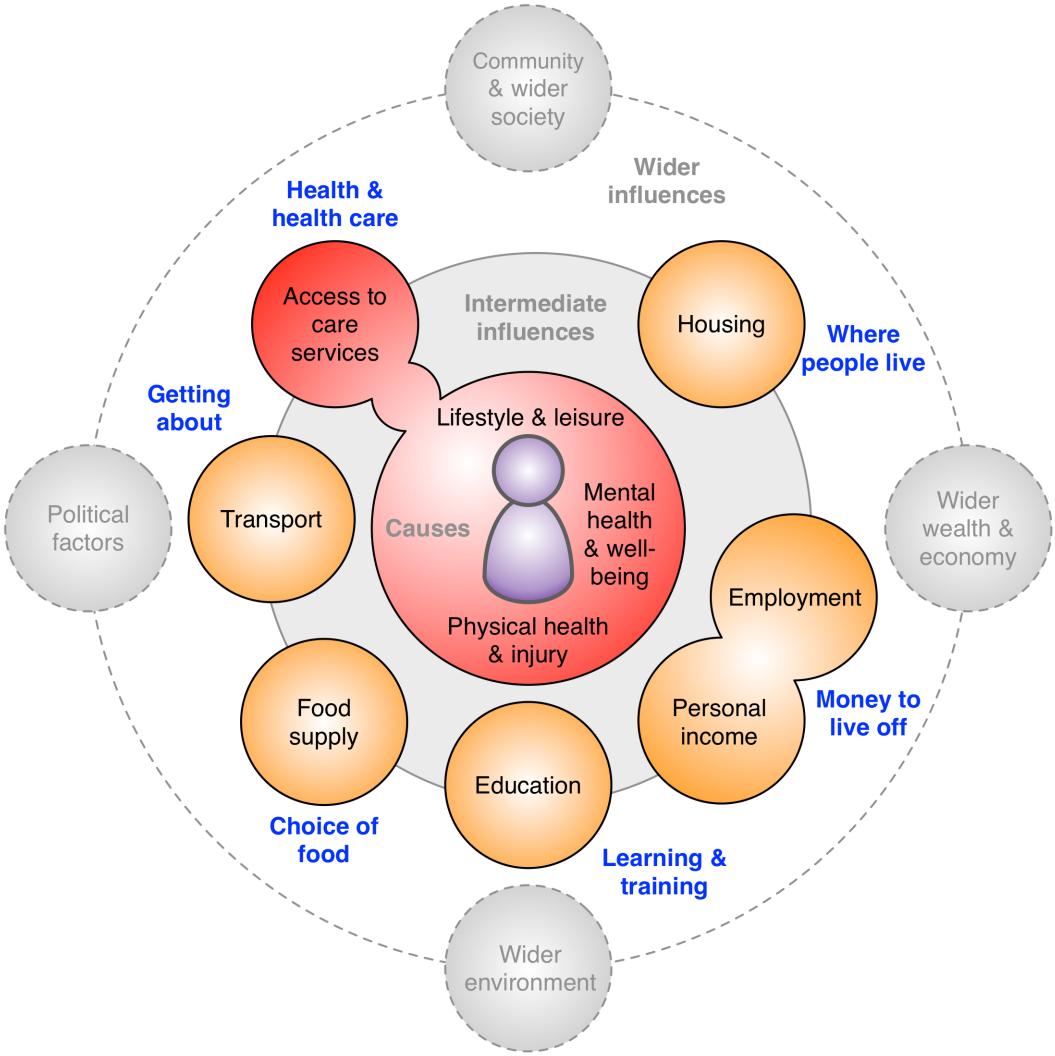

Fig. 1.2: Influences on the health of individuals and communities (after Dahlgren & Whitehead 1991)

1.4 Outline of approach to assessing needs and assets

Key informant perspective

Volunteer Glossop residents utilised prior training to conduct interviews with key informants, also members of the local community. Ten informants were selected 'purposively' (i.e. deliberately) because they are well placed to identify local issues. Informant roles comprised police officer; child minder; shop owner; publican; librarian; youth worker; school dinner lady; community volunteer and hairdresser. Informants represented Hadfield, Whitfield, Howard Town, Gamesley and Dinting (with deliberate bias towards more deprived areas). A questionnaire was developed around the topic scope for this assessment and piloted. The questionnaire focussed on the determinants of health in Glossop and did not ask about personal health concerns or experiences using health services. Both interviewer and interviewee received a small honorarium to cover costs and incentivise participation. A modest online survey of Glossop residents on the HPBC Citizen's Panel was also conducted to supplement key informant views on 'Where people live'.

Community profiling

Community profiling made use of routine information sources to identify key indicators and aggregate these for Glossop from ward-level data where possible. This activity focussed on summarising the characteristics of the determinants of health in Glossop and of illness in the local population using numbers and statistics, the most common measure being prevalence—what proportion of the population has a given illness (expressed as a percentage of the total). We attempt to make inferences about health needs in the Glossop population by comparing local data to data from elsewhere. In Chapter 8, by comparing local levels of health care activity to similar activity elsewhere, we aim to gauge how well local services are utilised.

Asset mapping

We map out the health-improving assets (people, facilities and services, for example) that are already present in Glossop. This puts a positive focus on what is there, rather than concentrating on what is not available—and by so doing can help us judge whether these existing assets are being used to their full potential. Another benefit of this activity is that by cataloguing available resources across all sectors of the healthcare economy we can identify synergies between assets with a view to encouraging related services to work together more effectively.

Service mapping

Similarly, by mapping out who brings what health-related services into Glossop we can identify whom should be talking to whom about closer working and shared goals, and look into any gaps in what is provided.

Stakeholder views

We used an online survey to gather information from invited service providers on their expert views and public-facing experiences to help understand their perspective on what is needed to improve health and the determinants of health in Glossop.

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1.5 How our report is structured

We begin with some basic information about the population of Glossop (Chapter 2). Each of the following chapters (3–8) relates to one of the six topic areas in scope, presenting what we found in accordance with the above framework and what key messages this information suggests for improving health in Glossop.

2. The people of Glossop

This chapter provides an overview of the population living in Glossop. It describes how the population is made up in terms of age, sex and ethnicity. It also looks at relative social deprivation by ward.

2.1 Age and sex of Glossop residents

The most reliable and current information about the population of Glossop comes from the national Census that was conducted in 2011. In 2011 there were 33,155 people living in Glossop, of which 49% were male and 51% female. This corresponds to 14,003 households and a breakdown by major age group shows that the overall proportions are consistent with the average for England (see Table 2.1). However, within Glossop the wards of Dinting and St. John's are notable for having higher proportions of people aged 65 or older, and Gamesley has the highest proportion of children aged under 16 years (over a quarter of the ward population).

Table 2.1: Population age groups, %	Children under 16	Working age adults	Older people 65+
Dinting	12.9	56.7	30.4
Whitfield	18.1	65.3	16.7
Old Glossop	20.1	65.6	14.3
Howard Town	16.9	69.7	13.4
Gamesley	26.6	60.6	12.8
Simmondley	20.4	66.3	13.3
Hadfield North	20.8	63.2	16.0
Hadfield South	18.2	65.3	16.5
Tintwistle	18.9	67.9	13.2
Padfield	20.4	70.6	9.0
St. Johns	15.0	64.2	20.7
Glossop (11 wards)	18.9	65.0	16.0
High Peak BC	18.1	64.6	17.2
Derbyshire CC	17.8	63.7	18.6
England	18.9	64.8	16.3

Source: Derbyshire Observatory population indicators, 2011 Census

Those who provide and commission (plan, purchase and monitor) services will often be interested in a best-guess estimate of the number of people in certain age bands and/or by sex; this information is given in Table 2.2.

Table 2.2: Population age composition in Glossop, numbers & % by sex

Age (years)	*Males*	*Females*	*Male %*	*Female %*
00–04	1,022	937	3.08	2.83
05–09	997	942	3.01	2.84
10–14	987	1,001	2.98	3.02
15–19	1,061	969	3.20	2.92
20–24	942	905	2.84	2.73
25–29	944	926	2.85	2.79
30–34	879	1,006	2.65	3.03
35–39	918	999	2.77	3.01
40–44	1,352	1,327	4.08	4.00
45–49	1,339	1,497	4.04	4.52
50–54	1,275	1,327	3.85	4.00
55–59	1,075	1,055	3.24	3.18
60–64	1,084	1,065	3.27	3.21
65–69	953	948	2.87	2.86
70–74	580	686	1.75	2.07
75–79	402	496	1.21	1.50
80–84	263	413	0.79	1.25
85–89	121	239	0.36	0.72
90+	49	174	0.15	0.52
Total	16,243	16,912	48.99	51.01

Source: ONS mid-2012 estimates of population, via Public Health Intelligence, DCC. Percentages may not add to 100 because of rounding.

The information in Table 2.2 can also be presented as a “population pyramid”, in which the proportions of men and women in each age band are stacked on top of each other. As Fig. 2.1 shows, Glossop has a substantial “foundation” of younger people with a much smaller “peak” of people in old age. However, there is a notable widening of the shape in the 40–54 age bands; although this pattern is seen among the Derbyshire population as a whole, it is more pronounced in Glossop. This means that relatively large numbers of people who have already been working for some time will be thinking about retirement in the next 10–25 years. For many people making this transition it will mean a drop in income, and some will experience deterioration in their general health. Looking forward, it also means there are opportunities to help prevent age-related illnesses and to plan for changes in demand on services.

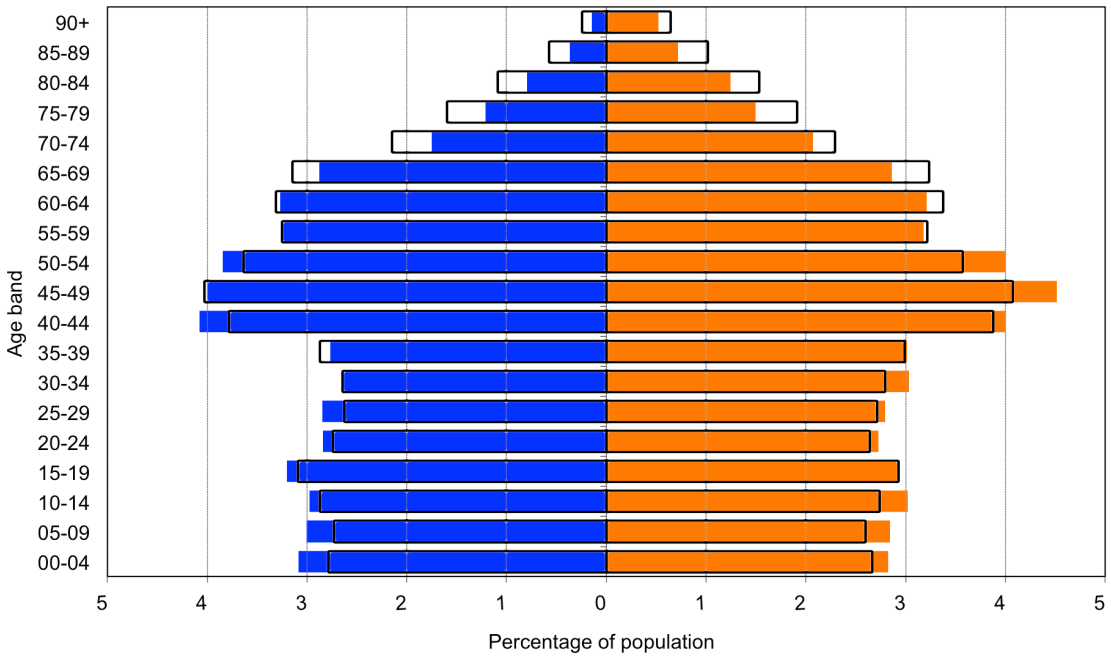

Fig. 2.1: Population pyramid showing proportions by age band in Glossop (males to left/ in blue; females to right/ in orange; outline is Derbyshire County comparator)
Source: ONS mid-2012 estimates of population, via Public Health Intelligence, DCC.

2.2 Population projection

A population projection estimates the size and other characteristics of the future population of an area, based on mathematical modelling. Population projections using Census 2011 data are not available from Derbyshire County Council for Glossop or for the High Peak local authority at this time.

2.3 Ethnic composition

The ethnic composition of the population in Glossop is compared in Table 2.3 below to that of the High Peak and to Derbyshire County. These data indicate a small minority of non-White groups (2.5%) in Glossop, typical of the county as a whole.

Table 2.3: Ethnic groups in Glossop compared to High Peak and Derbyshire

	Glossop		*High Peak*		*Derbyshire*	
Ethnic Group	*%*	*Number*	*%*	*Number*	*%*	*Number*
White: British	95.7	31,677	95.9	87,131	95.8	737,034
White: Other	1.8	595	2.0	1,823	1.7	13,060
Asian/Asian British*	0.6	190	0.5	483	0.9	7,068
Asian/Asian British: Chinese	0.2	80	0.3	228	0.2	1,727
Black/African/Caribbean/Black British	0.3	90	0.2	184	0.4	2,770
Mixed/multiple ethnic groups	1.3	419	1.0	944	0.9	7,119
Other ethnic group	0.1	39	0.1	99	0.1	908
All usual residents	100	33,090	100	90,892	100	769,686

Source: ONS Crown Copyright Reserved, from Nomis on 30 August 2013; via Public Health Intelligence, DCC;
*Excluding Chinese

2.4 Socio-economic status

Socio-economic differences are often compared using a 'deprivation score' (see box). People living in less affluent areas may be regarded as more vulnerable because of increased risks to their attaining or maintaining good health.

Key term: Social deprivation

Deprivation is a lack of resources of all kinds, not just financial.[1] The English Indices of Deprivation 2010 (IMD) combine measures of employment, income, health and disability, education skills and training, barriers to housing and services, crime and disorder, and living environment—weighted to produce an overall area-based score.

In Fig. 2.2 each geographic area (Lower Level Super Output Area, or LSOA) is associated with an Index of Multiple Deprivation score. These scores are then ranked nationally and divided into five equal parts to create bands (each band thus equating to 20% of the total population, known as a quintile). The scores for each LSOA in Glossop are then mapped to the corresponding national band by colour coding. Thus those areas of Glossop that are the lightest shade (e.g. Dinting) are among the most affluent 20% of the population nationally. Conversely, those areas that are the darkest shade (e.g. Gamesley) are among the most disadvantaged 20% of the national population.

Table 2.4 shows more detail about each quintile in Glossop. It is notable that two LSOAs are in the most deprived national quintile, corresponding to 8% of the population of Glossop and to 2,560 residents.

Table 2.4: Social deprivation in Glossop LSOAs, by national quintile

LSOA IMD 2010 quintile	*Number of LSOAs*	*Percentage of population*	*Number of residents*
1 (Most deprived)	2	7.6	2,560
2	3	16.2	5,500
3	6	27.2	9,210
4	4	20.9	7,092
5 (Least deprived)	6	28.1	9,540
		100	33,902

Source: IMD 2010 and ONS mid-2012 estimates of population, via Public Health Intelligence, DCC

Table 2.5 shows that Glossop has a higher proportion of people living in the most deprived areas of England than the High Peak overall (two of the High Peak's three 'most deprived' LSOAs are in Glossop). However, Glossop overall is relatively affluent compared to Bolsover and Chesterfield, both of which have over three times the proportion of their population living in the 'most deprived' quintile.

[1] Communities and Local Government. The English Indices of Deprivation 2010. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/6320/1870718.pdf

Table 2.5: People living in the 20% most deprived areas in England, % (IMD 2010)	% in most deprived quintile
Glossop (11 wards combined)	7.6
Amber Valley	8.9
Bolsover	27.3
Chesterfield	25.8
Derbyshire Dales	2.2
Erewash	16.3
High Peak	4.6
North East Derbyshire	10.3
South Derbyshire	1.7
Derbyshire CC	12.2
England	20.4

Quilt key:

Worse than England average	Similar to England average	Better than England average	No statistical comparison made

Source: Public Health England, via www.healthprofiles.info

Table 2.6 compares the sub-type of deprivation within Glossop by ward, revealing that Dinting, Simmondley and St John's are comparatively affluent whereas Gamesley, Hadfield North and Hadfield South are comparatively deprived.

Table 2.6: Index of Deprivation 2010, % (est. from MSOA level data)	Income deprivation	Child poverty	Older people in deprivation
Dinting	4.4	5.1	8.0
Whitfield	14.5	18.5	24.8
Old Glossop	11.8	15.2	20.1
Howard Town	14.5	18.5	24.8
Gamesley	22.0	30.8	28.6
Simmondley	4.4	5.1	8.0
Hadfield North	22.0	30.8	28.6
Hadfield South	18.2	25.6	24.7
Tintwistle	11.4	15.1	19.3
Padfield	11.4	15.1	19.3
St. Johns	4.4	5.1	8.0
Glossop (11 wards combined)	12.5	17.2	19.0
High Peak BC	10.2	13.7	14.4
Derbyshire CC	12.2	16.6	16.2
England	14.7	21.8	18.1

Quilt key:

Worse than England average	Similar to England average	Better than England average	No statistical comparison made

Source: Public Health England, via www.localhealth.org.uk

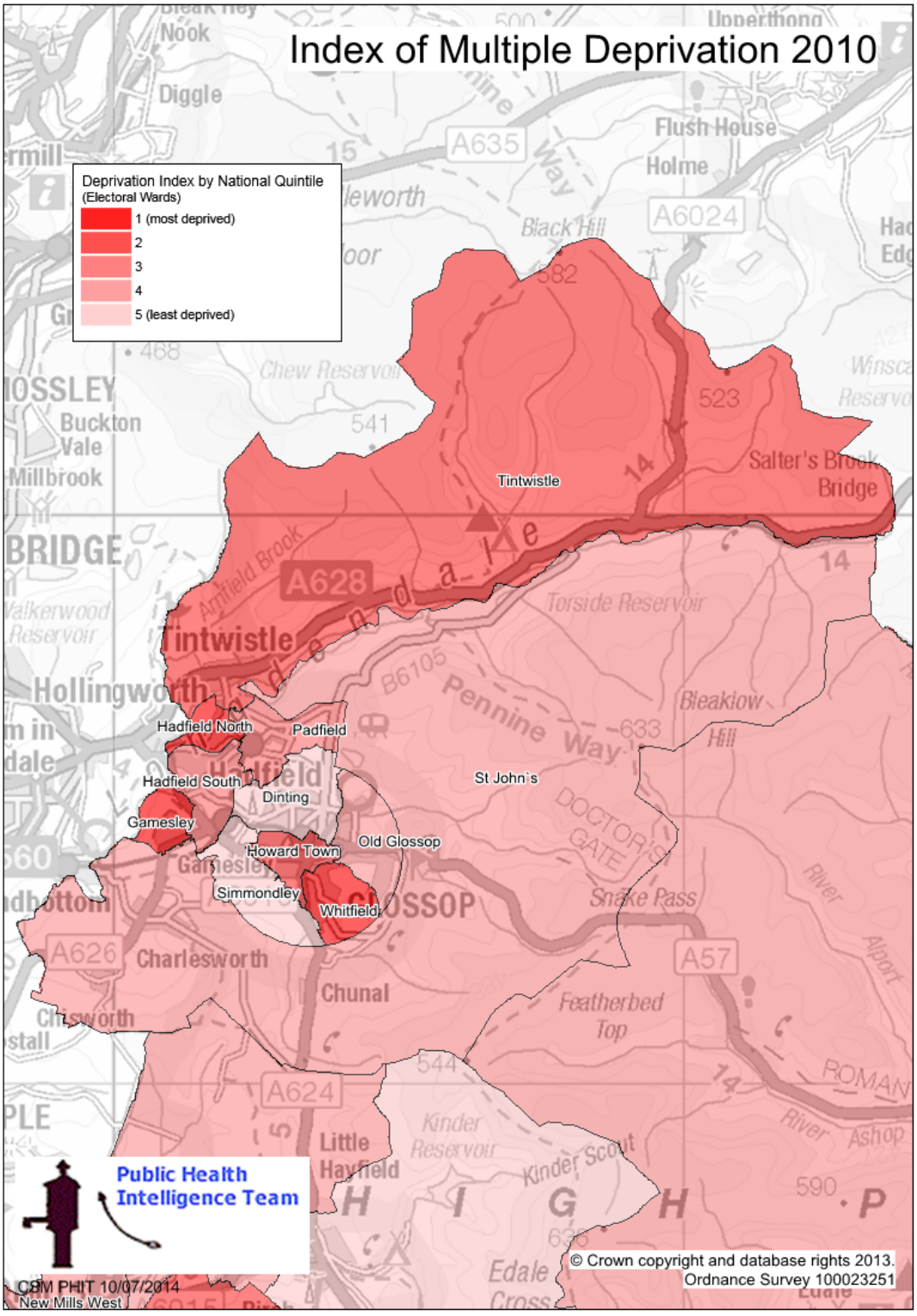

Fig. 2.2: Map of Glossop wards showing local area deprivation (see key)

3. Where people live

Our homes are where we bring up families, escape the pressures of work, or seek respite from the weather. For those living in unsuitable or poorly heated housing, they can contribute to chest infections, circulatory problems, joint pains and other cold-related diseases—including excess winter deaths. While access to affordable good quality homes is important, so too are healthy connections between the people living in them. Supportive communities provide social capital (mutually beneficial social networks), freedom from isolation, social inclusion, cohesion (the 'glue' that binds neighbourhoods together) and resilience (being able to call upon local assets when needed for a common good); their absence may give rise to a myriad of social problems. The built and natural environments that nurture our communities likewise influence population health. This chapter considers issues around housing, community life and the wider living space in Glossop.

