APPENDIX B: **Illustrative Cost Benefit Model in Detail**

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There is strong evidence that social capital has health benefits, and that conversely, poor social capital is associated with poor health, with regard to overall health and wellbeing, life expectancy, and specific conditions (Bennett, 2002; Fabrigoule et al, 1995; Bassuk et al, 1999; Berkman and Kawachi, 2000; Lochner et al 2003). Kawachi et al found that the odds ratio for self-rated fair or poor health associated with living in American states with the lowest levels of social trust was 1.41 when compared with high-trust states.

As part of his study, he looked at the link between self-rated poor health and mortality, and found:

> 'A recent review of 27 community studies concluded that even such a simple global assessment (self-described excellent / very good / good / fair / poor health used by the Behavioral Risk Factor Surveillance System (BRFSS)),appears to have high predictive validity for mortality, independent of other medical, behavioral, or psychosocial risk factors. For most studies, odds ratios (ORs) for subsequent mortality ranged from 1.5 to 3.0 among individuals reporting poor health compared with excellent health. The risk of mortality for self-rated poor health often exceeded that of smoking when these rates were reported in the same study. Furthermore, self-rated health has been shown in longitudinal studies to predict the onset of disability.' (Kawachi et al, 1999)

These findings suggest that a shift in a community from low level of social trust to high level, i.e. equivalent to changing a low-trust American state into a high-trust one, could produce a reduction in proportions with self-rated fair or poor health of 29 percentage points (100/141=0.709); and that this would be associated with corresponding reductions in mortality and improvements in health.

Such a margin of change would mean a sea-change in health. How do you move from low to high social trust in a community? This is what community development sets out to do, through stimulation of new community activities, groups, initiatives and networks. The HELP model adds a clear framework and mechanism for creating long-lasting momentum through residents' partnership with local public agencies . We used the findings from Kawachi and many other sources to create a transparent model to explore evaluation of HELP interventions. This model is the basis for the calculations in Chapter 6 of this report and is intended to be replicable.

The model contains an element for calculating cost savings associated with improvements in particular health indicators (which would be set against change in comparable control areas). The choice of indicator could be varied at a local level according to the prevalence of certain conditions, and relevant interventions as they develop. The model could initially be set up as a hypothesis, with targets at a locally decided level, and then populated by actual data as they emerged.

Health savings are the main focus of this illustrative model of cost benefits from investing in community development through the HELP approach . Other savings would accrue to policing, education, DWP and other services. The multifaceted nature of the benefits may suggest that

health agencies should seek to engage other local services in sharing the cost of the investment through a place-based budget or other mechanism.

An illustrative saving level of 5% is given in the menu of indicators below, comprising 2.5% as a result of a specific, targeted intervention affecting a proportion of the population agreed to be sufficiently significant; and an additional 2.5% added value where research supports the hypothesis of an improvement in social capital leading to a relevant health improvement, in the community in general or in specific groups of individuals, as supported by the literature: together a notional 5% to be achieved.

This is supported by findings that integrated health and well-being services can realise significant financial benefits. For example, studies have illustrated that integrated early intervention programmes can generate resource savings of between £1.20 and £2.65 for every £1 spent (POPPs, LinkAge Plus, Supporting People, self care schemes). Furthermore, for every £1 spent on balance/Tai Chi classes by the taxpayer in LinkAge Plus areas there is a health and social care saving of £1.35 (Turning Point / Connected Care, 2010).

The template below would evolve as relevant activities were generated, as is currently happening in the HELP pilots in Solihull and Townstal. The transparency of the model would allow local negotiation to consider risks of double-counting in cost savings and to avoid them.

The model reflects the multi-dimensional impact of streams of activity. For example, many of the research findings relevant to Cardiovascular Disease report a beneficial impact in relation to mental health; and the dance activities in Camborne reported under the heading 'Crime' clearly increase physical activity, and in the reported research context would have an impact on mental wellbeing.

1. Cardiovascular diseases

1.1 Community development effect

Spread of greater trust, cooperation, social and physical activity, empowerment and resilience among residents. Development of community resources and networks to host and foster extensions of care pathways to encompass a preventive community activity resource base which reduces incidence of CVD, assists rehabilitation, and reduces demand of the acute health sector.

1.2 Research base

Higher levels of *social trust* are associated with lower rates of most major causes of death, including coronary heart disease (Kawachi et al,1997).