3.1 What do the community feel is needed?

Key informant interviews

Informants were asked to describe Glossop as a community. Most felt there was community spirit/ closeness in some areas, but that these areas had firm divides and did not necessarily correspond to map boundaries. Disparity was well recognised between wealthier and poorer areas. One described Glossop as 'fractured', noting that 'Glossopdale' is a new term and that locals affiliate with smaller areas. At certain times these communities come together as one (e.g. Glossop Carnival or Armistice Day). Small communities could be friendly but at times nosey, but because people know each other they tend to stick together 'when things go wrong' and 'look out for each other'. There were differences of opinion as to whether living in Glossop offered an identity or sense of belonging.

⚠ Information sources and interpretation

The small number of key informant interviews collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Opinions have been paraphrased, but have not been reinterpreted.

Most considered house prices to be high and thus a determinant of where people would look within Glossop for housing. An insightful comment from one informant indicates locals may struggle to get on the property ladder due to low income levels, thus creating a perception that house prices are high (when, compared to other areas, they may even be low). Others acknowledged prices were comparatively cheaper, but one felt they were nevertheless 'high for the area' (presumably a reference to services/ infrastructure); a similar comment was made regarding the cost of renting. Wages may not cover rent for all Gamesley residents, some of whom

feel that the council could be more responsive to problems with council housing. Affordable bigger homes are in short supply in some areas.

The level of crime in Glossop was variously perceived to be high, average or low. It was commented that people might believe that the level is higher than in reality due to local media emphasis on 'big' or serious crime, when most was 'low-level' or 'petty'. Concerns were raised about some crime going unpunished, as well as 'mischievous children with an attitude'.

It was acknowledged that Glossop had a mix of safe and less safe areas. Whether or not people felt safe in their neighbourhood was thought to relate to age, with the suggestion that as people got older they might feel less safe—to a point where some areas became 'no go'. It was commented that some public walkways (e.g. from Dinting station and bus stop) were uneven, poorly lit and thus felt unsafe. Furthermore, living adjacent to a noisy pub might cause some to feel unsafe (possibly implying concerns about alcohol-related anti-social behaviour). People who are part of smaller communities might feel safer, with a more isolated minority who feel unsafe. If there is unwillingness to walk around the Gamesley estate at night, this could be wariness of outsiders rather than estate residents themselves.

If I had a magic wand…?

Informants were asked what one thing they would wish for to improve health and well-being in Glossop, if they had a magic wand. One informant felt local children would appreciate a 'whistle-stop area', while another called for more children's centres. Both suggestions were in the context of increasing the availability of inexpensive child-friendly activities. Others felt older young people (15–20 years) need more activities/ places to go and be safe. Suggestions were organised trips for children; cycling activities; new cinema, swimming baths or school; and keeping children's/ youth centres open throughout the day and evening.

Citizen's Panel survey

Glossop residents on HPBC's Citizen's Panel were asked "Which areas around where you live should be improved?" Responses are summarised as a "word cloud" in Fig. 3.1. The most frequent response suggests that concerns about litter, followed closely by footpaths, may be the prevalent issues.

⚠ Information sources and interpretation

The small number of survey responses (66), low return rate (19%) and online nature of the sample may introduce bias and reflect an incomplete picture of health needs or service provision.

Fig. 3.1: Word cloud for "Which areas around where you live should be improved?"; font size is proportionate to the frequency of each response.
Source: High Peak Borough Council Citizen's Panel survey of Glossop residents, 2014

On the question of "Which local activities do you participate in on a regular basis?" the most frequent response was walking (Fig. 3.2). Attending church and using the library also appear important.

Fig. 3.2: Word cloud for "Which local activities do you participate in on a regular basis?"; font size is proportionate to the frequency of each response.
Source: High Peak Borough Council Citizen's Panel survey of Glossop residents, 2014

Projects that some members of the Citizen's Panel felt they could be involved with that would benefit their community are depicted in Fig. 3.3. Groups were a frequent response, followed by walking.

Fig. 3.3: Word cloud for projects some residents could be involved in that would benefit the community; font size is proportionate to the frequency of each response.
Source: High Peak Borough Council Citizen's Panel survey of Glossop residents, 2014

More broadly, some members of the Citizen's Panel suggested a range of projects that would benefit their community (without their necessarily being involved in them). As Fig. 3.4 shows it is difficult to pick a clear favourite—in contrast to the difference that the element of personal participation makes (compare to Fig. 3.3).

Fig. 3.4: Word cloud for projects that some residents felt would benefit the community; font size is proportionate to the frequency of each response.
Source: High Peak Borough Council Citizen's Panel survey of Glossop residents, 2014

Activities that some Citizen's Panel members would like to participate in are depicted in Fig. 3.5. The most frequent responses may suggest a lack of desire to participate (possibly a degree of apathy) or lack of time to become more involved/ active within the local community, or alternatively that participation needs are currently being met.

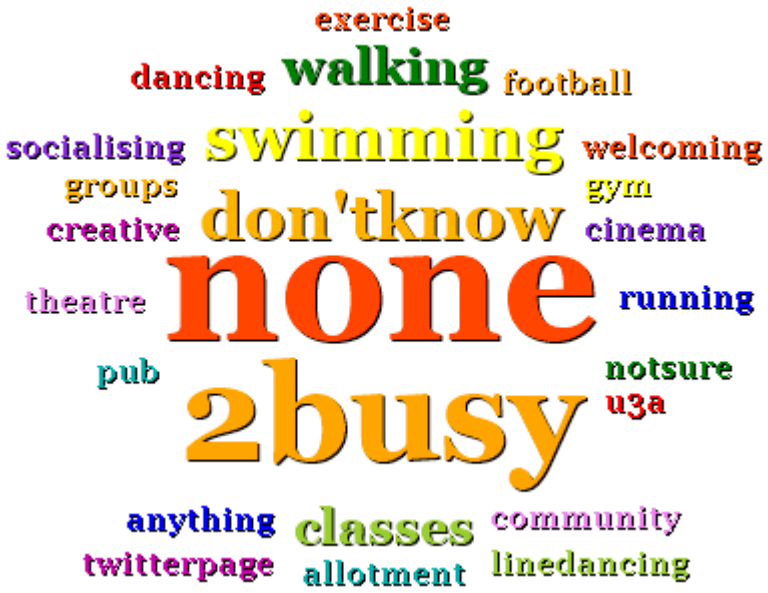

Fig. 3.5: Word cloud for activities that some residents could participate in; font size is proportionate to the frequency of each response.
Source: High Peak Borough Council Citizen's Panel survey of Glossop residents, 2014

3.2 What do the figures suggest might be needed?

Some information about housing, community safety and land use as determinants of health in Glossop is available from routinely collected statistics and surveys. This section summarises what we know about these topics using selected indicators. It should be considered in conjunction with the socio-economic profiles in Chapter 2.

⚠ Information sources and interpretation

The small number of indicators collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Some statistics are collated at ward level; where not directly measured at this geography then generally inferior modelled estimates may be used. Statistical comparisons may not adjust for population mix. Aggregate data may obfuscate variation in indicators between community groups.

Table 3.1 shows that in terms of centrally heated homes, Howard Town residents stand out as having less provision than is typical for England. Overcrowding doesn't seem to be an issue within homes in any Glossop ward. Despite Glossop overall having a similar proportion of pensioners living alone as elsewhere in England, the figures at ward level tell us that aggregated numbers hide important disparities. While Dinting and Simmondley have significantly less pensioners living alone, five other wards have significantly higher proportions of older people who may be at risk of social isolation and/or struggle to live independently (some with chronic illnesses).

Table 3.2 looks at tenure (the conditions under which housing is occupied) and confirms a large range of situations. For example, over 90% of homes in Dinting and

Simmondley are owned by those persons occupying them, compared to just over 30% of homes in Gamesley (which has around twice as much non-private rental properties as Whitfield and Hadfield North). Howard Town is the only ward in which more than a quarter of housing stock is privately rented.

Table 3.1: Housing & living environment indicators, % (2011 Census)	Households with central heating	Overcrowded (1+ rooms too few)	Pensioners living alone
Dinting	99.6	0.8	24.7
Whitfield	97.7	9.0	43.6
Old Glossop	97.9	3.1	33.1
Howard Town	95.5	6.1	37.9
Gamesley	98.5	9.7	47.4
Simmondley	99.2	1.4	18.7
Hadfield North	97.5	6.2	35.0
Hadfield South	98.3	3.2	29.7
Tintwistle	96.3	2.8	40.1
Padfield	97.8	6.7	38.1
St. Johns	97.7	1.8	29.3
Glossop (11 wards combined)	97.7	4.5	32.6
High Peak BC	97.7	4.8	31.7
Derbyshire CC	98.0	3.7	30.3
England	97.3	8.7	31.5

Quilt key:

Worse than England average	Similar to England average	Better than England average	No statistical comparison made

Source: Public Health England, via www.localhealth.org.uk

Table 3.2: Household tenure, % (2011 Census)	Owner-occupied	Rented from council/ association	Private/ other rented	Living rent-free
Dinting	93.9	1.7	3.6	0.8
Whitfield	50.5	35.2	12.0	2.3
Old Glossop	79.8	9.0	10.0	1.2
Howard Town	65.6	6.0	26.9	1.5
Gamesley	30.6	63.0	4.3	2.1
Simmondley	91.2	1.6	6.7	0.5
Hadfield North	56.1	29.1	12.5	2.4
Hadfield South	80.4	10.2	8.5	0.9
Tintwistle	74.2	12.9	12.0	1.0
Padfield	70.5	9.8	19.2	0.5
St. Johns	82.2	4.3	11.9	1.7
High Peak BC	72.6	12.7	13.4	1.2
Derbyshire CC	71.4	15.3	12.0	1.3

Source: Derbyshire Observatory 2011 Census Summary Profiles, via observatory.derbyshire.gov.uk

Table 3.3 illustrates that detached (generally higher value) homes are approaching 50% predominance in Dinting and Simmondley, whereas in excess of two thirds of homes in Gamesley and Howard Town are terraced, followed closely by Hadfield North at 60%. A quarter of Whitfield properties are flats, maisonettes or apartments.

Table 3.3: Household type, % (2011 Census)	Detached	Semi-detached	Terraced	Flat/ maisonette/ apartment	Other
Dinting	49.7	29.9	12.6	7.8	0.0
Whitfield	8.2	15.9	50.2	25.7	0.0
Old Glossop	37.1	25.6	27.3	10.0	0.0
Howard Town	4.0	9.7	68.7	17.7	0.0
Gamesley	3.8	13.4	77.7	5.0	0.0
Simmondley	49.0	26.7	23.3	0.9	0.1
Hadfield North	9.2	16.7	59.6	14.5	0.0
Hadfield South	24.1	34.7	34.5	6.7	0.0
Tintwistle	14.7	32.8	49.5	3.0	0.0
Padfield	15.3	27.1	49.0	8.7	0.0
St. Johns	37.1	27.9	30.2	4.4	0.4
High Peak BC	23.5	29.2	34.4	12.6	0.2
Derbyshire CC	31.8	38.7	20.6	8.6	0.3

Source: Derbyshire Observatory 2011 Census Summary Profiles, via observatory.derbyshire.gov.uk

Table 3.4 indicates that antisocial behaviour is a particular concern in Howard Town, Hadfield North, Whitfield, Padfield and Gamesley relative to the average number of calls received throughout the High Peak area. Howard Town is again notable for relatively high levels of total crime, violent crime and shoplifting. Dinting residents are up to twice as likely to experience domestic burglary as those in other Glossop wards or High Peak residents as a whole.

Table 3.5 presents data on land use that, although dated, is unlikely to have altered significantly. Around a fifth of available land in Old Glossop, Simmondley and Hadfield South is given over to domestic gardens—much more than the High Peak or Derbyshire-wide averages. This may be a proxy measure of potential for residents to grow their own produce to facilitate healthy eating (see also Chapter 5). Less than a third of Howard Town is greenspace, with five Glossop wards having more than two thirds of land categorised as greenspace, although only St. John's and Tintwistle exceed the High Peak average. Availability of greenspace may be a proxy measure of potential for physical activity and/or outdoor recreation in support of well-being (see also Chapter 8).

Table 3.4: Community safety	Antisocial behaviour	Total crime	Total violent crime	Domestic violence	Domestic burglary	Shoplifting
Dinting	24.2	27.0	3.5	2.5	4.1	0.6
Whitfield	80.7	42.0	12.8	6.2	1.4	0.0
Old Glossop	32.5	24.7	4.2	1.9	2.3	0.0
Howard Town	96.0	115.1	22.3	4.4	1.9	28.3
Gamesley	60.5	40.2	15.9	5.9	1.2	0.0
Simmondley	16.2	19.2	4.0	1.9	1.5	1.3
Hadfield North	87.0	49.9	10.9	6.8	2.0	2.5
Hadfield South	40.3	29.5	4.2	2.4	2.1	0.5
Tintwistle	32.0	32.4	7.5	4.8	1.9	0.0
Padfield	75.5	35.9	12.3	3.2	1.1	0.4
St. Johns	26.9	40.8	6.9	2.1	2.3	0.6
High Peak BC	46.3	40.9	7.7	3.3	1.8	3.4
Derbyshire CC	—	—	—	—	—	—

Source: Derbyshire Observatory, via observatory.derbyshire.gov.uk; Antisocial behaviour = call for service per 1,000 during 2011–12; Total crime = incidents per 1,000 during 2013–14; Total violent crime = incidents per 1,000 during 2012–13; Domestic violence incidents per 1,000 by home location of victim during 2009; Domestic burglary = incidents per 1,000 during 2013–14; Shoplifting = incidents per 1,000 during 2013–14

Table 3.5: Land usage, % of total land m^2 in 2005	Domestic gardens	Greenspace
Dinting	15.7	72.0
Whitfield	10.4	77.5
Old Glossop	22.7	53.2
Howard Town	15.5	28.5
Gamesley	11.9	64.3
Simmondley	21.7	57.5
Hadfield North	17.8	43.6
Hadfield South	21.7	47.5
Tintwistle	0.4	94.2
Padfield	9.5	76.2
St. Johns	0.6	97.4
High Peak BC	2.0	94.0
Derbyshire CC	4.0	90.0

Source: Derbyshire Observatory, via observatory.derbyshire.gov.uk

3.3 What assets do the community identify?

What Glossop has to offer

Informants felt Glossop residents valued the adjacent scenery and hills (a free activity). Living in Glossop could help maintain family ties. Friendly people, community groups, local shops (where you can get most things) and relative quiet were mentioned as positives. It was commented that there is 'an increasing amount going on' and that any disadvantages were outweighed by the advantages of living in Glossop.

⚠ Information sources and interpretation

The small number of key informant interviews collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Opinions have been paraphrased, but have not been reinterpreted.

Less positive aspects of living in Glossop included having to travel (the wish for a bypass was expressed and exposed main connecting roads were negatives); too much traffic/ the inadequate transport infrastructure; limited choice (e.g. two secondary schools); no longer a quiet area; lack of respect/ manners from local children with lack of parental control; little to keep young people occupied without travelling outside of the area; dogs fouling the peace garden and parks. Particularly common was the feeling of being separate and 'at the end of the line' for a lot of things, being 'forgotten' and not sharing much in common with the rest of the county (i.e. insular). One felt Glossop residents were made to feel like 'rejects' and lamented the lack of things to do, places to go/ relax and activities for children. Some informants commented that Gamesley tended to get funding to the chagrin of children in Hadfield and Glossop centre who were equally in need, but not offered summer programme outings (for example).

Asset mapping

Information Table 3.6 was collated primarily from Glossop residents attending a planned Community Voice meeting.

⚠ Information sources and interpretation

The 'snapshot' nature of the community asset listings is acknowledged; it should not be regarded as a comprehensive catalogue and may not reflect current asset status.

Table 3.6: Community-based assets identified for 'Where people live'

Name	Description	Address	Contact
Simmondley Park	Greenspace		High Peak Borough Council, Buxton Town Hall, Market Place, Buxton SK17 6EL 03451297777 or 0129828400
Pennine Road, Simmondley	Play area		
Manor Park	Greenspace	Manor Park Road, Glossop, SK13 7SH	
Howard Park	Greenspace		
Chapel Lane Park	Greenspace in Hadfield		
Newshaw Lane Play Park	Greenspace in Hadfield		
Roughfields	Open space	Padfield main road	
Brosscroft Park	Greenspace	Padfield main road	
Pyegrove Fields		Off Sheffield Road, Glossop	
Shirebrook Park	Greenspace	Shirebrook Drive, Glossop	
George Street Woods	Greenspace		
Trans Pennine Trail	Glossop – Penistone route 15.5 miles		
Playing Fields	Greenspace in Simmondley	Top of Pikes Lane	St Philip Howard School? 01457 853611
Cricket Ground and Club		Glossop	Alan Garlick Glossop Cricket Club, North Rd, Glossop, SK13 7AS glossopcbc@googlemail.com 01457 865107
Old Tennis Courts		Off Fauvel Road, Glossop	Derbyshire County Council
Red Core	Running track	Fauvel Road, Glossop	Glossopdale Community College
Grass area and hut for cadets		Fauvel Road, Glossop	ACF Centre 01332 772025
Rose Green WMC		4 Rose Green, Sheffield Road, SK13 8QH	01457 862580
Central Methodist Church		Chapel Street, Glossop, SK13 8AZ	01457 856464 info@glossopcentralmethodist.org.uk MS Society uses the building; Chairperson Grahame Barker 07501493920
St Lukes Church		Fauval Road, Glossop, SK13 7AR	01457 860412
Labour Club		11-13, Chapel Street, Glossop, SK13 8AT	01457 862265
Old Glossop Parish Church		Church Street South, Glossop, SK13 7RU	01457 852146
Glossop Golf Club		Sheffield Road, Glossop, SK13 7PU	Chairman Graham Dodd 01457 865247
Whitfield Youth and Community Centre	Youth centre	Ebenezer Street, Glossop, SK13 8JY	01457 852114

Name	Description	Address	Contact
Brownie / Scout Club		Simmondley	
Scout Hut		Hadfield	Brian Gray
Air Scouts		Hope Street, Old Glossop	
Hadfield Methodist Church		Station Road, Hadfield, Glossop, SK13 1AR	
Glossop Tennis Club		Pyegrove Road, Off Woodcock Grove, Glossop, SK138QS	Mick Owen
Glossop Bowling Club		Manor Park	
Hadfield Bowling Club		Paradise Street, Hadfield, SK131BA	http://www.hadfieldbowlingclub.blogspot.co.uk
Old Glossop Cricket Club		Manor Park Road, Glossop, SK13 7SQ	01457 855682
Hadfield Cricket Club		Newshaw Lane, Hadfield, Glossop, Derbyshire, SK132AT	07879334456 hsaccevents@gemail.com
Bradbury Community House	Meeting venue for all business groups, social groups and community associations	10 Market Street, Glossop, SK138AR	01457 860007 reception@bradbury-house.co.uk
Vineyard		18 Charlestown Road, Glossop, SK13 8JN	01457 853330
Swimming Pool Glossop		Places for People, Dinting Road, Glossop, Derbyshire, SK13 7DS	01457 842262
Geoffrey Allen Centre		Winster Mews, Gamesley	Church/ Derbyshire County Council 01457 858035
Hadfield Hall		Station Road, Hadfield	Joy Hallsworth 01457 865236 joy.hallsworth@gmail.com
Etherow Park		Woolley Lane, Hollingworth	
Hadfield Community Centre		Newshaw Lane, Hadfield	Derbyshire County Council 01457 854465
Glossop A E Centre		Talbot Street, Glossop	Derbyshire County Council 01457 852245
Glossop Pub	Pub	High Street West	
Oakwood Pub	Pub	67 High Street West, Glossop, SK13 8AT	01457 856573
The Chieftain	Pub	Green Lane, Hadfield, SK13 2DT	01457 860213

Name	Description	Address	Contact
Bluebell Wood Pub	Pub	Glossop Road, Gamesley, SK13 6EL	Amanda Leech 01457 899222
Commercial Inn	Pub	137 Manor Park Road, Glossop, SK13 7SH	Anthony and Leanne Parker-Snaith 01457 852071
Gamesley Community Cafe	Café	6 Winster Mews, SK130LU	Nick and Donna Rogers
Manor Park Cafe	Café	Manor Park Road, Glossop	John Brightmore
Rose Green Working Men's Club		4 Rose Green, Sheffield Road, SK13 8QH	01457 862580
Volunteer Centre Glossop	Community meeting space for voluntary & community groups	Howard Town House, High Street East, Glossop, Sk13 8DA	01457 865722
High Peak Nightstop	Emergency accommodation for the homeless	United Reformed Church, Hardwick Square East, Buxton SK17 6PT	07973 670595

Citizen's Panel survey

Glossop residents on HPBC's Citizen's Panel were asked "Which local groups improve your areas?" Sixty-six responses (a 19% return rate) are summarised in Fig. 3.6. The most frequent response suggests lack of knowledge about existing local groups/ assets may be typical.

Fig. 3.6: Word cloud for "Which local groups improve your areas?"; font size is proportionate to the frequency of each response.
Source: High Peak Borough Council Citizen's Panel survey of Glossop residents, 2014

3.4 What services are currently provided?

This section concerns formal arrangements between service commissioners and providers and in no way devalues the important contribution made by the community and voluntary sector; such community-led services/ assets are catalogued above in section 3.3.

Directly commissioned public health services

Public health within Derbyshire County Council (DCC) does not directly commission services related to housing, community safety, etc. Public health input into the Derbyshire Health and Wellbeing Board, however, provides opportunities to influence and support commissioning activity and/or service provision by partners.