A number of studies are consistent with the idea that areas with poor social capital have higher rates of cardiovascular disease (Augustin et al, 2008), in particular among lower-income individuals (Scheffler et al, 2008).

Loneliness and low levels of social integration significantly increase mortality. People with stronger networks are healthier and happier (Bennett, 2002). Social networks are consistently and positively associated with reduced morbidity and mortality (Fabrigoule et al, 1995).

Research also reports significant health benefits for individuals actively involved in community empowerment/engagement initiatives including improvements in physical and mental health, health related behaviour and quality of life (Piachaud, 2009; Grady, 2009).

On average, an inactive person spends 38% more days in hospital than an active person, and has 5.5% more family physician visits, 13% more specialist services and 12% more nurse visits than an active individual (Sari, 2008).

Cost-benefit analyses of cycling and walking infrastructure generally produce high benefit-cost ratios (BCRs). The median BCR in one such analysis was 5:1 which is counted as 'high value for money'. It appears that health benefits make a significant contribution to the high BCRs for cycling and walking projects (Cavill et al, 2008)

Physical inactivity is a significant, independent risk factor for a range of long-term health conditions (Foster et al, 2009). An active lifestyle:
• has a substantial impact on the risk of major non-communicable disease, including coronary heart disease (CHD), hypertension, type 2 diabetes, chronic kidney disease and some cancers;
• supports weight management – physical activity by itself can result in modest weight loss of around 0.5–1kg per month.
• can reduce the risk of stroke, and be used to treat peripheral vascular disease and to modify cardiovascular disease (CVD) risk factors such as high blood pressure and adverse lipid profiles (Department of Health, 2004).

Advice on physical activity should embrace the broader concept of health and activity – walking, dancing, playing with the grandchildren, or gardening (McMurdo, 1999).

A paper by Lomas (1998) offers an estimate of SROI for CD in heart disease. He estimates, based on available evidence from elsewhere, to what extent CD activities would reduce cardiac disease and compares those outcomes with those from more conventional approaches. He compares potential heart disease deaths in men prevented per 1000 exposed to each 'intervention' per year:

Social cohesion and networks of associations would prevent 2.9 fatal heart attacks or heart failure

Medical care and cholesterol-lowering drugs would prevent 4.0 fatal heart attacks in screened males

Routine access, free care would prevent 2.1 all cause deaths in high-risk males over 50 years old

1.3 Examples of relevant activities (from HELP pilot project in Smiths Wood, Solihull)

- Weight management
- Smoking Cessation
- Buggy Walking route for parents of young families
- Health trainers (one to one lifestyle/ health behaviour advice)
- Pedal Power: bikes supplied by Police, aimed at 'families with complex needs' referred by police, social services etc. Bikes restored and given to families with safety gear and on completion of cycling proficiency course. Older siblings and Dads teaching younger ones.

- Young people engaged in local woodland management, coppicing and den building. Outcomes are accredited training in woodland management; improving habitat diversity in woodland; positive outdoor experiences eg fire lighting, cooking and wood carving.

- Empty shops allocated by Council for use by community groups on a free lease. Cleaned, painted and decorated via voluntary activity, with young people painting murals and designing shop frontage. The shops attained an almost instant status as a community hub.

- Zumba dancing sessions

1.4 Indicator/s

CVD hospital admissions under age 75.

Mortality rate from cardiovascular disease has been a key health indicator for successive governments. It is a proposed health outcome indicator for the Coalition Government's Public Health Outcomes Framework (Department of Health, 2011). Circulatory diseases account for 35% of geographical health inequalities for males, and 30% for females (Health Inequalities Unit, 2008).

However, mortality rates are a long-term indicator to influence. Hospital admission rates are an indicator located further upstream. They are available at very local level in significant numbers, and offer a clearer focus for collaboration between health and other services in addressing the determinants of ill health, and prevention and rehabilitation pathways which engage and empower local people through community development. Finally, there is a strong and established link between deprivation and emergency admissions, with spending hotspots on acute services which have great potential for realising tangible savings to support a strategic shift towards prevention and early intervention, as well as addressing health inequalities (Griffiths, 2009). This is entirely in accord with the Government's new Public Health Outcomes Framework.

1.5 Average incidence in a population of 5,000

09/10 England 91 per 5000 (NHS Information Centre,2010)

1.6 Baseline from Smiths Wood, Solihull (adjusted to 5000 base)

(08/09) 242 per 5000

1.7 Cost of treatment

Average cost of admission £4,614 (NHS East Lancashire, 2010)

1.8 Illustrative 5% additional saving attributable to CD

12 admissions @£4614=£55,368

2. Depression

2.1 Community Development Effect

Increase of community activity and social networks alleviates stress, improves confidence and resilience, reduces the risk of depression, creates positive alternatives to antidepressants.

2.2 Research Base

National surveys of psychiatric morbidity in adults aged 16-64 in the UK show that the most significant difference between this group and people without mental ill-health problems is social participation (Jenkins et al, 2008). There is strong evidence that social relationships can reduce the risk of depression (Morgan and Swann, 2004).

Good personal support networks, for example friendship or a confiding relationship, and opportunities for social and physical activities, protect mental health and enable people at any age to recover from stressful life events like bereavement or financial problems (Cooper et al, 1999).

Men and women who scored highest in a survey on emotional health were twice as likely to be alive by the study's end. The link between subjective feelings of happiness and good health held even after controlling for chronic disease, smoking, drinking habits, weight, sex and education (Goodwin, 2000).

A systematic review of 22 studies evaluating the effectiveness of health promotion interventions to alleviate social isolation and loneliness among older people found that group activities like discussion and self-help groups, bereavement support and counseling, were all found to be effective (Cattan, 2002).

An active lifestyle:
• reduces the risk of depression and promotes many other positive mental health benefits, including reducing state and trait anxiety; improves physical self-perceptions and self-esteem; and can help reduce physiological reactions to stress;
• has been found to be just as effective in the treatment of mental ill health as anti-depressant drugs and psychotherapy (Mutrie, 2000; Biddle et al, eds., 2000)

Recent cross-sectional studies and controlled trials have suggested that exercise, such as aerobic classes and t'ai chi, provides both physical and psychological benefits in elder populations. These benefits include greater life satisfaction, positive mood states and mental well-being, reductions in psychological distress and depressive symptoms, lower blood pressure and fewer falls (World Health Organization, 2004; Li et al, 2001).

See also 1.2 above.

2.3 Example from HELP, C2 or similar projects

Wide range of activities to build social capital throughout HELP projects (see above)

2.4 Indicator/s

Depression diagnosed by primary care, based on data from 5 GP Practices serving area, applied proportionately. Ideally would be specific to geography, based on postcode analysis.

2.5 Average incidence in a population of 5,000

247 per 5000 *(IMS Disease analyser)* 'in contact with GP services per year, diagnosed as having either depression or mixed anxiety and depressionô

2.6 Baseline from Smiths Wood, Solihull (5000 base)

355 per 5000 based on practice data projected (09/10)

2.7 Average cost
£1355 p.p service cost; also £4694 p.p earnings lost (McCrone et al, 2008).

2.8 Illustrative 5% additional service saving attributable to CD
(not including the personal earnings lost)

5% reduction of 18 cases, service saving £24,390.

3. Obesity
3.1 Community Development Effect

Spread of health awareness and literacy, more community and physical activity. New / improved open spaces/ sports facilities negotiated by community groups.

3.2 Research Base
Being obese and being overweight both increase the risk of a range of diseases that can have a significant health impact on individuals, although the risks rise with BMI (Body Mass Index) and so are greater for the obese:

- Å 10 per cent of all cancer deaths among non-smokers are related to obesity
- Åthe risk of Coronary Artery Disease increased 3.6 times for each unit increase in BMI
- Å 85 per cent of hypertension is associated with a BMI greater than 25
- Åthe risk of developing type 2 diabetes is about 20 times greater for people who are very obese (BMI over 35), compared to individuals with a BMI of between 18 and 25
- Åup to 90 per cent of people who are obese have fatty liver. Non-alcoholic fatty liver disease is projected to be the leading cause of cirrhosis in the next generation
- Åobesity in pregnancy is associated with increased risks of complications for both mother and baby
- Å social stigmatisation and bullying are common and can, in some cases, lead to depression and other mental health conditions (Dept of Health, 2008).

The majority of children and young people classified by the HSE 2007 as overweight (77.3%) consider themselves to be about the right weight as do 46.3% of children classified as obese. 65% of children and young people classified as obese are trying to lose weight.