Related local authority service provision

Table 3.7 summarises services impacting health and well-being 'where people live' available to Glossop residents that are commissioned or directly provided by Derbyshire County Council (DCC) and/or High Peak Borough Council (HPBC).

Table 3.7: Local authority service provision for 'Where people live'

Service	Commissioner	Provider	Notes
Homeless young people	DCC; HPBC; DDDC	Adullam Housing	Supported housing for vulnerable young people
Social housing	—	HPBC	
Supported Housing services	DCC	Various	Paid for by Supporting People grant; contentious as service about to be cut significantly due to DCC cuts
Private rented	HPBC	Private landlords	Voluntary Landlord Accreditation Scheme promoting decent housing and fair and equitable management practices amongst participating landlords.
Disabled facilities grants	DCC	HPBC	Means tested grants to fit adaptations to people's homes
Affordable warmth pilot	DCC	Local Authority Energy partnership incld. HPBC	Pilot project to link housing and health data to target groups at risk of fuel poverty/excess winter deaths
Libraries	—	DCC	
Leisure & recreation	—	HPBC	
Waste collection	—	HPBC	Collection of municipal waste
Waste disposal	—	DCC	Treatment and disposal of municipal waste
Planning applications	—	HPBC	
Strategic planning	—	DCC	
Fire & rescue	—	DCC	

Tameside and Glossop CCG commissioned health services

Tameside and Glossop Clinical Commissioning Group (T&GCCG) does not directly commission services related to housing, community safety, etc. T&GCCG input into the Derbyshire Health and Wellbeing Board, however, provides opportunities to influence and support commissioning activity and/or service provision by partners.

3.5 What do service providers and others think?

Invited service providers, commissioners and other stakeholders shared experiences and views describing their take on what is needed to improve health and the determinants of health in Glossop.

⚠ Information sources and interpretation

The small number of stakeholder responses collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Opinions have been paraphrased, but have not been reinterpreted.

Successes and achievements

In the community sector, these include delivering a handy-van service; providing a free telephone advice service 5 days a week, with face-to-face advice dispensed from Bradbury House and GP surgeries and children's centres in Hadfield, Simmondley and Gamesley; and facilitating participation (i.e. local people helping local people).

For local authorities, these include replacing insulation, roofing and heating systems in Gamesley to make council properties more energy-efficient (saving tenants money on utility bills); a choice-based scheme to increase the transparency and efficiency of the letting process; and the 'My Summer' holiday programme that provides young people with access to free engaging sporting and healthy leisure activities and may have helped reduce complaints concerning antisocial behaviour.

Challenges in commissioning or delivering services

In the community sector, these include ensuring commissioners understand that service delivery in semi-rural areas costs more than it does in urban areas; on-going difficulties raising finance to provide services; and despite operating at near-capacity recognition that potential clients with unmet needs are not accessing advice/ appropriate services.

For local authorities, these include improving services (including access), responding to increasing accountability demands and meeting customer expectations—all within in the context of budgetary constraints/ funding cuts.

Barriers to participation

In the community sector, these include transport (which means going to clients, or providing transport to support parents of disabled children); reliance on volunteers (who tend to be older, middle class and female) who do not reflect client diversity; lack of understanding by the community about the role, structure and operation of services; and lack of understanding by funding bodies that community participation comes with added costs.

For local authorities, these include increasing availability of self-service options through investment in technology; lack of trust from residents concerning local authority motivations in consulting with them; and non-representational resident involvement structures (appealing predominantly to elderly residents).

Health improvement plans

In the community sector, these include reviewing the feasibility of expanding services currently delivered elsewhere into Glossop and building relationships with primary care to provide GP-based early intervention advice aiming to prevent adverse health outcomes.

For local authorities, these include replacement/ renewal of kitchens, bathrooms, roofing and heating systems in some properties with the aim of improving living conditions for council tenants; service remodelling to maximise independent living; and regular inspections of council-owned properties to ensure tenants live in acceptable conditions and are compliant with tenancy agreements.

Organisational aspirations

In the community sector, these include being responsive to community-identified need for expansion of service provision into Glossop and provision of a face-to-face advice service six days per week.

For local authorities, these include investment in housing stock maintenance, expanding provision of social housing and development of new services to support independent living.

Partnership opportunities

In the community sector, these include building on current partnerships to co-deliver and improve services and seeking new partnership opportunities with both voluntary sector and statutory organisations. Potential partners identified were Glossop Volunteer Centre, DCC multi-agency teams (MATs), Age Concern, The Royal British Legion, local authorities and housing associations.

For local authorities, partnership opportunities would be welcomed providing they fulfilled the organisation's aims and objectives.

3.6 What are the key messages?

The steering group identified several key messages concerning 'where people live':

Community identification: 'Community' within Glossop is not necessarily defined in geographic terms (for example, commuters may have different perspectives on local identity to residents born in Glossop); this implies identification of groups for health improvement intervention may not be as simple as naming particular wards.

Young people's needs: This assessment has identified an adult perspective on the needs of young people in Glossop, but it is not known whether this perspective is shared by young people themselves; further work to identify the needs of younger age groups in Glossop may be indicated.

Housing affordability: Perceptions that the cost of housing is high may be related to personal income level rather than to awareness of cost relative to elsewhere.

Social housing: The borough council have committed to continuing improvements to social housing in Glossop, although there are indications that some council tenants perceive the authority to be less responsive to requests for repairs to council properties than they could be; tension between ambitions to improve the supply of social housing and to repair existing properties in a timely fashion may be anticipated in the face of funding restrictions.

Community safety: There may be a discrepancy between the level of reported crime and the perceived level of crime in Glossop.

4. Money to live off

Most people are reliant on employment to provide household income, which in turn influences such things as housing quality, educational opportunities and affordability of healthy foods. Others forgo employment to provide unpaid services such as care giving, although some unpaid work may bring non-financial rewards. Poor health, such as disability or mental illness, can be a barrier to employment—which in turn can impede recovery or resilience. Those out-of-work are more likely to report illnesses such as depression, stress, alcohol misuse and high blood pressure. This chapter considers issues around having enough money to live off in Glossop.

4.1 What do the community feel is needed?

Informants commented that people living in different areas within Glossop differed considerably in terms of what they would consider affordable; it was clear they recognised 'rich' and 'poor' areas. Financial challenges identified included house prices; keeping up with rent; food; childcare; school uniforms; gas/ electricity bills; holidays and bus fares (the latter particularly when a journey involved boundary crossing). It was suggested that larger families in particular would struggle to pay for food and keep up with various bills. The use of food banks and fewer people going out were cited as examples that some families were having problems making ends meet. Those living on benefits or unable to work due to illness were also identified as being under financial stress, particularly so at certain times such as Christmas.

⚠ Information sources and interpretation

The small number of key informant interviews collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Opinions have been paraphrased, but have not been reinterpreted.

Finding suitable work within Glossop can be a real challenge, with available jobs tending to be low-paid and wage increases seeming unable to keep pace with price increases. Thus those in work (which increases costs e.g. transport) may not be significantly better off than those on benefits. Some people are taking additional part-time jobs, working evenings and weekends to fit around other family members and childcare constraints. Employed young people may have to continue living with parents out of financial necessity. Help managing personal finances was possibly needed by a lot of people not presently receiving it. Many grandparents are being asked to help look after grandchildren while parents go out work, and to support young families financially.

If I had a magic wand…?

Informants were asked what one thing they would wish for to improve health and well-being in Glossop, if they had a magic wand. It was suggested that access to job opportunities would improve if public transport were cheaper.

4.2 What do the figures suggest might be needed?

Some information about employment and income as a determinant of health in Glossop is available from routinely collected statistics and surveys. This section summarises what we know about these topics using selected indicators.

Information sources and interpretation

The small number of indicators collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Some statistics are collated at ward level; where not directly measured at this geography then generally inferior modelled estimates may be used. Statistical comparisons may not adjust for population mix. Aggregate data may obfuscate variation in indicators between community groups.

Table 4.1: Employment indicators 2012–13, (est. from MSOA level data)

	Unemployed†	Long-term unemployed‡
Dinting	1.7	3.4
Whitfield	4.1	12.4
Old Glossop	3.5	10.0
Howard Town	4.1	12.4
Gamesley	5.2	14.3
Simmondley	1.7	3.4
Hadfield North	5.2	14.3
Hadfield South	4.6	12.4
Tintwistle	3.3	8.5
Padfield	3.3	8.5
St. Johns	1.7	3.4
Glossop (11 wards combined)	3.5	9.5
High Peak BC	3.1	8.7
Derbyshire CC	3.2	8.3
England	3.8	10.1

Quilt key:

Worse than England average	Similar to England average	Better than England average	No statistical comparison made

Source: Public Health England, via www.localhealth.org.uk; † Monthly average claiming job seekers allowance, %; ‡ Claiming job seekers allowance for > 1 year, rate per 1,000

Table 4.1 indicates that the levels of both short-term and long-term unemployment within Glossop as a whole are similar to the averages for England. While residents of Dinting, Simmondley and St. John's are significantly more likely to escape unemployment (as estimated by job seekers allowance claims), those living in Gamesley, Hadfield North and Hadfield South are significantly more likely to be claiming job seekers allowance over the short term.

Unpaid care can be regarded as an asset, although it can sometimes be a necessity if paid-for services are not meeting care needs. Table 4.2 illustrates that residents of four wards are providing an hour or more of unpaid care per week in excess of the level that is typical for England (although such activity appears to be generally higher at both High Peak and county-level). Gamesley and Whitfield have excessive proportions of unpaid carers putting in 50 or more hours per week, while Simmondly and Padfield have comparatively low levels of such demand on carers.

Table 4.2: Providing unpaid care, % (2011 Census)	1+ hours per week	50+ hours per week
Dinting	11.8	2.1
Whitfield	10.4	3.1
Old Glossop	10.5	2.3
Howard Town	10.3	1.9
Gamesley	9.6	3.6
Simmondley	10.5	1.8
Hadfield North	9.4	2.8
Hadfield South	11.8	2.4
Tintwistle	11.7	2.7
Padfield	9.7	1.5
St. Johns	12.4	2.0
Glossop (11 wards combined)	10.7	2.3
High Peak BC	11.3	2.2
Derbyshire CC	12.1	2.7
England	10.2	2.4

Quilt key:

Worse than England average	Similar to England average	Better than England average	No statistical comparison made

Source: Public Health England, via www.localhealth.org.uk

Table 4.3 reveals levels of economic activity by Glossop ward that are broadly similar to the county average, with a range of about 14% for males (average 74.9%). Females in Glossop are about 8% less likely than males to be economically active, with a wider range of 20% across Glossop wards (average 67.0%). Dinting has the highest proportion of economically inactive males (followed by Gamesley), while Gamesley has the highest proportion of economically inactive females (followed by Dinting). These apparently similar positions are, however, likely to reflect differences in demographics, socio-economic status, etc.

Table 4.3: Economic activity, % (2011 Census)	Economically active males	Economically active females	Economically inactive males	Economically inactive females
Dinting	67.5	57.3	32.5	42.7
Whitfield	70.7	65.5	29.3	34.5
Old Glossop	76.9	69.5	23.1	30.5
Howard Town	77.1	72.7	22.9	27.3
Gamesley	69.9	55.7	30.1	44.3
Simmondley	78.7	70.9	21.3	29.1
Hadfield North	72.1	65.8	27.9	34.2
Hadfield South	76.7	68.0	23.3	32.0
Tintwistle	77.1	68.5	22.9	31.5
Padfield	81.9	74.9	18.1	25.1
St. Johns	76.1	67.9	23.9	32.1
High Peak BC	70.8	64.5	29.2	35.5
Derbyshire CC	69.1	61.9	30.9	38.1

Source: Derbyshire Observatory 2011 Census Summary Profiles (corrected); residents aged 16–74; A person aged 16 and over is described as economically active if, in the week before the census, they were: in employment, as an employee or self-employed, not in employment, but were seeking work and ready to start work within two weeks, or not in employment, but waiting to start a job already obtained and available; A person aged 16 and over is described as economically inactive if, in the week before the census, they were not in employment but did not meet the criteria to be classified as “Unemployed".

Table 4.4: Hours worked, % (2011 Census)	Males in full-time work	Females in full-time work	Males in part-time work	Females in part-time work
Dinting	84.7	55.2	15.3	44.8
Whitfield	70.7	64.7	29.3	52.7
Old Glossop	76.9	71.9	23.1	43.9
Howard Town	77.1	70.8	22.9	37.5
Gamesley	69.9	65.1	30.1	79.5
Simmondley	78.7	72.9	21.3	41.0
Hadfield North	72.1	68.3	27.9	51.9
Hadfield South	76.7	70.7	23.3	47.0
Tintwistle	77.1	69.0	22.9	46.0
Padfield	81.9	77.0	18.1	33.6
St. Johns	76.1	73.3	23.9	47.2
High Peak BC	85.6	52.8	14.4	47.2
Derbyshire CC	86.5	52.1	13.5	47.9

Source: Derbyshire Observatory 2011 Census Summary Profiles; employed residents aged 16–74; Full-time work = more than 30 hours per week; Part-time work = 30 hours or less per week

Of those who are economically active in Glossop, Table 4.4 tells us that the proportion of males in full-time work is less than is typical for High Peak or the county. On the other hand, a greater proportion of females are in full-time work than is typical for High Peak or the county. Gamesley, Whitfield and Hadfield North all

have just under a third of working males employed for 30 hours or less per week; Gamesley stands out as having the greatest proportion of female workers engaged in part-time positions.

Table 4.5: Industry of employment, % (2011 Census)	Services	Manufacturing	Other
Dinting	79.8	9.7	10.4
Whitfield	78.5	11.8	9.7
Old Glossop	80.4	10.3	9.3
Howard Town	79.2	11.6	9.2
Gamesley	76.3	15.0	8.8
Simmondley	79.1	12.2	8.7
Hadfield North	75.3	13.7	11.0
Hadfield South	76.1	13.5	10.3
Tintwistle	72.4	15.9	11.6
Padfield	78.7	11.8	9.6
St. Johns	73.3	10.5	11.7
High Peak BC	77.6	13.3	10.6
Derbyshire CC	73.7	14.9	11.4

Source: Derbyshire Observatory 2011 Census Summary Profiles; employed residents aged 16–74; Services = Wholesale and retail, business services, public services, other services; Other = Agriculture, forestry and fishing, mining, quarrying and utilities, and construction

Table 4.6: Occupational group, % (2011 Census)	Managerial & professional	Other non-manual	Manual
Dinting	57.9	22.6	19.6
Whitfield	35.8	30.2	34.2
Old Glossop	51.8	26.8	21.3
Howard Town	42.2	28.6	29.2
Gamesley	16.0	33.9	50.2
Simmondley	50.9	26.7	22.5
Hadfield North	30.7	30.4	39.0
Hadfield South	36.9	31.0	32.1
Tintwistle	41.5	26.2	32.4
Padfield	46.1	28.6	25.3
St. Johns	53.3	24.9	21.9
High Peak BC	40.8	27.1	32.0
Derbyshire CC	37.0	28.4	34.6

Source: Derbyshire Observatory 2011 Census Summary Profiles; employed residents aged 16–74; Services = Wholesale and retail, business services, public services, other services; Other = Agriculture, forestry and fishing, mining, quarrying and utilities, and construction

In Table 4.5 just over three quarters of Glossop's working population are employed in service-related industries, with a difference of only 8% between the ward with the highest proportion (Old Glossop) and that with the lowest (Tintwistle). Tintwistle and Gamesley marginally have the highest proportion of workers in manufacturing industries, corresponding to the county average.

Table 4.7: Households with dependent children, % (2011 Census)	No adult in employment
Dinting	0.8
Whitfield	5.7
Old Glossop	2.4
Howard Town	2.9
Gamesley	11.9
Simmondley	1.4
Hadfield North	5.8
Hadfield South	2.9
Tintwistle	3.2
Padfield	3.8
St. Johns	0.9
High Peak BC	2.9
Derbyshire CC	3.4

Source: Derbyshire Observatory, via observatory.derbyshire.gov.uk

Table 4.8: Benefit claimants, %	ESA claimants	DLA claimants	AA claimants	IS claimants	PC claimants
Dinting	0.9	3.3	15.5	0.4	5.8
Whitfield	5.3	10.6	21.1	5.6	40.9
Old Glossop	1.5	3.9	18.3	1.7	20.5
Howard Town	3.0	5.8	19.2	3.3	34.8
Gamesley	7.5	11.9	24.0	10.8	61.4
Simmondley	1.7	4.1	12.9	0.9	14.6
Hadfield North	4.1	9.3	28.2	5.8	45.5
Hadfield South	2.1	5.8	16.0	2.3	20.0
Tintwistle	2.7	5.7	22.1	2.7	29.5
Padfield	2.6	4.3	14.5	2.0	25.5
St. Johns	1.6	4.6	8.0	1.6	14.7
High Peak BC	4.7†	5.7†	13.1†	1.6†	17.6†
Derbyshire CC	4.1†	7.4†	13.4†	1.9†	18.9†

Source: Derbyshire Observatory; ESA = Employment Support Allowance, persons aged 16–64 (Feb 2012 or †Feb 2014); DLA = Disability Living Allowance, persons aged 0–64 (Feb 2012 or †Feb 2014); AA = Attendance Allowance, persons aged 65+ (Aug 2011 or †Feb 2014); IS = Income Support, persons aged 16–64 (Feb 2012 or †Feb 2014); PC = Pension Credits, persons aged 65+ (Feb 2013 or †Feb 2014)

Table 4.6 shows that residents of Gamesley are about a quarter as likely as those of Dinting to be engaged in managerial or professional roles. Half of employed Gamesley residents undertake manual work.

Gamesley has around four times the number of households in which no adult is in paid employment, compared to the High Peak norm (see Table 4.7). Gamesley has the highest level of claimants for most benefits (Employment Support Allowance, Living Allowance, Income Support and Pension Credits), while Hadfield North has the most Attendance Allowance claimants (followed by Gamesley; see Table 4.8).

4.3 What assets do the community identify?

Information sources and access barriers

Informants felt that locals would seek information or support concerning money matters from Citizen's Advice and noted that libraries can help direct people to appropriate sources. However, access barriers identified included low levels of literacy, poor computer skills, transport difficulties and the perceived stigma of having to ask. It was felt that those with money worries would be too ashamed/ proud to admit to problems (preferring to struggle rather than ask for help), or that by the time they did admit it to themselves it was 'too late'.

⚠ Information sources and interpretation

The small number of key informant interviews collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Opinions have been paraphrased, but have not been reinterpreted.

Other suggested local assets providing financial information or advice were churches, food banks, banks or building societies, Sure Start, health visitors, breakfast clubs at some schools and the Credit Union. Some people may lack knowledge about where to start asking for help, so putting this information in high-access areas (e.g. shops, GP surgeries, nurseries, etc.) was advocated. Several informants said that those seeking personal financial advice might find restricted opening times mean it can be difficult to obtain a suitable appointment, and also that attending with small children was difficult.

Asset mapping

The information in Table 4.9 was collated primarily from Glossop residents attending a planned Community Voice meeting.

⚠ Information sources and interpretation

The 'snapshot' nature of the community asset listings is acknowledged; it should not be regarded as a comprehensive catalogue and may not reflect current asset status.

Table 4.9: Community-based assets identified for 'Money to live off'

Name	Description	Address	Contact
Gamesley Community Cafe	Café	6 Winster Mews, SK130LU	Nick and Donna Rogers
Glossopdale Furniture Project	Accepts donations of unwanted furniture; helps people on low incomes to purchase good quality affordable furniture	8 Henry St, Glossop SK13 8BW	01457 857505
Glossop Citizens Advice Bureau	Free, independent, confidential & impartial advice on various issues, including benefits, debt & employment	Bradbury Community House, Market St, Glossop, SK13 8AR	0844 375 2712
Derbyshire Carers	Provides benefit advice relevant to carers	Howard Town House, High Street East, Glossop, SK13 8DA	01457 858383

4.4 What services are currently provided?

This section concerns formal arrangements between service commissioners and providers and in no way devalues the important contribution made by the community and voluntary sector; such community-led services/ assets are catalogued above in section 4.3.

Directly commissioned public health services

Public health within Derbyshire County Council (DCC) does not directly commission services related to employment and personal financial management. Public health input into the Derbyshire Health and Wellbeing Board, however, provides opportunities to influence and support commissioning activity and/or service provision by partners.

Related local authority service provision

Table 4.10 summarises services impacting health and well-being via 'money to live off' available to Glossop residents that are commissioned or directly provided by Derbyshire County Council (DCC) and/or High Peak Borough Council (HPBC).

Table 4.10: Local authority service provision for 'Money to live off'

Service	Commissioner	Provider	Notes
Income maximisation	—	DCC Welfare Benefits Service	Advice helpline
Income maximisation	DCC	CAB	Citizens Advice in all 6 GP surgeries; Citizens Advice in all children's centres
Debit management	DCC	Derbyshire Districts CAB	CAB sessions as above
Affordable credit and help to save	Various incld. DCC & HPBC	Manchester Credit Union	Credit Union provision in Gamesley and Glossop, extending to Hadfield shortly
Local taxation	—	HPBC	

Tameside and Glossop CCG commissioned health services

Tameside and Glossop Clinical Commissioning Group (T&GCCG) does not directly commission services related to employment and personal financial management. T&GCCG input into the Derbyshire Health and Wellbeing Board, however, provides opportunities to influence and support commissioning activity and/or service provision by partners.

4.5 What do service providers and others think?

Invited service providers, commissioners and other stakeholders shared experiences and views describing their take on what is needed to improve health and the determinants of health in Glossop.

⚠ Information sources and interpretation

The small number of stakeholder responses collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Opinions have been paraphrased, but have not been reinterpreted.

Successes and achievements

In the community sector, these include generating in excess of £500,000 in financial gains for users of the (financial advice) service during the last year.

For local authorities, these include processing housing benefit and council tax reduction claims quickly and accurately.

For primary care providers, this includes a long history of working to identify and help with benefit entitlement (pre-dating CAB's practice presence).

Challenges in commissioning or delivering services

In the community sector, these include the detrimental and confusing effects of welfare reform, which has placed an additional workload burden on the (financial advice) service.

For local authorities, these include being able to maintain current performance levels.

Other perspectives

No stakeholder comments were received in relation to barriers to participation, health improvement plans, organisational aspirations or partnership opportunities.

4.6 What are the key messages?

The steering group identified several key messages concerning 'money to live off':

Getting (to) work: Transport connects people to jobs.

Employment and education: A relationship between occupational group and educational attainment seems evident at ward level, with manual occupations (Table 4.6) corresponding to lack of qualifications or education to lower-level qualifications (Chapter 7, Table 7.3).

Reduced earnings: The proportion of Glossop males in part time work is notability higher (23.5% ward average) than the County average (13.5%); part time work is associated with reduced earnings potential.

Benefit claimants: Variation in proportion of benefit claimants by ward likely reflects demographic differences in part, although more information is needed to comment on possible disparities in access to welfare rights advice and uptake of benefit entitlements in relation to need.

Employment role models: Gamesley stands out for having a high proportion of households where no adult is in employment, which could contribute to the normalisation of this situation among young people on the estate.

Welfare advice: It seems necessary to find more effective ways of increasing community understanding of what community-based welfare/ financial advice services are available, and to reinforce messages that such advice is independent.

5. Choice of food

Poor diet is linked to a wide variety of illnesses, some of which are characterised by deficiency and some by excess. Healthy eating is not only about nutrient balance, but also the amount of food eaten in relation to physical activity. Poor diet contributes to disability and early deaths from heart disease, cancer and diabetes and is more common in deprived areas ('food poverty'). Diet also impacts other influences on health, such as child development and school achievement, or fitness to undertake some occupations. Furthermore, we know that children who are obese are more likely to be obese as adults. Healthy family and school meals are thus important, but making choices about what to eat is complex. Influences on choice include taste preference, affordability, access to shops, food availability, education about healthy eating, cooking skills, time pressures, cultural norms, family structure and more. This chapter considers issues around choice of food in Glossop.

5.1 What do the community feel is needed?

Informants felt most Glossop residents had a variety of shops/ outlets to access a range of food options, including supermarkets (e.g. Marks & Spencer, Tesco, Aldi, Iceland, Heron Foods, etc.), independent local stores, bakers, butchers and an open market.

⚠ Information sources and interpretation

The small number of key informant interviews collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Opinions have been paraphrased, but have not been reinterpreted.

The majority regarded fresh or good quality food as expensive (particularly in the smaller shops, although this was not thought specific to Glossop). 'Glossop' was identified as the main shopping area, with some local shops in Hadfield, Gamesley, Tintwistle and in the hamlet of Chisworth; Padfield and the village of Charlesworth was identified as not having local/ 'fruit & vege' shops. Supermarkets were recognised as being generally more affordable, although were not always local and therefore less accessible to those with greater need. Good deals could be found if you were in a position to look around. The number of allotments to support self-grown produce was said to be limited.

If I had a magic wand…?

Informants were asked what one thing they would wish for to improve health and well-being in Glossop, if they had a magic wand. No suggestions were received in relation to choice of food.

5.2 What do the figures suggest might be needed?

Some information about choice of food as a determinant of health in Glossop is available from routinely collected statistics and surveys. This section summarises what we know about this topics using selected indicators.

⚠ Information sources and interpretation

The small number of indicators collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Some statistics are collated at ward level; where not directly measured at this geography inferior modelled estimates may be used. Practice-level health indicators taken from the Quality and Outcomes Framework (QOF) database are used where ward-level statistics are unavailable; QOF is widely considered to under-estimate community prevalence of ill health. Furthermore, prevalence recorded in QOF relates to both the health status of the practice population and clinical coding by practices. Interpretation of GP practice QOF data in comparison to peer group, CCG or English average is complex; the direction of any difference is noted (higher or lower) but no speculative interpretation is attempted. Statistical comparisons may not fully adjust ('weight') for population mix. Aggregate data may obfuscate variations in indicators between community groups. Time-trend data are not presented, meaning it is not possible to comment on relative improvement in the 'snapshot' indicators shown.

Table 5.1: Child† & adult‡ weight indicators, %

	Obese children (reception)	Excess weight (reception)	Obese children (Year 6)	Excess weight (Yr 6)	Obese adults
Dinting	—	12.0	—	—	19.5
Whitfield	9.3	21.3	22.4	43.3	23.0
Old Glossop	5.5	15.9	20.0	35.0	22.1
Howard Town	6.4	12.1	16.5	32.1	23.0
Gamesley	10.1	26.1	16.4	29.1	24.9
Simmondley	5.4	23.2	12.4	32.0	19.5
Hadfield North	—	26.9	13.0	33.3	24.9
Hadfield South	6.0	19.3	17.2	26.6	24.2
Tintwistle	—	17.0	—	—	22.9
Padfield	9.9	18.5	15.8	31.7	22.9
St. Johns	—	—	—	—	19.5
Glossop (11 wards combined)	7.1	19.7	16.6	32.3	22.3
High Peak BC	7.3	20.9	15.5	31.1	23.3
Derbyshire CC	8.2	21.8	18.3	32.9	25.3
England	9.4	22.5	19.1	33.5	24.1

Quilt key:

Worse than England average	Similar to England average	Better than England average	No statistical comparison made

Source: Public Health England, via www.localhealth.org.uk; † 2010–11 to 2012–13 HSCIC data; ‡ 2006–8 est. from MSOA-level data for population aged 16+ years

Table 5.1 indicates that measurement of overweight and obesity at Reception for Glossop children occurs with less frequency than is typical for England. However, by Year 6 this 'advantage' appears to have been lost, with the average Glossop child being as likely to be overweight or obese as elsewhere in England. The level of adult obesity in Glossop is probably similar to the national average, although these data are modelled from larger geographic areas and based on self-reporting.

Table 5.2: Obesity prevalence by Glossop GP practice, % (2012–13)	Practice A	Practice B	Practice C	Practice D	Practice E	Practice F	Tameside & Glossop CCG	England
Obesity prevalence†	12.3	13.2	12.8	16.1	12.9	14.0	12.4	10.7
Peer group average	13.2	10.5	10.5	13.8	10.5	10.2	—	—

Quilt key:

Statistically higher than England average	Statistically similar to England average	Statistically lower than England average	No statistical comparison made

Source: Public Health England, via www.fingertips.phe.org.uk; † Quality and Outcomes Framework data for patients aged 16+ years with a BMI greater than or equal to 30 in the last 15 months; Peer group average provides comparison to GP practices having similar characteristics in terms of practice population structure, deprivation score & rurality.

Table 5.3: Healthy eating adults†, % (est. from MSOA level data)	Healthy eating adults
Dinting	35.7
Whitfield	28.5
Old Glossop	30.5
Howard Town	28.5
Gamesley	24.7
Simmondley	35.7
Hadfield North	24.7
Hadfield South	26.5
Tintwistle	29.8
Padfield	29.8
St. Johns	35.7
Glossop (11 wards combined)	30.0
High Peak BC	31.3
Derbyshire CC	28.1
England	28.7

Quilt key:

Worse than England average	Similar to England average	Better than England average	No statistical comparison made

Source: Public Health England, via www.localhealth.org.uk; † 2006–8 est. from MSOA-level data for population aged 16+ years

In contrast to the dated modelled obesity estimates in Table 5.1, recent Quality and Outcomes Framework (QOF) data indicate most general practices in Glossop have a significantly higher proportion of patients aged 16+ years measured as obese on body mass index (BMI) criteria compared to England (see Table 5.2).

Overall, we estimate that just under a third (30%) of adults in Glossop eat a healthy diet; this is similar to the proportion of health-eating adults in England. Healthy eating by adults ranges from an estimated low of 24.7% in Gamesley and Hadfield North, to a high of 35.7% in Dinting, Simmondley and St. John's (see Table 5.3).

Other potentially useful indicators relating to choice of food/ good nutrition include breastfeeding initiation (% of maternities), uptake of free school meals (% of eligible pupils) and prevalence of dental caries (average number of decayed, missing and filled teeth per child). However, these data are not routinely available at ward level and could not be aggregated for Glossop.

5.3 What assets do the community identify?

Information sources and access barriers

Sure Start was identified as a possible resource for young people to obtain information about making healthy food choices. It was thought older residents in particular might find it harder to access appropriate shops due to the travel requirement, but might seek support with making good food choices from Bradbury House (a community building in the town centre of Glossop). Food is available on Sunday from a church in Glossop; some schools and children's centres offer family cooking courses. As well as dependence on local availability, cost and knowledge about alternative places to shop were identified as barriers to such choice.

⚠ Information sources and interpretation

The small number of key informant interviews collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Opinions have been paraphrased, but have not been reinterpreted.

Information should be available at GP surgeries from doctors/ nurses and from health visitors. Some people might be unsure about healthy eating options, and could look to other members of their communities for inspiration. Residents without access to a car were identified as having a restricted food choice, in terms of both price and variety. Doing a weekly grocery shop by bus is difficult and those working full-time find it easier to access supermarkets rather than supporting independent shops. Even when food prices are reasonable, other expenses mean it can be difficult to allocate income to spend on food.

Asset mapping

The information in Table 5.4 was collated primarily from Glossop residents attending a planned Community Voice meeting.

⚠ Information sources and interpretation
The 'snapshot' nature of the community asset listings is acknowledged; it should not be regarded as a comprehensive catalogue and may not reflect current asset status.

Table 5.4: Community-based assets identified for 'Choice of food'

Name	Description	Address	Contact
Glossop Pub	Pub	High Street West	
Oakwood Pub	Pub	67 High Street West, Glossop, SK13 8AT	01457 856573
The Globe	Pub	High Street West, Glossop	
The Chieftain	Pub	Green Lane, Hadfield, SK13 2DT	01457 860213
Bluebell Wood Pub	Pub	Glossop Road, Gamesley, SK13 6EL	Amanda Leech 01457 899222
Commercial Inn	Pub	137 Manor Park Road, Glossop, SK13 7SH	Anthony and Leanne Parker-Snaith 01457 852071
Gamesley Community Cafe	Café	6 Winster Mews, SK130LU	Nick and Donna Rogers
Manor Park Cafe	Café	Manor Park Road, Glossop	John Brightmore
Manor Stores	Convenience store	32 Manor Park Road, Glossop, Derbyshire, SK137SH	01457 865773
Gladstone Stores	Convenience store	66 Gladstone Street, Glossop, SK13 8NG	01457 854269
Geoffrey Allen Centre		Winster Mews, Gamesley	Church/ Derbyshire County Council 01457 858035
Central Methodist Church	Café; Also De-Caf, Dementia Café run by Age UK	Chapel Street, Glossop, SK13 8AZ	01457 856464 info@glossopcentralmethodist.org.uk MS Society uses the building; Chairperson Grahame Barker 07501493920
St Lukes Church		Fauval Road, Glossop, SK13 7AR	01457 860412
Labour Club		11-13, Chapel Street, Glossop, SK13 8AT	01457 862265
Glossop Market	Weekly indoor and outdoor market	High Street Glossop	
Waterfall	Foodbank provided by St James & St Lukes Church	The Grapevine, Charlestown Road, Glossop	
Community Companions Time Out Shopping Service	Support to enable people who would otherwise struggle on their own to do their weekly shopping		
Community Transport	Weekly trip to Tesco		
Local churches	Lunch clubs		
Age Concern	Lunch clubs		

5.4 What services are currently provided?

This section concerns formal arrangements between service commissioners and providers and in no way devalues the important contribution made by the community and voluntary sector; such community-led services/ assets are catalogued above in section 5.3.

Directly commissioned public health services

Public health within Derbyshire County Council (DCC) does directly commission services related to choice of food as part of lifestyle services; these are considered in Chapter 8. Public health input into the Derbyshire Health and Wellbeing Board also provides opportunities to influence and support commissioning activity and/or service provision by partners.

Related local authority service provision

Table 5.5 summarises services impacting health and well-being via 'choice of food' available to Glossop residents that are commissioned or directly provided by Derbyshire County Council (DCC) and/or High Peak Borough Council (HPBC).

Bare Necessities is a voluntary organisation funded by local business, HPBC, DCC, fundraising by volunteers, schools, supermarkets and others including a joint Big Lottery Fund. During the seven months for which 2014 data are available (February through August), Bare Necessities distributed 9,432 meals at a cost of approximately £9,617 (an average of 1,347 meals per month to an average of 150 people per month, with costs of about £1,373 per month). These figures suggest a typical cost-per-meal of just less than one pound. No fresh foods are distributed; all provisions are non-perishable and most are donated via supermarket fundraising, harvest festivals in schools and community donation points (e.g. libraries, shops, schools).

Table 5.5: Local authority service provision for 'Choice of food'

Service	Commissioner	Provider	Notes
Food bank	Various incld. Lottery & DCC	Bare Necessities	Distribution points in 3 children's centres (Whitfield, Hadfield, Gamesley), Adult Education (Gamesley) & Glossop Primary Care Centre

Tameside and Glossop CCG commissioned health services

Tameside and Glossop Clinical Commissioning Group (T&GCCG) does not directly commission services related to choice of food, although member general practices do dispense information about healthy eating and weight management. T&GCCG input into the Derbyshire Health and Wellbeing Board also provides opportunities to influence and support commissioning activity and/or service provision by partners.

5.5 What do service providers and others think?

No stakeholder perspectives relating to choice of food were received aside from the observation from a stakeholder that planning permission for a supermarket to locate a store just below Gamesley on the Brookfield site was declined.

5.6 What are the key messages?

The steering group identified several key messages concerning 'choice of food':

Facilitating choice: Transport widens choice in terms of healthy eating and price.

Obesity prevalence: The high level of adult obesity recorded by Glossop GP practices is a concern, with complex causes and implications.

Knowledge gaps: More information is required to understand local influences of food choice and its relationships with other determinants of health, such as the 'community' value of local shops and the financial viability of education about 'spending to save' via larger but less frequent shopping trips.

6. Getting about

Good transport links are enabling. It is well established that access to health-promoting services is inequitably distributed in favour of those with access to a car (yet most of the harms arising from their use, such as injury and pollution, are disproportionately experienced by more deprived members of society). Transport can enable access to health and social services, other key amenities, employment opportunities, reduce isolation and if 'active' (e.g. cycling) deliver exercise—all of which can be especially problematic for people with disabilities. This chapter considers issues around getting about within and into/ out of Glossop.

6.1 What do the community feel is needed?

Informants expressed differing opinions over public transport links within Glossop. They were described as 'terrible' in relation to difficulties getting off the Gamesley estate after 5pm. Some felt that travel within Glossop was hard without the ability to drive. Others considered local bus services to be good/ fairly accessible (even exceptional), believing ticket price to be fair within an area, but noting that bus passes used by older people were restricted to certain areas. Bus stops seem to be well used. Train services for Hadfield and Glossop were appraised as 'not bad', frequent and reasonably priced. Some areas are better served than others.

⚠ Information sources and interpretation

The small number of key informant interviews collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Opinions have been paraphrased, but have not been reinterpreted.

It was almost universally felt that Glossop residents had difficulties traveling out of the area, with roadways and public transport connections described as a 'nightmare' (heavy traffic along Mottram Moor/ A57 was specifically mentioned). The transport infrastructure was felt to be insufficient for the Glossop population. Comments noted high volumes of road traffic and rail delays; the latter means Hadfield at the 'end of the line' is sometimes 'missed out' at the start or end of the day—resulting in problems for both commuters and school children. Manchester by train was easy, but getting to Buxton was perceived as more complicated.

If I had a magic wand…?

Informants were asked what one thing they would wish for to improve health and well-being in Glossop, if they had a magic wand. There were calls for cheaper/ better public transport in and out of Glossop and for a transport hub in Gamesley. A bypass was suggested to relieve standing traffic through Tintwistle and beyond.

6.2 What do the figures suggest might be needed?

Some information about transport as a determinant of health in Glossop is available from routinely collected statistics and surveys. This section summarises what we know about transport using selected indicators; note that indicator profiles for disability (an important access consideration) are provided in Chapter 8.

⚠ Information sources and interpretation

The small number of indicators collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Some statistics are collated at ward level; where not directly measured at this geography then generally inferior modelled estimates may be used. Statistical comparisons may not adjust for population mix. Aggregate data may obfuscate variation in indicators between community groups.

Table 6.1 confirms a large disparity in household access to a car or van; nearly half of Gamesley residents (46%) and as few as 6% of Simmondley residents depend on other means of transport. Residents of Whitfield, Hadfield North and Howard town also experience greater challenges with independent transport compared to the county average of one fifth of the population in this position. From Table 6.2 working Howard Town residents are marginally the highest users of public transport, the lowest users of private or hire vehicles (e.g. taxis) and—along with Gamesley—most likely use active travel (e.g. walking, riding a bicycle). More than three quarters of workers from Simmondley and Tintwistle get to work by non-public vehicles.

Table 6.1: Access to private transport, % (2011 Census)	No household access to car or van
Dinting	12.4
Whitfield	39.8
Old Glossop	16.6
Howard Town	29.1
Gamesley	45.5
Simmondley	5.5
Hadfield North	32.6
Hadfield South	18.8
Tintwistle	16.4
Padfield	17.7
St. Johns	9.0
High Peak BC	19.6
Derbyshire CC	20.1

Source: Derbyshire Observatory 2011 Census Summary Profiles

Table 6.2: Method of travel to work, % (2011 Census)	Public transport	Private or hire vehicle	Active travel
Dinting	10.1	70.0	11.7
Whitfield	13.7	61.6	19.8
Old Glossop	11.7	71.2	9.2
Howard Town	16.0	57.1	21.2
Gamesley	14.0	61.6	21.1
Simmondley	9.4	75.3	9.1
Hadfield North	11.1	68.2	16.1
Hadfield South	9.4	72.9	13.0
Tintwistle	8.4	78.8	7.8
Padfield	12.8	71.4	10.7
St. Johns	7.8	74.6	5.4

Source: Census 2011, employed usual residents aged 16–74 yrs, via http://www.nomisweb.co.uk/census/2011/qs701ew; Public transport = Underground, metro, light rail, tram, train, bus, minibus or coach; Vehicle = Taxi, motorcycle, scooter, moped, driving a car or van or passenger in a car or van; Active travel = Bicycle or foot

6.3 What assets do the community identify?

Key informant interviews: information sources and access barriers

Cost was repeatedly raised as an access barrier to use of existing public transport, both within Glossop and when going outside of Glossop. The cost of a bus fare between Hadfield and Glossop was thought to be excessive. It was suggested that asking for help with transport difficulties could be seen as a sign of 'weakness'.

⚠ Information sources and interpretation

The small number of key informant interviews collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Opinions have been paraphrased, but have not been reinterpreted.

The lack of a proper bus station was seen as a barrier to use of bus networks. It was noted that most but not all buses had been made accessible, but suggested people with disabilities (including deaf or blind people) could easily miss their bus. Taking prams on the bus was difficult. People near the town centre had an advantage over those less central e.g. Gamesley residents wanting to take the train. Some people (including current drivers) may lack the knowledge to make use of existing public transport options. Getting directly to Tameside Hospital via public transport was not considered straightforward.

Asset mapping

The information in Table 6.3 was collated primarily from Glossop residents attending a planned Community Voice meeting.

⚠ Information sources and interpretation
The 'snapshot' nature of the community asset listings is acknowledged; it should not be regarded as a comprehensive catalogue and may not reflect current asset status.

Table 6.3: Community-based assets identified for 'Getting about'

Name	Description	Address	Contact
Rail station		Norfolk Street, Glossop, SK13 8BS	
Rail station		Station Road, Hadfield	
Rail station		Dinting	
Volunteer Centre Car Scheme	Volunteer drivers help people with disabilities, older people, sick children, people with learning disabilities & people with mental health problems to attend medical & similar appointments.	Volunteer Centre Howard Town House, High Street East, Glossop, SK138DA	Community Companions Team 01457865722
Community Transport Glossop	Minibus service	Mill Street, Glossop, SK13 8PT	01457 861635

6.4 What services are currently provided?

This section concerns formal arrangements between service commissioners and providers and in no way devalues the important contribution made by the community and voluntary sector; such community-led services/ assets are catalogued above in section 6.3.

Directly commissioned public health services

Public health within Derbyshire County Council (DCC) does not directly commission services related to public, private or patient transport. Public health input into the Derbyshire Health and Wellbeing Board, however, provides opportunities to influence and support commissioning activity and/or service provision by partners.

Related local authority service provision

Table 6.4 summarises services impacting health and well-being via 'getting about' available to Glossop residents that are commissioned or directly provided by Derbyshire County Council (DCC) and/or High Peak Borough Council (HPBC).

Table 6.4: Local authority service provision for 'Getting about'

Service	Commissioner	Provider	Notes
Local bus service	—	Private sector & DCC	Some services subsidised by DCC
Community transport services	—	DCC	Specifically for older people/ people with mobility problems
Gold Card	DCC	Private sector	Free bus travel at off-peak hours
B-Line	DCC	Private sector	Subsidised bus travel for people aged 11–18 yrs
Highways	—	DCC	
Transport planning	—	DCC	

Tameside and Glossop CCG commissioned health services

Tameside and Glossop Clinical Commissioning Group (T&GCCG) does not directly commission services related to public, private or patient transport. However, T&GCCG currently part-fund the Volunteer Centre's Car Scheme. Furthermore, T&GCCG input into the Derbyshire Health and Wellbeing Board provides opportunities to influence and support commissioning activity and/or service provision by partners.