The Chief Medical Officer advises that children and young people should participate in a minimum of 60 minutes of at least moderate intensity physical activity each day. 32% of children and young people age 11–15 believe that people their own age should take part in physical activity every day of the week (Roberts and Marvin, 2011).

An active lifestyle supports weight management – physical activity by itself can result in modest weight loss of around 0.5–1kg per month (Foster et al, 2009).

Collective efficacy - the willingness of community members to look out for each other and intervene when trouble arises - is negatively associated with BMI, risk of overweight, and overweight status, when levels of neighbourhood disadvantage have been taken into account. This suggests that future interventions to control weight by addressing the social environment at the community level may be promising (Cohen et al, 2006).

There is little evidence specifically on the cost effectiveness of non-pharmacological interventions such as diet, physical activity and behavioural treatment in the treatment of obesity. Notwithstanding the limited evidence in an already obese population, these types of interventions appear to be a cost-effective use of resources (NICE, 2006). Dietary interventions seem particularly cost effective due to the low levels of staff contact needed, as do group interventions (Goldfield et al, 2001). The degree of cost effectiveness of non-pharmacological interventions is highly sensitive to the duration of benefit. If weight loss relative to trend remains constant for 5 years post intervention before returning to baseline, the cost per QALY in the best-performing non-pharmacological studies ranges from £174 to £9971 (NICE, 2006).

3.3 Example from HELP, C2 or similar projects
See CVD section above for material on physical activity, healthy lifestyle advice.

Renovation of park with new play facilities (Townstal); establishment of skateboard park and other facilities (Redruth, Beacon project).

3.4 Indicator/s
% obese, adult and child.

3.5 Average incidence in a population of 5,000
08/09: Reception class: 480/5000; Year 6: 915/5000
Adults: England proportion 24.2% (2006-8), 9.46m (1210/5000)

3.6 Baseline from Smiths Wood, Solihull figures (5000 base)
08/09: Reception class: 985/5000; Year 6: 1,110/5000
Adults: ratio of Reception and Yr6 (equally weighted) SWANN / National = 1.5. Adult rate for England 24.2 x 1.5 = 36.3%, i.e. 1815/5000

3.7 Average cost
Adults: derived from data on wider cost of raised BMI and obesity, adjusted proportionately to obesity alone; and estimated future cost of diseases related to BMI minus CHD (covered in Part 1 above) (£7.32bn 2007) (McPherson et al, 2007); applied to UK adult population: £648.30 per obese person.

3.8 Illustrative 5% additional saving attributable to CD
Adults: rate of 36.3% applied to adult Smiths Wood population estimate of 3,181 = 1,155. 5% is 58, @ £648.30p.a. = £37,601

4. Older people: social and physical activity and reducing falls
4.1 Community Development Effect
An increased level of community activity, particularly physical activity suitable for older people (including walking groups) provides a network which can raise the level of physical and mental wellbeing, improving muscle strength and balance; and with neighbourhood-level commissioning of community groups this can be tailored to reduce the risk of falls and assist recovery.

4.2 Research Base
See references to physical activity 1.2 and 2.2 above.

Ageing and inactivity leads to muscle loss and increases falls risk. Only 14% of 75 year olds are sufficiently active to maintain health (Skelton et al., 1999). Older people can regain 27% of muscle strength reversing age related decline by 15 years by attending one exercise class a week and doing home exercises (Skelton and McLaughlin, 1996).

NICE find a programme of muscle strengthening and balance retraining, individually prescribed at home by a trained health professional, and a 15-week Tai Chi group exercise intervention, to be beneficial (NICE, 2004).

A randomised control trial offering community-based support to older people who had experienced falls resulting in emergency ambulance calls but who were not conveyed to hospital achieved a halving of subsequent falls compared to a control group. The intervention offered training in strength and balance, assessment of hazards in the home and modifications to the environment, advice and practice in getting up from the floor (provided by the occupational therapists), and group sessions on fall prevention in local community centres including one hour of muscle strengthening and balance training (Logan, 2010).

Through the Healthy Communities Collaborative, there was evidence of an improvement in social capital within the communities involved in the reducing falls programme, resulting in:
- 12% increase in people's perception of whether their area was a good place to live
- 12% increase in people's perception of whether individuals show concern for each other
- 22% increase in the number of people who knew where to get advice about falls
- 48% increase among participants in the proportion who thought they could change and improve things in their communities (Coulter, 2009).