6.5 What do service providers and others think?

Invited service providers, commissioners and other stakeholders shared experiences and views describing their take on what is needed to improve health and the determinants of health in Glossop.

⚠ Information sources and interpretation

The small number of stakeholder responses collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Opinions have been paraphrased, but have not been reinterpreted.

Successes and achievements

In the community sector, these include supporting residents who cannot readily access public transport; providing affordable transport to hard-to-reach stakeholder groups; recruitment of a large number of Glossop residents to a volunteer driver scheme who undertook numerous journeys, making every effort to cover all requests.

For local authorities, these include maintaining good local bus services despite reductions in funding available; development of a good network of multi-user trails to connect Glossop to other towns, villages and countryside; and supporting a vibrant town centre with complementary pedestrian facilities.

For primary care providers, this includes the flexibility of volunteer drivers in taking people to health sites not covered by community transport (e.g. GP to GP practice).

Challenges in commissioning or delivering services

In the community sector, these include providing a complete and efficient service to Glossop in the absence of a permanent local operational base; continuing service provision to rural outposts in the face of imminent funding cuts; tokenistic funding contributions that do not cover costs to ensure service sustainability; recruitment of volunteers; and the viability of continuing any service beyond the planned withdrawal of funding in two years (in the absence of a reduction in service user demand).

For local authorities, these include diminishing budgets to deliver services and projects; growing traffic levels through the town, causing congestion and access problems; and recent upsurge in demand for housing development putting pressure on the transport network in the future.

Barriers to participation

In the community sector, these include cuts to personal finance packages; lack of knowledge about services by potential users; lack of an accessible vehicle to cater to the needs of wheelchair users; restrictions on the type of medical conditions volunteer drivers can support (e.g. people with incontinence problems); booking requests for transport at short notice or times such as early morning that inconvenience elderly volunteer drivers.

For local authorities, these include utilising effective communication and feedback channels to achieve proper public engagement and meeting growing public expectation and demand for services.

Health improvement plans

In the community sector, these include establishing a local base of operations to facilitate elderly and infirm passengers to access local doctor's surgeries and clinics; expansion of existing services that promote independent living and foster social interaction by bringing people together (e.g. transport for stakeholder groups, hospital appointment transport where public transport is unsuitable, befriending, supported shopping, training and awareness for volunteers in relation to dementia and mental ill health).

For local authorities, these include building on legacy events (e.g. Summer of Cycling and Tour de France) to encourage more people to cycle to work, school and for leisure; and developing sustainable travel initiatives that improve access to services without adding to traffic congestion.

Organisational aspirations

In the community sector, these include provision of complete transport services for all those needing it and development of new transport-linked services e.g. 'home from hospital', sitting services and domiciliary gardening, cleaning and/or laundry services.

For local authorities, these include local implementation of national transport initiatives to reduce levels of through traffic in the town; and—if money were no object—free bus travel and free cycle hire with an improved cycle-friendly infrastructure, plus a travel plan coordinator to help individuals plan their journeys more effectively and sustainably.

Partnership opportunities

In the community sector, these include strengthening existing links and forging new links. Potential partners identified were Glossop Volunteer Centre, Age UK, Glossop Community Transport, Tameside and Glossop CCG, Alzheimer's Society, local authority (Adult Care) and individual GP practices (e.g. acting as a single point-of-contact for referrals to community-based transport services).

For local authorities, these include learning from successful partnerships such as the Tour de France (involving DCC, HPBC, Peak District National Park and United Utilities) and building better links with local businesses.

6.6 What are the key messages?

The steering group identified several key messages concerning 'getting about':

Proportionate services: Transport provision in Glossop may be mismatched to local requirements to support improved access to employment, health care and other community amenities, food choice, educational opportunities and beneficial lifestyle changes.

Cost barriers: Cost can be a barrier to travel outside of Glossop via public transport and access to information about passes/ concessions may need improving.

Active travel: Glossop is not active travel-friendly (e.g. walking, cycling) and road safety considerations may dictate that alternative forms of physical activity should be more heavily promoted given the anti-obesity and other benefits of regular exercise.

Planning for the future: Transport needs revisiting using a 'whole system' approach. Currently, car ownership seems to be a necessity rather than luxury, and there are no incentivised car sharing schemes in place to maximise existing vehicle use. Volunteer driver eligibility criteria are strict and may inhibit greater utilisation of this resource. Planning needs to take into account proposed cuts to public transport and community transport services in the Glossop area.

7. Learning and training

Higher educational attainment is generally linked to fewer risk-taking behaviours, better lifestyle choices, improved child health, a longer life expectancy, more effective use of health information and health services, social cohesion and greater uptake of preventative healthcare interventions (such as vaccinations or cancer screening). Education has a complex interaction with other determinants of health, most notably employment and performance of the wider economy. This chapter considers issues around learning and training opportunities in Glossop.

7.1 What do the community feel is needed?

Educational opportunities for very young children were thought to be limited, although a number of informants referred to children's centres in various contexts.

⚠ Information sources and interpretation

The small number of key informant interviews collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Opinions have been paraphrased, but have not been reinterpreted.

Informants noted that schools and colleges were close by (typically in walking distance) and felt there was a good range of local schools. Impressions of local schools were generally but not unanimously positive. Schools have their own characteristics that reflect the areas they serve; split sites might be a source of frustration. Some informants reflected that they had not received the help they felt was needed at school, which made accessing further education much harder. One informant felt that school meals should be free for all children, noting that some parents were struggling to feed themselves. It was suggested by some informants that a limited range of college courses was offered at a limited range of times.

In terms of opportunities for people to learn new skills or gain new knowledge following compulsory education, informants felt Glossop residents had access to good adult education services. Information about adult education courses is available in a number of places and leaflets have been delivered door-to-door, although others felt opportunities were not sufficiently well advertised. It was suggested that apprenticeships were becoming increasingly difficult to secure.

If I had a magic wand…?

Informants were asked what one thing they would wish for to improve health and well-being in Glossop, if they had a magic wand. It was suggested that children's education could be further improved to help them grow up and get good jobs.

7.2 What do the figures suggest might be needed?

Some information about learning and training as determinants of health in Glossop is available from routinely collected statistics and surveys. This section summarises what we know about these topics using selected indicators.

⚠ Information sources and interpretation

The small number of indicators collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Some statistics are collated at ward level; where not directly measured at this geography then generally inferior modelled estimates may be used. Statistical comparisons may not adjust for population mix. Aggregate data may obfuscate variation in indicators between community groups.

Child development is measured as the percentage of pupils achieving 78 points across all 13 early years foundation stage profile (EYFSP) scales as collated by local authorities, including a minimum number in particular areas of learning and development, by the end of the academic year in which they turn 5. Although using estimates based on larger geographic areas, Table 7.1 indicates this probably ranges from a low of 59.4% in Gamesley and Hadfield North to a high of 85.6% in Dinting, Simmondley and St. John's. We can also estimate the percentage of pupils further along the educational pathway who achieve five General Certificate of Secondary Education (GCSE) subject grades ranging from A*–C including English and maths by the end of Key Stage 4 (Year 10 and 11, when pupils are aged 14–16 years) in local authority-maintained schools. These data again suggest under-attainment by pupils in Gamesley and Hadfield North, with continuing above-average attainment by Dinting, Simmondley and St. John's pupils in particular. These data also raise concerns about pupil attainment/ school performance in Hadfield South, similarly coming in below the England average. Glossop-level aggregate figures obfuscate these disparities, suggesting local indicators better the England average.

Table 7.2 provides more detail about pre- and primary school attainment. Noteworthy observations are the low levels of pre-school attainment in Hadfield South and Gamesley; the comparatively high prevalence of pupils with special educational needs in Gamesley, Whitfield and Padfield; the high proportion of persistently absent pupils in Padfield; and the high performance of Key Stage 2 pupils in Simmondley. For the latter indicator, 62.5% Level 4+ attainment in Dinting and 85.5% in Hadfield South appears somewhat incongruous. There is no clear relationship between absenteeism (primary phase) and educational attainment (at Key Stage 2).

Table 7.1: Child development & education indicators, % (est. from MSOA level data)	Development at age 5 2011–12	GCSE achievement 2011–12†
Dinting	85.6	75.2
Whitfield	73.7	65.2
Old Glossop	76.6	68.0
Howard Town	73.7	65.2
Gamesley	59.4	52.0
Simmondley	85.6	75.2
Hadfield North	59.4	52.0
Hadfield South	61.6	56.0
Tintwistle	67.6	64.6
Padfield	67.6	64.6
St. Johns	85.6	75.2
Glossop (11 wards combined)	71.9	64.3
High Peak BC	67.8	63.2
Derbyshire CC	68.2	63.5
England	63.5	58.8

Quilt key:

Worse than England average	Similar to England average	Better than England average	No statistical comparison made

Source: Public Health England, via www.localhealth.org.uk; †5A*–C (incld. Eng & Maths) GCSE

Table 7.2: Pre-school & primary school attainment, %	Pre-school attainment	Special educational needs	Persistently absent	Level 4+ in Eng & Maths
Dinting	88.2	6.4	1.0	62.5
Whitfield	65.4	17.0	4.0	80.8
Old Glossop	66.7	9.7	1.2	70.5
Howard Town	68.6	11.0	2.7	77.1
Gamesley	57.5	18.3	3.9	55.3
Simmondley	75.0	7.0	1.2	91.4
Hadfield North	73.9	14.9	2.1	61.1
Hadfield South	50.0	13.8	1.6	85.4
Tintwistle	57.1	12.2	4.4	69.2
Padfield	71.4	16.8	6.9	66.7
St. Johns	69.2	14.3	5.1	63.6
High Peak BC	67.2	—	—	83.9†
Derbyshire CC	68.3	—	—	82.7†

Source: Derbyshire Observatory; Pre-school educational attainment = Early Years Foundation Stage pupils achieving 78+ points overall and 6+ in all PSED and CLL (2011); Primary phase pupils with special educational needs (2012); Primary phase pupils defined as persistently absent (2011); Key stage 2 pupils achieving Level 4+ in English and Maths (2011 or 2012†)

Table 7.3: Secondary & further educational attainment indicators, % (2011 Census)	Full-time students aged 16–17	Full-time students aged18–74	No qualification aged 16+	Highest = Level 1 aged 16+	Highest = Apprentice aged 16+	Highest = Level 4 aged 16+
Dinting	98.0	3.3	14.4	9.7	4.2	43.9
Whitfield	83.3	2.4	28.0	15.2	3.2	22.1
Old Glossop	95.3	3.9	16.9	11.8	3.5	36.2
Howard Town	87.3	3.0	20.3	13.9	3.5	29.5
Gamesley	77.8	3.3	39.8	19.0	3.0	7.4
Simmondley	91.1	3.3	12.5	12.7	4.0	37.0
Hadfield North	91.8	4.1	30.0	14.4	3.7	19.0
Hadfield South	86.2	3.1	22.4	13.8	4.3	26.5
Tintwistle	93.8	3.7	21.0	14.6	3.3	26.7
Padfield	89.0	3.8	16.0	14.3	3.5	31.3
St. Johns	87.5	2.7	15.9	12.8	3.4	36.3
High Peak BC	88.0	3.9	20.9	13.1	4.0	29.4
Derbyshire CC	86.3	2.9	25.7	14.1	4.3	23.7

Source: Derbyshire Observatory 2011 Census Summary Profiles; Level 1: 1-4 O Levels/CSE/GCSEs (any grades), Entry Level, Foundation Diploma, NVQ Level 1, Foundation GNVQ, Basic/Essential Skills; Level 4 and above: Degree (for example BA, BSc), Higher Degree (for example MA, PhD, PGCE), NVQ Level 4-5, HNC, HND, RSA Higher Diploma, BTEC Higher level, Foundation degree (NI), Professional qualifications (for example teaching, nursing, accountancy).

Table 7.3 shows that Gamesley has the lowest proportion of eligible young people aged 16 or 17 engaged in full-time education, and Dinting the highest. Variation by ward for such engagement by adults aged 18–74 years is less than 2%. About 40% of Gamesley residents aged over 16 years have no formal qualification, with Hadfield North and Whitfield not too far behind. Gamesley residents are most likely to be educated to a basic qualification level and by far the least likely to have completed a degree or similar level qualification (7.4%, compared to 43.9% of Dinting residents).

A 2011 report[1] by University of Derby on young people not in education, employment or training (NEETs) notes that, as at November 2009 the total size of the NEET cohort aged 16–18 in Glossop was 79, of which 58% were aged 18 years; almost three quarters (73.4%) had been in NEET less than 6 months. Nearly a third (30.4%) of those in NEET in Glossop had a category of learning difficulty and/or disability (LDD) while still at school (similar to the Derbyshire County average of 27.3%); 8.9% had a persisting (post-16 years) LDD. The Glossop NEET cohort comprised individuals from several vulnerable groups: teenage parent (9), pregnant (6), supervised by Youth Offending Service (3), looked after in care (2), substance misuse (1) and in more than one vulnerable group (19).

[1] Hutchinson J, Korzeniewski R, Moore N. (2009). Career learning journeys of Derby and Derbyshire NEETs (March 2011). University of Derby. http://www.derby.ac.uk/media/derbyacuk/contentassets/documents/ehs/icegs/Career-Learning-Journeys-of-Derby-and-Derbyshire-Neetsderbyshire-Neets.pdf

7.3 What assets do the community identify?

Information sources and access barriers

Informants felt that locals would seek information about learning and training opportunities from libraries (although it could be hard to find there), via adult education (e.g. Geoffrey Allen Centre), Glossop Guild, volunteer centre, job centre, local training organisations, Connexions (careers advice service), free papers/ advertising (posters, door-to-door), youth/ community centres, doctor's/ dental surgeries and schools.

⚠ Information sources and interpretation

The small number of key informant interviews collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Opinions have been paraphrased, but have not been reinterpreted.

However, access barriers to these information sources included low levels of literacy, the cost of evening classes and 'having the guts' to take action. Juniper was identified as a careers resource for young people and Sure Start as a learning resource for young mothers (e.g. how to manage difficult child behaviour). Fathers might not fully participate in learning activities via Sure Start due to having to work and/or perception that it is a 'women's place'. Further education might be inaccessible to young people due to cost (fees and travel), whereas participation in adult education might be hampered by a limited range of courses, course costs, travel requirements, inconvenient course times and difficulties making (or affording) childcare arrangements. It was suggested that financial assistance and the provision of crèches would widen access for parents of young children.

Asset mapping

The information in Table 7.4 was collated primarily from Glossop residents attending a planned Community Voice meeting.

⚠ Information sources and interpretation

The 'snapshot' nature of the community asset listings is acknowledged; it should not be regarded as a comprehensive catalogue and may not reflect current asset status.

Table 7.4: Community-based assets identified for 'Learning and training'

Name	Description	Address	Contact
Geoffrey Allen Centre		Winster Views, Gamesley, Glossop, SK130LU	Derbyshire County Council 01457 858035
Gamesley Children's Centre		Gamesley Community Centre, Melandra Castle Road, Gamesley, Glossop, SK136UQ	Derbyshire County Council 01629 533 185

Name	Description	Address	Contact
Hadfield Children's Centre		Hadfield Nursery School, Off Queen Street, Hadfield, Glossop, SK132DW	Derbyshire County Council 01457 860729 hadfieldcc@derbyshire.gov.uk
Simmondley Primary School		Pennine Road, Simmondley, Glossop, SK13 6NN	Mrs Debbie Greaves 01457 852721
St Philip Howard School		St. Mary's Road, Glossop, SK13 8DR	01457 853611 headteacher@st-philiphoward.derbyshire.sch.uk
Gamesley Community Primary School		Grindleford Grove, SK13 6HW	Deborah Meredith 01457 853721 enquiries@gamesley.derbyshire.sch.uk
Glossopdale Community College		Glossopdale Community College, Talbot Road, Glossop, SK13 7DR	Derbyshire County Council Carol Ollerenshaw 01457 862336
St Margaret Catholic Primary School		Glossop Road, SK13 6JH	Margaret Hyde 01457 855818 headteacher@st-margarets.derbyshire.sch.uk
Hadfield Community Centre		Newshaw Lane, Hadfield	Derbyshire County Council 01457 854465
Glossop Library		Victoria Hall, Talbot Street, Glossop, SK13 7DQ	01457 852616
Hadfield Library		Station Road, Hadfield, Glossop, SK13 1AA	01457 852589
Adult Education		Talbot Street, Glossop SK13 7DG	Derbyshire County Council 01457 852245 glossop.ace@derbyshire.gov.uk
Geoffrey Allen Centre		Winster Mews, Gamesley	Church/ Derbyshire County Council 01457 858035
Central Methodist Church		Chapel Street, Glossop, SK13 8AZ	01457 856464 info@glossopcentralmethodist.org.uk MS Society uses the building; Chairperson Grahame Barker 07501493920
St Lukes Church		Fauval Road, Glossop, SK13 7AR	01457 860412
Gamesley Community Cafe	Café	6 Winster Mews, SK130LU	Nick and Donna Rogers
Juniper Training		58 Surrey St, Glossop, SK13 7AJ	01457 869963 glossop@junipertraining.co.uk
Volunteer Centre Glossop	Informal learning (accredited and non accredited) to gain skills and knowledge for volunteering / employment	Howard Town House, High Street East, Glossop, SK13 8DA	01457 865722

7.4 What services are currently provided?

This section concerns formal arrangements between service commissioners and providers and in no way devalues the important contribution made by the community and voluntary sector; such community-led services/ assets are catalogued above in section 7.3.

Directly commissioned public health services

Public health within Derbyshire County Council (DCC) does not directly commission services related to learning and training, except for the Community Health Trainer Service currently provided by Pennine Care NHS Foundation Trust (see Chapter 8). Public health input into the Derbyshire Health and Wellbeing Board also provides opportunities to influence and support commissioning activity and/or service provision by partners.

Related local authority service provision

Table 7.5 summarises services impacting health and well-being via 'learning and training' available to Glossop residents that are commissioned or directly provided by Derbyshire County Council (DCC) and/or High Peak Borough Council (HPBC).

Table 7.5: Local authority service provision for 'Learning and training'

Service	Commissioner	Provider	Notes
Children's centres	—	DCC	In Gamesley, Glossop and Hadfield
Schools	Department for Education	DCC	See http://www.schools-search.co.uk/school-search-town.php?town=Glossop
Adult education	—	DCC	See http://www.derbyshire.gov.uk/education/adult_education/
Derbyshire Youthinc	—	DCC	Replaces Connexions Derbyshire; see http://derbyshireyouthinc.com

Tameside and Glossop CCG commissioned health services

Tameside and Glossop Clinical Commissioning Group (T&GCCG) does not directly commission services related to learning and training. However, member general practices play a critical role in the education and training of health professionals. T&GCCG input into the Derbyshire Health and Wellbeing Board provides opportunities to influence and support commissioning activity and/or service provision by partners.

7.5 What do service providers and others think?

Invited service providers, commissioners and other stakeholders shared experiences and views describing their take on what is needed to improve health and the determinants of health in Glossop.

⚠ Information sources and interpretation

The small number of stakeholder responses collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Opinions have been paraphrased, but have not been reinterpreted.

Successes and achievements

For schools, these include most students continuing to full-time education (with smaller numbers going into employment with training and very few falling into the NEET category); pride in helping turn young people into morally conscious individuals; being community-focussed (e.g. the sports department opens evenings and weekends); and being at the heart of the Catholic community.

For colleges, these include collaboration with Jobcentre Plus locally to publicise vocational courses and offer training; partnership with a local organisation to deliver workplace-based training in warehousing; and being the institution of choice for students wishing a continuing education.

Challenges in commissioning or delivering services

For schools, these include identifying funding for new developments; raising learner aspirations; and delivering a wide range of community-based programmes.

For colleges, these include travel time/ distance between Glossop and Buxton for students and the affordability and/or convenience of public transport links.

For local authorities, these include habitual non-attendance at school resulting in isolation at home, low aspirations and a generational cycle of unemployment.

For primary care providers, this includes recognition that practices can play a role beyond ‘health’ (e.g. budgetary support to fund early years literacy development).

Barriers to participation

For schools, these include poor parenting skills; engagement of young people in outside activities; and insular mind-sets [it is unclear to whom this comment refers].

For colleges, these include the adverse effect of travel distance and seeming lack of regular public transport to Buxton on update of Jobcentre Plus referrals and lack of knowledge about bus services between Glossop and Buxton during term time.

Health improvement plans

For schools, these include widening community-based programmes to include health improvement activities (e.g. offering a wider range of inter-generational sports activities); implementing the government agenda for children and young people with special educational needs and disabilities (SEND) with care plans from age 3 to 25 years; and improving and developing the personal, social and health education (PSHE) curriculum.

Organisational aspirations

For schools, these include fostering highly successful, motivated, inspired and developed young people, with a thirst for life based on good moral principles, who become mature and responsible citizens.

For colleges, these include increasing the level of training offered to Jobcentre Plus customers and young people in the area and continued promotion of courses to 16–18 year olds alongside information about term-time transport opportunities.

Partnership opportunities

For schools, these include membership of the 'Peak 11' High Peak and Derbyshire Dales Learning Federation (see http://www.peak11.co.uk) and collaboration with another Derbyshire school on a leadership programme.

For colleges, these include working more closely with organisations providing services to benefit claimants (such as Jobcentre Plus and local community organisations) to develop courses that improve skills and employability.

7.6 What are the key messages?

The steering group identified several key messages concerning 'learning & training':

Younger voices: This assessment identifies the need to better understand what young people think about education and training—particularly young residents of Gamesley, Hadfield North and Whitfield, who may be at higher risk of finishing compulsory education with no qualification.

Access barriers: A better understanding of local barriers to adult education such as transport and childcare is needed, as is information on resident awareness of existing education-focussed assets in and around Glossop.

Pooling assets: Educator willingness to partner with the community sector has the potential to improve resourcing and utilisation of wider community assets (both people and buildings, such as a network of peer educators teaching life skills outside of classrooms).

Tailored training: Some training may be impeded by small numbers that impact course viability, with the result that meeting demand may be usurped by systems that effectively push people into training that satisfies performance indicators only.

Learning environment: The perception that there may be a fall-off in educational attainment between leaving primary school and leaving secondary school merits further investigation, including the possible role of experiences outside of school in shaping attitudes to education.

Careers advice: There is limited local provision of careers advice (Connexions Derbyshire had offered a restricted service; a National Careers Service access point operates at Glossop Adult Education Centre).

Volunteering benefits: Opportunities to develop the soft skills required for employment (e.g. self-confidence, able to communicating appropriately, work in a team, etc.) should not be overlooked; volunteering offers an opportunity to re-gain or learn these skills.

8. Health and health care

Lifestyle choices and circumstances (such as deprivation) can have marked effects on health in later life; some risk behaviours such as smoking and drinking are 'clustered' together, causing worse harm in combination. Behaviours are influenced by factors both internal (e.g. attitude or habit) and external to individuals (e.g. the wider 'choice environment' and availability of alternatives). Long-term illness and disability adversely affects individuals, families, communities, health and social care services and wider society. There are a wide range of factors that potentially impact upon people's mental health and—more broadly—sense of well-being. Mental and physical health and well-being are inextricably linked and are fundamental to an individual's ability to undertake their daily activities. Good mental health is likely to help counteract the negative aspects of a physical health condition and conversely good physical health can have positive impacts upon mental health and well-being. Many factors may contribute to the poor physical health of individuals, including genetics, lifestyle choices, personal psychology and medical factors such as the presence of other conditions. Such factors work in concert with the wider determinants of health to produce a profile of disease at a population level. This chapter considers issues around health and health care in Glossop.

8.1 What do the community feel is needed?

Key informants were not asked to comment directly on health and health care needs in order to maintain confidentiality. However, they were asked to help identify sources of information about health and well-being (and barriers to such resources) and these views are summarised below in section 8.3.

If I had a magic wand…?

Informants were asked what one thing they would wish for to improve health and well-being in Glossop, if they had a magic wand. One wished for a local walk-in health centre with a central space for groups to meet that was open to all and where all support groups had a presence. Another wish was to improve people's teeth and reduce obesity.

8.2 What do the figures suggest might be needed?

Some information about health status and access to health care as a determinant of health in Glossop is available from routinely collected statistics and surveys. This section summarises what we know about these topics using selected indicators.

⚠ Information sources and interpretation

The small number of indicators collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Some statistics are collated at ward level; where not directly measured at this geography inferior modelled estimates may be used. Practice-level health indicators taken from the Quality and Outcomes Framework (QOF) database are used where ward-level statistics are unavailable; QOF is widely considered to under-estimate community prevalence of ill health. Furthermore, prevalence recorded in QOF relates to both the health status of the practice population and clinical coding by practices. Similarly, proxy measures of health service utilisation in QOF reflect patient-related and GP practice-related factors. Interpretation of GP practice QOF data in comparison to peer group, CCG or English average is complex; the direction of any difference is noted (higher or lower) but no speculative interpretation is attempted. Statistical comparisons may not fully adjust ('weight') for population mix. Aggregate data may obfuscate variations in indicators between community groups. Time-trend data are not presented, meaning it is not possible to comment on relative improvement in the 'snapshot' indicators shown.

Health and well-being

Health is said to be more than the absence of disease[1], however, routine statistics focus almost exclusively on the latter so it is very challenging to find information about how 'healthy' the people of Glossop are. There is national interest in the measurement of happiness, satisfaction or well-being (feeling good and functioning well; some also talk of physical and social well-being). 'Five ways to Well-being' have been suggested: these are connect (e.g. with neighbours); be active (e.g. dance); take notice (e.g. mindfulness of scenery); keep learning (e.g. fix something) and give (e.g. volunteer).[2] This framework has some overlap with indicators collated from multiple sources by the UK Office of National Statistics, grouped into 10 domains: Personal well-being; Our relationships; Health; What we do; Where we live; Personal finance; The economy; Education and skills; Governance; and The natural environment.[3] These domains correspond well to the topic scope of this report, but unfortunately the published data do not resolve smaller than regional or local authority level, so indicators are unavailable for Glossop.

Lifestyle

Prevalence estimates of overweight and obesity in children and of obesity and healthy eating behaviour in adults are given in Chapter 5 (although obesity is also closely linked to physical activity as another externally-influenced lifestyle choice).

GP Patient Survey results for self-reported smoking prevalence and ex-smoking prevalence are similar to the England average among patients registered with Glossop practices (see Table 8.1).

[1] http://www.who.int/about/definition/en/print.html
[2] http://www.neweconomics.org/projects/entry/five-ways-to-well-being
[3] http://www.ons.gov.uk/well-being

Table 8.1: Smoking status by Glossop GP practice, % (2012–13)	Practice A	Practice B	Practice C	Practice D	Practice E	Practice F	Tameside & Glossop CCG	England
Self-reported smoking prevalence†	28.3	18.3	16.3	26.1	14.0	21.0	20.5	18.1
Peer group average	21.8	17.6	17.6	25.8	17.6	15.5	—	—
Self-reported ex-smoking prevalence†	34.2	33.3	30.7	32.3	23.3	22.7	29.8	27.3
Peer group average	28.4	27.4	27.4	25.7	27.4	29.3	—	—

Quilt key:

Statistically higher than England average	Statistically similar to England average	Statistically lower than England average	No statistical comparison made

Source: Public Health England, via www.fingertips.phe.org.uk; † GP Patient Survey data; Peer group average provides comparison to GP practices having similar characteristics in terms of practice population structure, deprivation score & rurality.

Table 8.2 indicates that binge drinking behaviour by residents in Glossop wards is probably no different than is typical for England. Nevertheless, binge drinking by a fifth to one quarter of the adult population in Glossop is a public health concern. Such concern is reflected by more accurate data showing that hospital stays for alcohol-related harm are higher than expected for Glossop as a whole, with residents of six wards having significantly more hospital stays for alcohol-related harm compared to the England norm.

Table 8.2: Alcohol-related behaviour and harm, % aged 16+ years (2008–12)	Binge drinking behaviour†	Hospital stays for alcohol-related harm‡
Dinting	21.1	82.8
Whitfield	25.9	124.8
Old Glossop	24.6	112.7
Howard Town	25.9	124.8
Gamesley	22.3	132.3
Simmondley	21.1	82.8
Hadfield North	22.3	132.3
Hadfield South	23.2	121.8
Tintwistle	24.8	102.3
Padfield	24.8	102.3
St. Johns	21.1	82.8
Glossop (11 wards combined)	23.5	108.8
High Peak BC	23.4	100.8
Derbyshire CC	21.6	100.5
England	20.0	100.0

Quilt key:

Worse than England average	Similar to England average	Better than England average	No statistical comparison made

Source: Public Health England, via www.localhealth.org.uk; † 2006–8 % est. from MSOA-level data for population aged 16+ years; ‡ 2008–12 indirectly age-standardised admission ratio (takes into account the number of observed admissions compared to the number of expected admissions, applying the age-specific rates of the standard—in this case national—population)

A bespoke needs assessment on alcohol and drug use/ misuse in Glossop has been undertaken recently.[4] Key findings in relation to alcohol misuse prevalence include:

- Alcohol-related mortality (deaths regarded as being most directly due to alcohol consumption) in Glossop are statistically similar to Derbyshire rates;
- Alcohol-attributable mortality (based on applying attributable fractions to causes of death) have increased in Glossop but decreased in Derbyshire;
- Alcohol-specific admissions for Glossop males continue to rise whereas High Peak and national rates have begun to decline, and for females both Glossop and High Peak rates have risen recently;
- Alcohol-attributable admissions for Glossop males have risen faster than in the High Peak or England, with no clear trend for Glossop females.

Key findings in relation to substance misuse prevalence include:

- Reduced visibility of misuse compared to Tameside and Greater Manchester, possibly due to stigma and insufficient presence of services;
- Class A drug use is deemed relatively low by service providers/ agency workers, although service users indicate higher (and increasing) prevalence;
- Cannabis use in Glossop is highly prevalent and likely socially normalised.

Routine indicators for physical activity are available only at district level. In the APS7 survey[5] (10/2012 to 10/2013) 38% of 16+ year olds in High Peak participated in 30 minutes of moderate-intensity sport at least once per week. The England average for the same period was 35.7%. The percentage of the High Peak population engaging in recommended levels of physical activity in 2012 was 58.5%, with 3.5% of High Peak adults having low levels of physical activity in 2013 (both figures are similar to the England average).[6] How these figures relate to Glossop is unknown.

Disability

The percentage of patients recorded by GP practices[7] as having a learning disability is similar to the England value for all GP practices in Glossop (see Table 8.3). Self-reported sensory impairment and long-term back, joint or arthritic problems are similar to the England average across most GP practices in Glossop.

Table 8.4 shows self-reporting of health status and long-term limiting illness or disability affecting daily activity or work are significantly worse in Gamesley and Hadfield North, yet significantly better in Simmondley and Padfield compared to England. This reflects variation seen between wards that can be masked by aggregated data for Glossop as a whole, which appears similar to England.

[4] Burgess-Allen, J. Glossopdale drugs & alcohol health needs assessment. Derbyshire County Council, 2014.
[5] https://www.sportengland.org/research/who-plays-sport/
[6] Active People Survey, Sport England, via http://fingertips.phe.org.uk/
[7] The QOF LD001 indicator descriptor is 'The contractor establishes and maintains a register of patients aged 18 or over with learning disabilities'; this does not refer to local authority maintained registers.

Table 8.3: Disability indicators by Glossop GP practice, % (2012–13)	Practice A	Practice B	Practice C	Practice D	Practice E	Practice F	Tameside & Glossop CCG	England
Recorded learning disability †	0.3	0.6	0.5	0.4	0.5	0.6	0.5	0.5
Peer group average	0.6	0.4	0.4	0.7	0.4	0.5	—	—
Self-reported blindness or severe visual impairment ‡	1.6	1.4	—	1.8	0.0	3.3	1.8	1.1
Peer group average	1.2	0.8	0.8	1.2	0.8	1.0	—	—
Self-reported deafness or severe hearing impairment ‡	4.1	2.4	3.8	3.5	3.1	1.3	4.5	4.0
Peer group average	4.9	3.4	3.4	4.5	3.4	4.2	—	—
Self-reported long-term back problem ‡	13.6	7.2	10.2	11.0	7.6	8.8	13.1	10.2
Peer group average	11.8	9.3	9.3	12.3	9.3	9.7	—	—
Self-reported arthritis or long-term joint problem ‡	16.7	9.6	10.2	17.4	9.5	20.8	16.5	13.1
Peer group average	16.8	11.5	11.5	15.7	11.5	13.4	—	—

Quilt key:

Statistically higher than England average	Statistically similar to England average	Statistically lower than England average	No statistical comparison made

Source: Public Health England, via www.fingertips.phe.org.uk; † Quality and Outcomes Framework data; ‡ GP Patient Survey data; Peer group average provides comparison to GP practices having similar characteristics in terms of practice population structure, deprivation score & rurality.

Table 8.4: Health status & long-term illness or disability, % (2011)	People reporting very bad health	People reporting bad or very bad health	People reporting long-term limiting illness or disability
Dinting	0.8	4.7	20.8
Whitfield	1.5	9.0	24.2
Old Glossop	0.9	3.5	14.7
Howard Town	1.2	5.9	18.4
Gamesley	1.9	9.5	24.3
Simmondley	0.6	3.4	12.9
Hadfield North	1.8	8.1	22.9
Hadfield South	1.3	5.3	18.1
Tintwistle	1.2	5.3	17.7
Padfield	0.7	4.6	14.8
St. Johns	0.8	4.8	17.0
Glossop (11 wards combined)	1.1	5.5	17.8
High Peak BC	1.1	5.2	18.1
Derbyshire CC	1.3	6.2	20.4
England	1.2	5.5	17.6

Quilt key:

Worse than England average	Similar to England average	Better than England average	No statistical comparison made

Source: Public Health England, via www.localhealth.org.uk

Mental health and well-being

The percentage of Glossop GP patients known to have a mental health condition and the percentage of patients self-reporting long-term mental health problems are similar to or lower than the England average (see Table 8.5). Registered patients diagnosed with dementia are also similar to the England value across most practices. The percentage of adult patients diagnosed with depression is significantly higher compared to the England value across all practices in Glossop.

Table 8.5: Mental health indicators by Glossop GP practice, % (2012–13)	Practice A	Practice B	Practice C	Practice D	Practice E	Practice F	Tameside & Glossop CCG	England
Mental health conditions (all ages) †	0.59	0.56	0.65	1.32	0.33	0.85	0.76	0.84
Peer group average	0.97	0.77	0.77	1.05	0.77	0.76	—	—
Dementia (all ages) †	0.4	0.6	0.8	1.5	0.2	1.0	0.6	0.6
Peer group average	0.6	0.5	0.5	0.5	0.5	0.7	—	—
Depression (aged 18+ years) †	14.0	7.7	8.6	16.5	8.5	10.2	7.5	5.8
Peer group average	6.5	6.0	6.0	7.1	6.0	5.6	—	—
Self-reported long-term mental health problem ‡	6.4	3.1	6.7	7.6	5.4	5.2	4.6	4.5
Peer group average	5.5	4.2	4.2	6.4	4.2	4.0	—	—

Quilt key:

Statistically higher than England average	Statistically similar to England average	Statistically lower than England average	No statistical comparison made

Source: Public Health England, via www.fingertips.phe.org.uk; † Quality and Outcomes Framework data; ‡ GP Patient Survey data; Peer group average provides comparison to GP practices having similar characteristics in terms of practice population structure, deprivation score & rurality.

There are no indicators available that estimate the community prevalence of self-harming behaviours, which is likely to greatly exceed the number of episodes that require hospital attention. Hospital stays for self-harm are significantly higher across Glossop as a whole compared to England (see Table 8.6). At ward level, self-harming by Gamesley, Hadfield North and Hadfield South residents accounts for this excess. Note that these figures are estimated from Hospital Episode Statistics (HES) data collected for larger-than-ward geographic areas (MSOAs) within Glossop.

Table 8.6: Self-harm, Indirectly age standardised admission ratios, (2008/9–2012/13)	Hospital stays for self-harm
Dinting	72.2
Whitfield	132.2
Old Glossop	117.0
Howard Town	132.2
Gamesley	182.3
Simmondley	72.2
Hadfield North	182.3
Hadfield South	153.2
Tintwistle	99.8
Padfield	99.8
St. Johns	72.2
Glossop (11 wards combined)	120.4
High Peak BC	102.6
Derbyshire CC	116.1
England	100

Quilt key:

Worse than England average	Similar to England average	Better than England average	No statistical comparison made

Source: Public Health England, via www.localhealth.org.uk; Estimated from MSOA-level HES data; indirectly age-standardised admission ratios take into account the number of observed admissions compared to the number of expected admissions, applying the age-specific rates of the standard (in this case national) population.

Physical health and injury

The selected physical health indicators in Table 8.7 for patients of Glossop GP practices show that most practice populations may have higher prevalence of chronic obstructive pulmonary disease (COPD) compared to both the England average and peer-group averages. All practice populations are similar to or lower than the England average for proportion of patients known to have diabetes, chronic kidney disorder, epilepsy and osteoporosis. Other indicators suggest a more mixed picture at practice population level.

Table 8.7: Physical health indicators by Glossop GP practice, % (2012–13) †	Practice A	Practice B	Practice C	Practice D	Practice E	Practice F	Tameside & Glossop CCG	England
Recorded diabetes (aged 17+ years)	5.1	5.8	4.9	6.3	5.5	5.3	6.7	6.0
Peer group average	6.7	5.6	5.6	6.8	5.6	5.8	—	—
Recorded hypertension (high blood pressure, all ages)	16.8	13.8	13.8	15.0	13.9	13.3	14.7	13.7
Peer group average	15.4	12.7	12.7	13.5	12.7	15.0	—	—
Recorded coronary heart disease (all ages)	3.4	3.8	3.4	4.8	3.3	4.3	4.2	3.3
Peer group average	4.2	2.8	2.8	3.5	2.8	3.7	—	—
Recorded heart failure (all ages)	0.7	1.3	0.9	0.5	0.3	1.1	0.7	0.7
Peer group average	0.9	0.6	0.6	0.7	0.6	0.8	—	—
Recorded stroke or transient ischaemic attack (all ages)	1.1	2.5	2.1	2.4	1.0	3.1	1.9	1.7
Peer group average	1.9	1.4	1.4	1.6	1.4	1.9	—	—
Recorded chronic obstructive pulmonary disease (all ages)	2.8	2.4	2.5	5.1	1.2	2.0	2.6	1.7
Peer group average	2.5	1.5	1.5	2.6	1.5	1.7	—	—
Recorded chronic kidney disease (aged 18+ years)	4.2	3.0	3.4	4.6	1.9	2.2	3.2	4.3
Peer group average	4.9	3.8	3.8	4.3	3.8	4.7	—	—
Recorded cancer (all ages)	1.9	2.6	2.0	1.8	2.1	2.6	1.9	1.9
Peer group average	2.0	1.8	1.8	1.5	1.8	2.3	—	—
Recorded epilepsy (aged 18+ years)	0.8	1.1	0.8	1.3	0.9	1.3	0.9	0.8
Peer group average	0.9	0.7	0.7	1.0	0.7	0.8	—	—
Recorded osteoporosis (aged 50+ years)	0.0	0.1	0.4	0.8	0.2	0.5	0.2	0.2
Peer group average	0.2	0.2	0.2	0.2	0.2	0.3	—	—
Recorded hypothyroidism (underactive thyroid, all ages)	3.8	4.4	3.7	3.0	4.3	3.8	4.0	3.2
Peer group average	3.5	3.1	3.1	2.9	3.1	3.6	—	—

Quilt key:

Statistically higher than England average	Statistically similar to England average	Statistically lower than England average	No statistical comparison made

Source: Public Health England, via www.fingertips.phe.org.uk; † Quality and Outcomes Framework data; Peer group average provides comparison to GP practices having similar characteristics in terms of practice population structure, deprivation score & rurality.

Many falls are preventable and in older people this may contribute to 'avoidable admissions' as a result of injuries sustained, including hip fractures. In Table 8.8 emergency hospital admissions for hip fracture in people aged 65+ years, elective hip replacements and elective knee replacements are probably similar to the England average across all wards, with Glossop as a whole having significantly fewer emergency admissions for hip fractures than the England average.

Table 8.8: Hospital admissions, Standardised admission ratios, (2008/9–2012/13)	Emergency admission for hip fracture aged 65+ years	Elective hip replacement	Elective knee replacement
Dinting	82.3	110.5	91.4
Whitfield	88.3	96.0	128.3
Old Glossop	86.9	100.5	116.9
Howard Town	88.3	96.0	128.3
Gamesley	87.1	77.3	98.0
Simmondley	82.3	110.5	91.4
Hadfield North	87.1	77.3	98.0
Hadfield South	74.3	75.0	94.6
Tintwistle	59.0	70.6	87.9
Padfield	59.0	70.6	87.9
St. Johns	82.3	110.5	91.4
Glossop (11 wards combined)	81.1	92.6	102.4
High Peak BC	93.2	117.5	103.5
Derbyshire CC	100.2	119.3	122.4
England	100.0	100.0	100.0

Quilt key:

Worse than England average	Similar to England average	Better than England average	No statistical comparison made

Source: Public Health England, via www.localhealth.org.uk; Estimated from MSOA-level HES data

Deaths and life expectancy

From Table 8.9 Glossop as a whole has significantly more early deaths than expected from circulatory diseases and coronary heart disease, but is similar to England for early deaths from cancer and all-causes in people aged <65 years and <75 years. Early deaths from cancer are similar to or better than England in each ward, with Old Glossop and Simmondley being similar to or better than the England average across all early death indicators. However, significantly more early deaths than expected compared to England can be seen in most indicators for Whitfield. Hadfield North, Howard Town and Gamesley also have one or more indicators that show higher than expected early deaths compared to England.

All-age mortality in Glossop shows a mixed picture (see Table 8.10). All-age mortality due to stroke is similar to England for Glossop as whole. All-cancer, all-age mortality is similar to or better than England with the exception of Gamesley. However, there is higher than expected all-age mortality for all-causes, all circulatory disease, coronary heart disease and respiratory diseases in Glossop as a whole. At ward level only Old Glossop, Simmondley and Dinting compare favourably to England on the basis of one or two indicators. Howard Town and Gamesley fare the least well, with four of six indicators being worse than expected for England. Five wards experience excess respiratory disease deaths, with six of 11 wards recording high all-cause mortality.

Table 8.9: Early deaths, standardised mortality ratio (2008–12)	All-cause mortality†	All-cause mortality‡	Cancer‡	All circulatory diseases‡	Coronary heart disease‡
Dinting	81.0	92.1	87.3	138.9	195.8
Whitfield	157.7	168.3	106.6	264.8	237.9
Old Glossop	66.6	70.1	47.9	112.9	160.2
Howard Town	132.5	125.0	102.1	193.1	236.7
Gamesley	107.5	139.0	155.3	137.7	228.4
Simmondley	50.3	56.7	55.7	72.8	61.1
Hadfield North	261.5	198.3	163.7	251.5	198.4
Hadfield South	99.0	110.8	130.8	103.5	120.8
Tintwistle	74.4	100.6	111.2	137.0	147.8
Padfield	88.7	105.0	91.6	131.1	191.9
St. Johns	69.9	98.5	84.5	121.3	130.9
Glossop (11 wards combined)	98.0	105.4	95.6	138.7	161.7
High Peak BC	95.2	98.0	100.0	112.4	116.9
Derbyshire CC	94.5	97.0	98.4	101.5	108.8
England	100.0	100.0	100.0	100.0	100.0

Quilt key:

Worse than England average	Similar to England average	Better than England average	No statistical comparison made

Source: Public Health England, via www.localhealth.org.uk; † aged < 65 years; ‡ aged < 75 years; standardised mortality ratios (SMRs) allow comparison to England only, so wards cannot be directly compared to each other.

Table 8.10: All-age mortality, standardised mortality ratio (2008–12)	All-cause	All cancer	All circulatory disease	Coronary heart disease	Stroke	Respiratory diseases
Dinting	99.7	67.6	112.4	132.8	86.5	86.5
Whitfield	120.7	110.0	167.7	196.3	120.1	97.4
Old Glossop	74.6	57.6	102.1	128.6	68.3	83.2
Howard Town	142.9	98.6	173.0	240.7	146.5	176.7
Gamesley	132.8	155.5	125.2	212.2	66.4	181.8
Simmondley	79.0	54.7	81.4	89.7	93.8	81.3
Hadfield North	156.5	111.7	145.7	163.2	178.4	206.7
Hadfield South	115.7	105.9	124.6	147.6	105.2	151.8
Tintwistle	101.3	134.1	105.4	110.7	97.5	83.2
Padfield	132.1	102.1	123.4	129.3	101.5	217.9
St. Johns	99.1	86.2	133.4	127.3	186.7	91.9
Glossop (11 wards combined)	110.1	91.9	125.2	151.5	110.5	125.9
High Peak BC	100.2	97.9	108.9	119.7	95.3	96.5
Derbyshire CC	101.8	97.4	104.9	112.9	98.6	100.7
England	100.0	100.0	100.0	100.0	100.0	100.0

Quilt key:

Worse than England average	Similar to England average	Better than England average	No statistical comparison made

Source: Public Health England, via www.localhealth.org.uk

Differences (gaps) in life expectancy are a common measure of overall inequalities in health outcomes. Life expectancy is 9.3 years lower for men and 8.4 years lower for women living in the Glossop ward with the worst life expectancy at birth compared to the ward with the highest (based on available pooled 2008–12 data; see Table 8.3).

Key term: Health inequalities

Social differences in health status (e.g. disability-free life expectancy) or in access to the determinants of health (e.g. education). Because many inequalities are also unjust, they are sometimes referred to interchangeably as health inequities.

The average life expectancy at birth in Derbyshire (2008–12 data) is 78.9 years for males and 82.7 years for females. However, as Table 8.11 illustrates Glossop shows variation at local ward level, with life expectancy at birth for females being significantly better than the England average in Old Glossop at 85.5 years but significantly worse than the England average in Hadfield North at 77.1 years. Life expectancy at birth for males is significantly better than the England average in Simmondley at 83.9 years, whereas in Whitfield life expectancy at birth for males is significantly lower than the England average at 74.9 years.

Table 8.11: Life expectancy at birth, years (2008–12)	Males	Females
Dinting	—	—
Whitfield	74.6	78.2
Old Glossop	83.0	85.5
Howard Town	77.1	79.0
Gamesley	76.3	79.5
Simmondley	83.9	83.5
Hadfield North	—	77.1
Hadfield South	77.8	81.7
Tintwistle	78.2	84.3
Padfield	77.0	80.6
St. Johns	—	—
Glossop (11 wards combined)	—	—
High Peak BC	79.2	82.7
Derbyshire CC	78.9	82.7
England	78.9	82.8

Quilt key:

Worse than England average	Similar to England average	Better than England average	No statistical comparison made

Source: Public Health England, via www.localhealth.org.uk

8.3 What assets do the community identify?

Information sources and access barriers

Informants felt that support with well-being could be obtained from libraries offering health and well-being zones, advice and signposting services. However, access barriers identified included low levels of literacy and poor computer skills. Also mentioned were churches, social services, Citizen's Advice, friends and family, FaceBook, Sure Start, food banks, community groups, doctors and clinics—although transport was considered a barrier to accessing some of these.

⚠ Information sources and interpretation

The small number of key informant interviews collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Opinions have been paraphrased, but have not been reinterpreted.

Timely GP/ counselling appointments appear problematic for some (e.g. outside of working hours). There were thought to be some cultural barriers, although the nature of these was not detailed. Difficulty making people aware of local support networks was raised, but even with knowledge, self-confidence or motivation to act may be lacking. Locals will support each other 'over a brew' and Glossop Primary Care Centre was regarded as preferable to travelling to Tameside Hospital for minor ailments.

Asset mapping

The information in Table 8.12 was collated primarily from Glossop residents attending a planned Community Voice meeting.

⚠ Information sources and interpretation

The 'snapshot' nature of the community asset listings is acknowledged; it should not be regarded as a comprehensive catalogue and may not reflect current asset status.

Note that general practices, dentists and opticians serving Glossop were also identified as community-based assets; these are listed below in section 8.4.

Table 8.12: Community-based assets identified for 'Health and health care'

Name	Description	Address	Contact
Peak Health Clinic	Physiotherapy	88 High Street West, Glossop, SK13 8BB	Phil Stock 01457 86978 philstock1@aol.com
Shire Hill Hospital	Physiotherapy	Bute Street, Glossop, SK13 7QP	01457 850400
Glossop Primary Care Centre	Various health & community facilities	George Street, Glossop, SK13 8AY	01457 728860
Geoffrey Allen Centre		Winster Mews, Gamesley	Church/ Derbyshire County Council 01457 858035
Hadfield Community Centre		Newshaw Lane, Hadfield	Derbyshire County Council 01457 854465
Central Methodist Church		Chapel Street, Glossop, SK13 8AZ	01457 856464 info@glossopcentralmethodist.org.uk MS Society uses the building; Chairperson Grahame Barker 07501493920
St Lukes Church		Fauval Road, Glossop, SK13 7AR	01457 860412
Gamesley Community Cafe	Café	6 Winster Mews, SK130LU	Nick and Donna Rogers
MS Society	Support group	Via Central Methodist Church, Glossop	Sue Edwards, Secretary
Visually Impaired People's group (VIPs)	Support group	Via Volunteer Centre Glossop, Howard Town House, High Street East, Glossop	Paul Kiddy
Alzheimer's Society	Advice and support, Singing for the Brain	Adult Social Services, Talbot Street, Glossop	Meena Patel, Community Support Worker
Alcoholics Anonymous	Support group	Via Volunteer Centre Glossop	
Narcotics Anonymous	Support group	Via Volunteer Centre Glossop	
High Peak women's Aid	Domestic Abuse (includes services for children)	Glossop SK13 8AE	01457 856675
Stockport Cerebral Palsy	Provides support to families in High Peak	Volunteer Centre Glossop	01457 856300
Derbyshire Carers (Glossop)	Support group for carers	Volunteer Centre Glossop	01457 858383
Big S	Support group for those with brain injury	Via Central Methodist Church, Glossop	
Community Companions (befriending)	Befriending service for lonely and socially isolated	Volunteer Centre Glossop	01457 865722
Volunteer Centre Car Scheme	Transport to health and health related appointments	Volunteer Centre Glossop	01457 865722
Age UK Day Care Service		Via Bradbury House, Glossop	
Bumps and Babes	Groups in Hadfield and Glossop	Via NCT	0844 243 6137
Mama cafe	Support group for new parents	Via the Soup Seller, Glossop	01457 868695
Peaks and Dales Mental Health Advocacy	Independent advocates for vulnerable adults		01298 74004
MIND	Saturday Club for adults with mental health issues	Via Social Care, Talbot Street, Glossop	Andrew Leeson

8.4 What services are currently provided?

This section concerns formal arrangements between service commissioners and providers and in no way devalues the important contribution made by the community and voluntary sector; such community-led services/ assets are catalogued above in section 8.3.

Directly commissioned public health services

Derbyshire County Council (DCC) directly commission most services related to public health. Outside of formal commissioning arrangements, DCC also support other health improving services available to Glossop residents via partnerships, grant funding and service-level agreements. These include local advocacy and training for Making Every Contact Count (MECC) and initiatives to reduce health inequalities (e.g. Citizen's Advice in children's centres; Credit Union development; food bank support and support for welfare assessments). Public health input into the Derbyshire Health and Wellbeing Board also provides additional opportunities to influence and support commissioning activity and/or service provision by partners. Under recent legislation upper-tier local authorities are responsible for the public health improvement services listed in Table 8.13.

Note that some additional public health services are commissioned at a national level by NHS England. These include children's public health services for ages 0–5 years (until 2015), immunisation programmes, national screening programmes and sexual assault referral services.

Public Health England plays a role in supporting DCC to commission public health services (particularly through knowledge and health intelligence services and health promotion guidance), and also in supporting the DCC response to communicable disease threats, environmental hazards and emergency planning and response. All such input should be available to help meet public health care needs in Glossop.

Table 8.13: Public health services commissioned by DCC or TMBC

Service	Commissioner	Provider	Notes
Starting and developing well			
Children's services	TMBC until Oct 2015 then DCC	DCHS, HPBC, Pennine Care NHS Foundation Trust to Oct 2015	National Childhood Measurement Programme; breastfeeding peer support; Five60 (physical activity and nutrition programme in junior schools); health promotion; school nursing; re-procurement by Oct 2015. NB Children's public health services currently cover ages 5–19, but will include 0–5 yrs (thus health visiting) from 2015.
Reducing & preventing birth defects	DCC	—	No services in place.
Accidental injury prevention	DCC	—	No provision for Glossop; targeting the under 5s in rest of County via DCHS and HPBC providers.
Living and working well			
Lifestyle services	DCC	Pennine Care NHS Foundation Trust to Nov 2014	Including Health Trainers. For example, stop smoking, weight management, physical activity; new service currently out to tender
Sexual health services	DCC	Stockport Foundation Trust	Sexual health promotion; chlamydia screening; community & sexual health clinics; genito-urinary medicine; re-procurement by Apr 2015
Alcohol treatment services: Tier 2	DCC	Derbyshire Alcohol Service	
Alcohol treatment services: Tier 3	DCC	Adaction	
Alcohol treatment services: Tier 4	DCC	Various	Residential detoxification is determined on a case-by-case basis
Drug treatment services	DCC	Derbyshire Healthcare Foundation Trust & Cottage Lane Surgery	Derbyshire Healthcare Foundation Trust work alongside Phoenix Futures as a sub-contracted partner. Treatment is being delivered through a shared care arrangement with Dr Dow at Cottage Lane Surgery, Gamesley and a specialist clinic held at the Primary Care Centre, Glossop. Enhanced service agreements are in place for needle & syringe programme provision at pharmacies in Glossop and Hadfield, and for supervised consumption of methadone and buprenorphine at pharmacies in Glossop, Hadfield and Gamesley.
Health at work	DCC	—	No services in place.
Ageing well			
Older people's services: NHS Health Checks	TMBC until Apr 2015 then DCC	Pennine Care NHS Foundation Trust to Apr 2015	5-yearly invites to "well" persons aged 40–74 to assess their risk of heart disease, stroke, kidney disease and diabetes; re-procurement by Apr 2015
Older people's services: falls prevention	DCC	T&G CCG	Falls prevention is part of T&G CCGs integrated services model; this extends Derbyshire provision into Glossop (delayed from planned April 2014 start).
Seasonal mortality	DCC	Local Authority Energy Partnership (LAEP); DCC public health staff	LAEP project funded for 2 years beginning Sep 2014 targets poor energy-efficient housing, low income, and people with long-term conditions to offer financial support for installation of energy efficient measures & signposting to other identified services. DCC Health Wealth and Wellbeing project in areas of deprivation offers affordable warmth, provider switching service, income maximisation and health information.
Other services			
Public mental health	DCC	—	No services in place.
Dental public health services	DCC	DCHS, Pennine Care NHS Foundation Trust	Oral health promotion specification currently out for comments; service for re-procurement in 2017

Public health activity

Smoking cessation services are currently provided through a combination of GP practice, pharmacy and community service delivery. The number of smoking cessation service users accessing support and 4-week quitters have dropped substantially for the 2013/14 financial year (see Table 8.14). These recent changes to numbers of service users have been attributed to a national trend in personal use of 'e-cigarettes' as an alternative to traditional cigarette smoking, as well as to the economic downturn and rising cost of smoking. Smoking cessation services are able to offer behavioural support but are unable to prescribe nicotine replacement therapy to people using e-cigarettes and such users are not counted towards service 4-week quit targets. Changes in legislation (coming into effect in 2016) are expected to see e-cigarettes classified as medicines.

Table 8.14: Glossop smoking cessation service throughput and output, by time trend

Indicator	2010/11	2011/12	2012/13	2013/14
Number of service users (GP, pharmacy, community)	612	657	528	342
Number of service users registered with GP	595	638	509	330
Number of 4-week quits	229	215	204	114
Proportion of 4 week quits, % (No. of 4-weeks quits/ No. of service users)	37.4	32.7	38.6	33.3

Source: Pennine Care NHS Foundation Trust

Table 8.15 shows total activity during the most recent financial year within GP practices and pharmacies delivering smoking cessation services in Glossop, together with numbers of quitters at four weeks—some of whom have had their successful cessation status validated via carbon monoxide measurement.

Table 8.15: Glossop smoking cessation service, by provider (2013/14)

Smoking cessation provider	Total smokers	Total 4-wk quits	CO validation
GP practices	207	74	34
Pharmacies	6	<3	<3

Source: Pennine Care NHS Foundation Trust; CO = carbon monoxide (CO)-validated smoking status

Table 8.16 shows the number of service users living in Glossop or registered with a Glossop GP practice who accessed the 'Weight matters' exercise and weight loss programme for obese adults expecting to lose 10% of their total body weight. No outcome data were available from the service provider.

Table 8.16: Glossop 'Weight matters' throughput, by time trend

Indicator	2010/11	2011/12	2012/13	2013/14
No. service users living in Glossop	150	168	107	119
No. service users registered at Glossop GP	131	149	103	101

Source: Pennine Care NHS Foundation Trust

The Glossop-specific drugs and alcohol health needs assessment referred to in section 8.2 provides insight into uptake of current alcohol and drug services. Table 8.17 shows the approximate throughput for these services in Glossop (possibly 100–120 residents in total; accurate data are lacking for complex reasons documented in the source report). No outcome data were available relating to these service users.

Table 8.17: Approximate Glossop alcohol and drug service throughput (2013)

Service	Service users
Pennine alcohol	38
ADS alcohol	36
Acorn alcohol	<5
Pennine drugs	27
Phoenix futures drugs	<5
Acorn drugs	<5
Lifeline drugs	<5
Pennine drugs & alcohol	<5

Source: Burgess-Allen, J. Glossopdale drugs & alcohol health needs assessment. Derbyshire County Council, 2014.

The Health Trainer service offers locally provided motivational support for people wanting to make healthy lifestyle changes. This includes one-to-one support around healthy eating, physical activity, weight management, smoking cessation, drinking sensibly and support with breastfeeding. Clients can self-refer into the service or be referred by a health or social care professional. According to data provided by Pennine Care NHS Foundation Trust the number of Glossop residents referred to the service was 101 in 2013/14, down from 325 in 2012/13. Of these, about half (49%) had a personal health plan in 2013/14.

Data on NHS Health Checks carried out in Glossop are not routinely published at GP practice, ward or district level and there may be some concerns about data quality.

Related local authority provision

Outside of the public health budget, Derbyshire County Council (DCC) have direct responsibility for provision of social care and High Peak Borough Council (HPBC) have direct responsibility for environmental health services. Local authority input into the Derbyshire Health and Wellbeing Board also provides opportunities to influence and support commissioning activity and/or service provision by partners.

NHS England primary care provision

Primary medical (GP contract) and enhanced services are commissioned by NHS England. Glossop is served by six general medical practices, with a combined registered patient population during 2013 of 31,700 (potentially equating to 96% of the estimated population size of Glossop in 2012).[8] General practices serving Glossop are listed in Table 8.18.

[8] A combined list size approximating 96% of the Glossop population seems a reasonable proxy for Glossop-specific data; bidirectional flow of patients across the Tameside border probably averages out.

Table 8.18: General medical practices based in Glossop

Name	List size (2013)	Address	Contact
Howard Street Medical Practice	3,575	Howard Street Glossop SK13 7DE	T: 01457 854321 F: 01457 854439 http://www.general-practitioners-uk.co.uk/15276-doctor-Howard-Medical-Practice.html
Manor House Glossop	12,965	Manor Street Glossop SK13 8PS	T: 01457 860860 F: 01457 860017 http://www.manorhousesurgery.co.uk/
Lambgates Surgery	6,500	1-5 Lambgates Glossop SK13 1AW	T: 01457 869090 F: 01457 857367 http://www.lambgatessurgery.co.uk/
Cottage Lane Surgery	2,126	47 Cottage Lane Gamesley Glossop SK13 6EQ	T: 01457 861343 F: 01457 864301 http://www.cottagelanesurgery.co.uk/
Simmondley Medical Centre	3,588	15a Pennine Road Simmondley Glossop SK13 6NN	T: 01457 862305 F: 01457 857610 http://www.simmondleymedicalpractice.co.uk/
Manor House Hadfield	2,946	82 Brosscroft Hadfield Glossop SK13 1DS	T: 01457 860860 F: 01457 857739 http://www.manorhousesurgery.co.uk/

Sources: Public Health England National General Practice Profiles, via fingertips.phe.org.uk

NHS England commission NHS Pharmaceutical Services (see Table 8.19). CCGs and local authorities may also commission services from pharmacies. Pharmacies do not just deal with prescriptions; they are also a key source of advice. They have a consultation room and can advise on how to treat minor conditions, carry out 'advanced services' including Medicine Use Reviews (structured adherence-centred reviews with patients on multiple medicines) and the New Medicines Service (support for people with long-term conditions newly prescribed a medicine to help improve medicines adherence). Some will provide services such as flu injections and supervised drug consumption.

Table 8.19: Community pharmacies based in Glossop (via NHS Choices)

Name	Address	Contact
Boots Pharmacy	17-19 High Street West, Glossop SK13 8AL	01457 852011
Cohens Pharmacy	7 High Street West, Glossop SK13 8AZ	01457 852044
Co-op Pharmacy	Norfolk Street, Glossop SK13 8BH	01457 864127
Moorland Ltd.	5 Pennine Road, Simmondley SK13 6NN	01457 866300
Tesco Pharmacy	Wrens Nest Road, Glossop SK13 8HB	01457 889847
Your Local Boots	116 Station Road, Hadfield SK13 1AL	01457 853635
The Mews	14 Winster Mews, Gamesley SK13 0LU	01457 861366

NHS England also commission dental care; Table 8.20 lists Glossop-based services.

Table 8.20: Dental practices based in Glossop (via NHS Choices)

Name	Address	Contact
Hadfield Dental Care	73-75 Station Road, Hadfield, Glossop SK13 1DB	01457 867635
Simmondley Dental Practice	13 Pemmine Road, Simmondley, Glossop, SK13 6NN	01457 865693
Durgan and Ashworth Dental Care	124 High Street West, Glossop, SK13 8HJ	01457 865241
George Street Dental Practice	Glossop Primary Care Centre George Street Glossop SK13 8AY	01457 850550
Station House Dental Practice	1 Station Street Glossop, SK13 8BT	01457 852004 reception@shdp.co.uk

NHS England also commission primary ophthalmic (eye care) services, including NHS sight tests (see Table 8.21).

Table 8.21: Opticians based in Glossop (via NHS Choices)

Name	Address	Contact
Glossop Eyewear	11 George Street Glossop SK13 8AY	01457 862411
Jackson's Opticians	27 High Street West Glossop, SK13 8AZ	01457 852233
Sarah Dineen	107a Station Road Hadfield Glossop SK13 1AR	01457 868111
Complete Community Care	6 Springwood Glossop Derbyshire SK13 6XR	0161 297 0240 manchester@ccchealth.co.uk

Primary care activity

The GP Patient Survey, commissioned by NHS England and carried out independently, is designed to show how people feel about their GP practice. On the whole, the percentage of patients reporting satisfaction with indicators of service received from practices in Glossop are higher compared to the Tameside and Glossop CCG average. There are a small number of indicators where improvements could be made to increase patient satisfaction.

Table 8.22: Primary care service indicators by Glossop practice, weighted % (2014)	Practice A	Practice B	Practice C	Practice D	Practice E	Practice F
The last GP seen or spoke to was good at giving them enough time	93.0	91.0	87.0	89.0	93.0	88.0
The last GP seen or spoke to was good at listening to them	95.0	88.0	88.0	96.0	91.0	94.0
The last GP seen or spoke to was good at explaining tests and treatments	88.0	83.0	85.0	89.0	83.0	88.0
The last GP seen or spoke to was good at involving them in decisions about care	82.0	75.0	70.0	86.0	68.0	87.0
The last GP seen or spoke to was good at treating them with care and concern	91.0	84.0	81.0	89.0	89.0	93.0
Had confidence and trust in the last GP they saw or spoke to	96.0	97.0	93.0	94.0	96.0	98.0
The last nurse seen or spoke to was good at giving them enough time	91.0	86.0	96.0	87.0	91.0	84.0
The last nurse seen or spoke to was good at listening to them	91.0	86.0	88.0	88.0	91.0	83.0
The last nurse seen or spoke to was good at explaining tests and treatments	89.0	80.0	83.0	87.0	90.0	81.0
The last nurse seen or spoke to was good at involving them in decisions about care	79.0	76.0	76.0	84.0	75.0	74.0
The last nurse seen or spoke to was good at treating them with care and concern	89.0	84.0	80.0	90.0	89.0	84.0
Had confidence and trust in the last nurse seen or spoke to	92.0	91.0	91.0	93.0	91.0	92.0
Would describe their overall experience of this surgery as good	95.0	93.0	93.0	98.0	98.0	97.0
Would recommend this surgery to someone new to the area	87.0	85.0	91.0	90.0	92.0	92.0

Quilt key:

Higher than weighted CCG average	Lower than weighted CCG average

Source: NHS England-commissioned GP Patient Survey (2014), via www.gp-patient.co.uk

Tameside and Glossop CCG commissioned health services

Tameside and Glossop Clinical Commissioning Group (T&GCCG) directly commission most services related to community-based and urgent or elective secondary health care. Their input into the Derbyshire Health and Wellbeing Board also provides opportunities to influence and support commissioning activity and/or service provision by partners. Under the Health and Social Care Act (2012) CCGs are responsible for commissioning the health services listed in Table 8.23.

It is important to note that CCG commissioning of services is taking place in a highly dynamic health care environment. For example, opportunities for integration of health and social care to provide more services closer to home and keep people out of hospital are being explored through *Care Together*. Hospital-based care may also change through *Healthier Together*, which proposes alterations to services across the hospitals in Greater Manchester that serve Glossop patients.

Table 8.23: Health services commissioned by Tameside and Glossop CCG

Service	Provider	Notes
Urgent & emergency care	Ashton Primary Care Centre	Walk-in centre to treat minor illnesses or injuries
	Tameside Hospital or other Greater Manchester A&E departments	A&E for serious illness and injuries; Specialist urgent care (e.g. trauma, stroke) may be provided by hospitals across Greater Manchester
	North West Ambulance Service NHS Trust	Paramedic emergency services 24 hours, 365 days a year to those people in need of emergency medical treatment; NHS 111 telephone service (replaces NHS Direct) for urgent medical help or advice when not a life-threatening situation
	gtd	Out-of-hours GP services 6.30pm to 8.00am on weekdays and all day at weekends and on bank holidays
Cancer care	Various	Tameside Hospital based services and others across Greater Manchester; Diagnosis and treatment of cancer accessed through GP; Some chemotherapy available from Ashton Primary Care Centre
Diagnostic services	Various	For example, nerve conduction studies, endoscopy, non-obstetrics ultrasound, CT scans, X-ray; Accessed through GPs; Most services available in community and hospital locations; Some available at Glossop Primary Care Centre and Glossop GP practices
Elective hospital-based care (non-surgical)	Various	Accessed through GP; Most services available at Tameside and other hospitals; Some specialist services based in other Greater Manchester hospitals; Some services available in community locations; Limited services in Glossop e.g. dermatology, audiology
Elective hospital-based care (surgical)	Various	Most services available at Tameside and other hospitals; Some specialist services based in other Greater Manchester hospitals
Eye care	Various	Some opticians provide glaucoma assessment and cataract assessment
End-of-life	Various	Supporting people (patients, carers & families) at home & preventing unnecessary admissions to hospital for people at the end of their life
Maternity & newborn services	Various	Some services available in community and some hospital locations
Children's healthcare	Various	Some services available in community and some hospital locations
Learning disability services	Pennine Care NHS Foundation Trust	Most services available in the community
Mental health services	Pennine Care NHS Foundation Trust	Most services available in the community
Nursing & therapy services	Various	Most services available in the community some from Glossop Primary Care Centre and some from Shire Hill Hospital
Continuing health care	Various	Only available for people assessed as having a "primary health need" and who have a complex medical condition and substantial and on-going care needs
Infertility services	Various	Accessed through GP

Secondary care activity

Referrals from primary care to secondary care for patients of GP practices in Glossop show significantly higher rates of referrals for all outpatient attendances and referrals to general surgery across all GP practices (see Table 8.24). Significantly higher rates can also be seen for referrals to orthopaedics in most practices. Rates of referrals to general medicine, paediatrics, urology and dermatology are similar to or lower than the England value for patients across all Glossop GP practices.

Table 8.24: Referrals to secondary care by Glossop GP practice, Crude rate per 1,000 population (2010–11)	Practice A	Practice B	Practice C	Practice D	Practice E	Practice F	Tameside and Glossop CCG	England
Outpatient attendances (all referrals)	1116.0	931.0	955.0	928.0	1121.0	1058.0	1089.0	853.0
Peer group average	946.0	813.0	813.0	907.0	813.0	856.0	—	—
GP referrals to outpatients (1st attendance)	204.0	155.0	182.0	193.0	263.0	175.0	200.0	192.0
Peer group average	193.0	187.0	187.0	189.0	187.0	193.0	—	—
GP referrals to general medicine (1st attendance)	11.4	5.6	4.5	10.8	16.6	4.6	8.0	10.8
Peer group average	11.7	10.2	10.2	11.2	10.2	11.2	—	—
GP referrals to general surgery (1st attendance)	37.0	37.0	38.0	38.0	40.0	45.0	35.0	24.0
Peer group average	25.0	23.0	23.0	23.0	23.0	25.0	—	—
GP referrals to gynaecology (1st attendance)	19.0	12.0	16.0	13.0	30.0	14.0	17.0	17.0
Peer group average	18.0	17.0	17.0	19.0	17.0	16.0	—	—
GP referrals to orthopaedics (1st attendance)	36.0	23.0	30.0	33.0	62.0	30.0	33.0	21.0
Peer group average	22.0	21.0	21.0	18.0	21.0	23.0	—	—
GP referrals to urology (1st attendance)	8.0	6.8	6.8	10.3	11.1	6.7	8.8	8.0
Peer group average	8.4	7.4	7.4	7.2	7.4	8.3	—	—
GP referrals to paediatrics (1st attendance)	4.7	5.5	6.2	7.5	10.8	4.9	6.2	6.2
Peer group average	5.7	6.7	6.7	6.8	6.7	5.9	—	—
GP referrals to dermatology (1st attendance)	7.2	3.2	7.9	4.2	6.1	5.6	10.7	13.9
Peer group average	14.0	12.9	12.9	12.4	12.9	15.0	—	—

Quilt key:

Statistically higher than England average	Statistically similar to England average	Statistically lower than England average	No statistical comparison made

Source: Public Health England, via www.fingertips.phe.org.uk; Peer group average provides comparison to GP practices having similar characteristics in terms of practice population structure, deprivation score & rurality.

Figure 8.1 shows the percentage of referrals from all GP practices in Glossop to secondary care providers between April 2013 and June 2014. This indicates that the vast majority of all referrals from GP practices in Glossop are seen at Tameside Hospital NHS Foundation Trust, with the second highest proportion being seen at Stockport NHS Foundation Trust (together accounting for over three-quarters of referral activity).

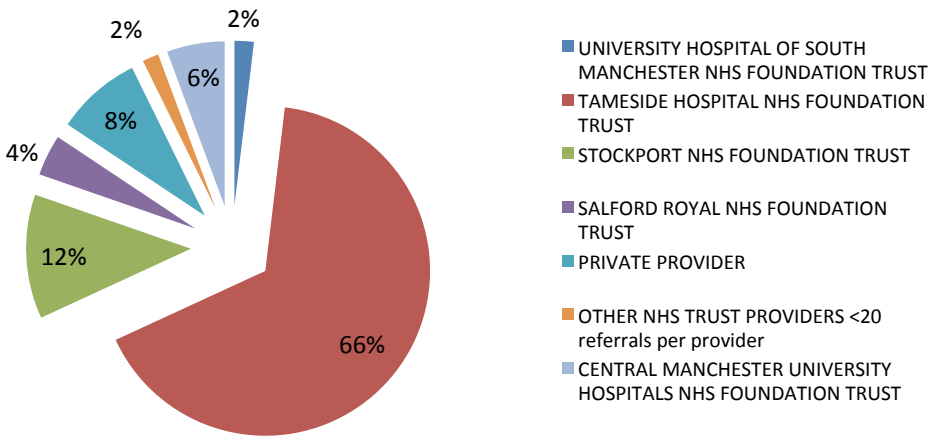

Fig. 8.1: Referrals from all Glossop practices to secondary care providers, April 2013 to June 2014, % of total
Source: Tameside & Glossop CCG

Table 8.25: Emergency hospital admission ratios, (2008/9–2012/13)	All causes	Coronary heart disease	Stroke	Myocardial infarction (heart attack)	Chronic obstructive pulmonary disease
Dinting	81.6	96.2	88.5	123.8	72.7
Whitfield	106	136.2	120.3	140.9	146.7
Old Glossop	99.4	124.3	111.1	135.9	124.3
Howard Town	106	136.2	120.3	140.9	146.7
Gamesley	123.2	171.6	149	168.3	191.1
Simmondley	81.6	96.2	88.5	123.8	72.7
Hadfield North	123.2	171.6	149	168.3	191.1
Hadfield South	114.7	159.6	118.7	148.9	165.1
Tintwistle	98.7	137.2	61.3	112.7	114.6
Padfield	98.7	137.2	61.3	112.7	114.6
St. Johns	81.6	96.2	88.5	123.8	72.7
Glossop (11 wards combined)	101.1	130.3	105.4	135.8	125.4
High Peak BC	100.9	119.1	103.8	133	97.6
Derbyshire CC	99.6	106.1	96	119.2	89.1
England	100	100	100	100	100

Quilt key:

Worse than England average	Similar to England average	Better than England average	No statistical comparison made

Source: Public Health England, via www.localhealth.org.uk; Estimated from MSOA-level HES data

Emergency hospital admission ratios listed in Table 8.25 reveal that Glossop as a whole has significantly worse than expected hospital admissions for coronary heart disease, myocardial infarction and chronic obstructive pulmonary disease compared to England. Although most wards are similar to or better than the England averages, Gamesley, Hadfield North and Hadfield South residents have significantly higher emergency admissions for all indicators except stroke.

Table 8.26: Emergency hospital attendance/ admission by Glossop GP practice (2010/11)	Practice A	Practice B	Practice C	Practice D	Practice E	Practice F	Tameside and Glossop CCG	England
A&E attendances (all ages)	249.0	224.0	249.0	366.0	209.0	226.0	330.0	387.0
Peer group average	327.0	266.0	266.0	362.0	266.0	255.0	—	—
A&E attendances, 2009/10–2011/12 (aged 0-4 yrs)	416	334	408	455	293	301	498	488
Peer group average	553	440	440	601	440	409	—	—
A&E attendances, 2009/10–2011/12 (aged 5-17 yrs)	228	230	232	363	226	207	310	287
Peer group average	327	262	262	329	262	266	—	—
A&E attendances, 2009/10–2011/12 (aged <18 yrs)	288	259	280	390	243	233	365	345
Peer group average	392	316	316	410	316	305	—	—
A&E admissions (all ages)	2.0	1.0	2.0	3.0	3.0	2.0	2.0	10.0
Peer group average	11.0	9.0	9.0	13.0	9.0	8.0	—	—
Emergency admissions, all causes (all ages)	91.0	82.0	88.0	130.0	70.0	81.0	103.0	89.0
Peer group average	105.0	79.0	79.0	110.0	79.0	85.0	—	—
Emerg. admissions, all causes, 2009/10–2011/12 (<18 yrs)	79.3	72.8	87.5	132.3	75.9	64.9	92.3	67.6
Peer group average	82.3	60.7	60.7	84.7	60.7	61.5	—	—
Emerg. respiratory admissions, 2009/10–2011/12 (aged <18 yrs)	3.2	4.4	5.2	6.9	3.8	3.0	4.7	3.6
Peer group average	4.2	2.8	2.8	4.6	2.8	3.2	—	—
Admissions due to injury, 2009/10–2011/12 (aged <18 yrs)	15.6	13.1	15.5	20.4	10.1	7.9	14.2	12.1
Peer group average	14.4	10.9	10.9	14.9	10.9	11.2	—	—
CHD emergency admissions (per 100 patients on QOF register)	9.2	5.7	8.5	11.8	10.0	9.7	8.8	7.1
Peer group average	7.1	6.9	6.9	7.4	6.9	6.5	—	—
Emergency admissions for chronic conditions	18.8	14.8	14.4	27.7	18.0	15.1	19.4	15.0
Peer group average	19.0	13.3	13.3	20.7	13.3	14.0	—	—
Long term conditions emergency bed days (per 1,000 days)	504.0	563.0	398.0	609.0	343.0	479.0	630.0	470.0
Peer group average	596.0	403.0	403.0	553.0	403.0	495.0	—	—

Quilt key:

Statistically higher than England average	Statistically similar to England average	Statistically lower than England average	No statistical comparison made

Source: Public Health England, via www.fingertips.phe.org.uk; Peer group average provides comparison to GP practices having similar characteristics in terms of practice population structure, deprivation score & rurality; Crude rate per 1,000 population unless otherwise stated

In Table 8.26, with some exceptions, rates of emergency hospital attendances or admissions are broadly similar to or lower than the England average value across all GP practice populations in Glossop.

Table 8.27: Elective admissions by Glossop GP practice	Practice A	Practice B	Practice C	Practice D	Practice E	Practice F	Tameside and Glossop CCG	England
Elective inpatient admissions (all ages)	30.5	30.7	31.6	24.9	31.8	30.2	30.9	25.6
Peer group average	29.0	24.0	24.0	25.9	24.0	27.0	—	—
All elective admissions, 2009/10–2011/12 (<18 yrs)	66.2	46.1	36.6	47.5	53.6	44.6	51.9	47.3
Peer group average	50.8	44.2	44.2	52.0	44.2	44.4	—	—
Day case admissions (all ages)	96.1	83.6	95.8	77.1	88.1	102.7	93.9	93.2
Peer group average	1.5.5	85.6	85.6	91.0	85.6	99.9	—	—
CHD elective admissions (per 100 patients on QOF register)	7.7	2.2	4.3	2.0	7.5	0.0	3.7	5.3
Peer group average	4.9	5.6	5.6	4.7	5.6	5.0	—	—
Respiratory disease admissions	20.0	18.0	17.0	27.0	16.0	17.0	22.0	17.0
Peer group average	20.0	15.0	15.0	22.0	15.0	16.0	—	—
Diabetes admissions	1.9	1.8	0.9	0.5	1.4	0.0	1.9	1.1
Peer group average	1.4	1.0	1.0	1.5	1.0	1.0	—	—
COPD admissions	3.6	3.2	1.2	4.2	1.1	1.8	3.5	2.1
Peer group average	3.3	1.7	1.7	3.5	1.7	1.9	—	—
Cancer admissions	31.0	25.4	23.9	16.5	21.0	22.5	23.7	28.6
Peer group average	31.5	24.6	24.6	24.2	24.6	31.8	—	—
Long-term neurological admissions, 2011/12	4.5	7.3	6.5	7.0	5.8	4.1	7.1	5.7
Peer group average	6.4	5.4	5.4	5.8	5.4	6.2	—	—

Quilt key:

Statistically higher than England average	Statistically similar to England average	Statistically lower than England average	No statistical comparison made

Source: Public Health England, via www.fingertips.phe.org.uk; Peer group average provides comparison to GP practices having similar characteristics in terms of practice population structure, deprivation score & rurality; Crude rate per 1,000 population for 2010/11 unless otherwise stated

Table 8.27 indicates rates of elective admission are generally similar to or lower than the England average across Glossop practices.

8.5 What do service providers and others think?

Invited service providers, commissioners and other stakeholders shared experiences and views describing their take on what is needed to improve health and the determinants of health in Glossop.

⚠ Information sources and interpretation

The small number of stakeholder responses collated for this assessment may introduce bias and reflect an incomplete picture of health needs or service provision. Opinions have been paraphrased, but have not been reinterpreted.

Successes and achievements

For primary care providers, these include service provision by a compassionate and dedicated team; access to community-based diagnostics and specialists; training GPs of the future as well as nursing and para-clinical staff; good survey ratings for practice staff; initiation and expansion of exercise-related activities; passing inspection by the Care Quality Commission (CQC); providing excellent patient care in an increasingly pressured environment; excellent Quality and Outcomes Framework (QOF) performance; offering same/ next day access to all who need it; evolving into a large highly-functioning GP practice; and developing new services closer to home.

For patient participation groups, these include forging strong links with Healthwatch Derbyshire and Tameside, Tameside and Glossop CCG and the Health and Well-being Sub-committee for Derbyshire Dales and the High Peak; feeding comments, concerns and issues to relevant agencies; and keeping patient participation group members updated.

Challenges in commissioning or delivering services

For the community sector, these include providing one-to-one support to disabled children/ young people with complex needs.

For local authorities, these include addressing issues relating to mental health for adults and young people.

For primary care providers, these include managing differences between health (Tameside) and social care (Derbyshire) and ensuring liaison between services; increased workload as a result of secondary care shifting into the community; a nationwide reduction in GP workforce; difficultly recruiting regular GPs (salaried or with partnership prospects) due to the attractiveness of high locum GP earnings; constrained working hours in which to deliver high-quality care consistently; the financial stability to afford, provide and retain well-trained and experienced staff who can respond to increasing workload; being responsive to the needs of the population within workforce restrictions and without extra funding to support innovation; commissioning services with medical but not accountancy or business training; lack of investment in primary care; over-complex contracting arrangements with commissioning organisations; potential for difficulty maintaining continuity of care (key to patient satisfaction and control of referral/ prescribing costs) within large practices; and not all GPs see 15 minute consultations as aspirational.

For patient participation groups, these include issues around clarity of ownership and openness/ ease of cross-border communication (between commissioners, service providers and service users); difficulty in accessing services in Tameside since public transport services have been cut; and failure by commissioners/ providers to recognise that Glossop has a uniqueness that is not always best served by applying 'fixes' that work elsewhere without adaptation.

Barriers to participation

For primary care providers, these include transport links, especially for patients needing assistance to come for appointments; limited hours of availability to meet the needs of the working population with no extra finance to open for longer hours; the poor condition of roads and paths that hinder disabled and elderly use of services; and inadequate self-care systems and signposting mechanisms.

For patient participation groups, these include general apathy.

Health improvement plans

For primary care providers, these include provision of good-quality consultations with trained professionals who deal with acute medical problems in a timely fashion; widening access to health promotion/ health improvement services (e.g. smoking cessation, weight management, sexual health); delivering opportunistic health promotion via literature, online materials, health-related events as part of every contact with a health professional; expanding established services but with bias to address unmet needs (e.g. counselling services for elderly patients); forming a federation of GPs to co-develop healthcare; developing a community dementia clinic; developing a smartphone app as an aid to communication between GPs, hospital, social services and voluntary organisations.

For patient participation groups, these include developing a group of Healthwatch Champions specifically for Glossopdale; supporting T&GCCG to develop a Tameside and Glossop Patient Reference Group; and gradually building on the confidence and functions of patient participation groups.

Organisational aspirations

For primary care providers, these include increasing funding of a mental health service in conjunction with MIND; being able to provide a transport service to support people getting to surgery for appointments; finding more administrative time to manage workflow and administration of efficient early-warning systems that could help avoid unnecessary admission to hospital; and increasing GP numbers sufficiently so all patients can be offered 15 minute appointments routinely and without an undue wait to be seen.

For patient participation groups, these include provision of transport for people who are infirm or who cannot transport themselves from home to hospital and back or who find existing transport options problematic.

Partnership opportunities

For primary care providers, these include working more closely with residential care organisations; working with the local health economy and partner agencies to improve the communication and service responsiveness for patients; and expanding collaboration between Glossop practices (e.g. joint service provision including mental health, elderly and dementia care; grant provision; workforce sharing).

8.6 What are the key messages?

The steering group identified several key messages concerning 'health and health care':

Inequalities: There are geographic inequalities in health and health outcomes within Glossop (as there are inequalities in the determinants of health, noted elsewhere).

Lifestyle data: Measured (rather than estimated or self-reported) information about lifestyle behaviours and their consequences in Glossop is limited in relation to healthy eating, obesity, physical activity, smoking and drug misuse.

Alcohol misuse: Harms related to alcohol misuse are a concern in Glossop, as noted in a recent alcohol and substance misuse needs assessment; excess alcohol is also an important contributor to adult obesity.

Mental health: Information about mental well-being in Glossop is lacking, however, indicators relating to prevalence of depression and self-harm behaviours may suggest the need for initiatives to improve mental health.

Transport and timing: Transport to/ from health-related amenities appears to be an issue for some Glossop residents; this is probably linked in with hours of service availability and/or scheduling of transport options.

Interpretation of variation: Potential reasons for variation in condition prevalence and in health care activity measured at ward and/or practice level require discussion informed by local insights to facilitate a shared understanding between stakeholders regarding what is being measured and what actions may be appropriate.

System complexity: Commissioning and provision of health services is particularly complex in Glossop, with fragmentation resulting from unique cross-border issues.

Enthusiasm and ideas: Stakeholder enthusiasm and innovative thinking to improve health and health services is noted and will require more collaboration between statutory and non-statutory partners, with wider input into service design and delivery leading to innovative models of delivery (e.g. referral of GP patients to community-based lifestyle interventions).