Cost saving per fall less per year was identified by the Healthy Communities Collaborative as £800 p.p. in hospital costs, £82 in ambulance costs, and £1883 in avoided residential care costs. Hip fracture costs £18,421 per patient (National Hip Fracture Database, 2010) (not yet in projection here)

For every £1 spent on balance/Tai Chi classes by the taxpayer in LinkAge Plus areas there is a health and social care saving of £1.35. This suggests that balance classes are a highly effective way to reduce the incidence and associated costs of falls, leading to fractures, hospitalisation and operations (Turning Point / Connected Care, 2010).

4.3 Example from HELP, C2 or similar projects

LinkAge Plus and other projects have supported peer group physical activity, with buddying (Activity Buddies on a British Heart Foundation model) providing support to the less able and less confident with mutual benefit. Dance tailored to older people by East London Dance, engaging a passion (and skill) for healthy activity shared by many in their younger days. See the Well Centre, Bonny Downs Community Association, East London, for a wide range of healthy community activities, including Tai Chi and dance classes.

4.4 Indicator/s

Emergency ambulance calls for falls.
Number of older people engaging in organised social and physical activities in area; Hip fracture data – to be obtained.

4.5 Average incidence in a population of 5,000
Ambulance calls for falls 422/5000 people aged 65 and over (Department of Health, 2009; Age UK, 2010).

4.5 Baseline from Smiths Wood, Solihull figures (5000 base)
Ambulance calls for falls / back 2009/10 total 120: estimated that 90% are falls (separate category for back pain)

4.7 Average cost
Cost saving per fall less per year was identified by the Healthy Communities Collaborative as £800 p.p. in hospital costs, £82 in ambulance costs, and £1883 in avoided residential care costs

4.8 Illustrative 5% additional saving attributable to CD
5 falls less, @£2765: £13,825

5. Emergency hospital admissions
5.1 Community Development Effect
If levels of health and wellbeing improve due to increased social capital and healthy activity, use of acute services will reduce. There is major potential for added value through focused community investment (commissioning) in areas of very high levels of emergency admissions, associated with high levels of deprivation – there is a strong association between deprivation and emergency admissions, and therefore geographical hotspots of spending on acute services part of which can be reinvested in preventive community level activity, reducing demand too of primary care.

5.2 Research Base
Research in the London Boroughs of Sutton and Merton mapped the annual cost of emergency admissions of people aged 50 and over in small area format (SOA, average population c.1500). The variation was extremely wide, from £2,677 to £622,540. These were both outliers: but there were seven SOAs with HRG costs above £350,000, and seven below £50,000. The variation between quartiles was also very wide: the top quartile of SOAs accounted for £17m (42% of costs of admission of people aged 50 and over); and the bottom quartile for £5m (12% of costs) (Griffiths, 2009).

5.3 Example from HELP, C2 or similar projects
Remarkably given the evidence presented in this paper, this has not been tested in health-related community development.

5.4 Indicator/s
Emergency hospital admissions

5.5 Average incidence in a population of 5,000
440 (08/09)

5.6 Baseline from Smiths Wood, Solihull figures (5000 base)
(09/10) 589 per 5000 (509 cases)

5.7 Average cost
£1592 (Smiths Wood dataset, Solihull NHS Care Trust)

57.8 Illustrative 5% additional saving attributable to CD
25 cases, £39,800

6. Accident and Emergency attendance
6.1 Community Development Effect
There is a strong case for linking community development to reduce crime and alcohol abuse with intelligence regarding A&E attendance, in order to reduce alcohol-related violence and health expenditure related to it.

6.2 Research Base
35% of all A&E attendances involve alcohol-related harm, rising to 70% of A&E attendances at peak times. In a recent A&E study:

- 41% of attendees had been drinking
- 14% were intoxicated
- 43% identified as problematic users
- Cost - Up to £1.6bn to the NHS

PCTs have a duty to work in partnership with other responsible authorities to tackle crime & disorder. There is emerging evidence that A&E intelligence can have an impact on targeting police and other resources to reduce violence (Sheehan and Nurse, 2006).

Emergency Medicine can contribute to community violence prevention by working with public health and local crime reduction/community safety partnerships to measure community violence; identifying serial (repeat) attenders and referring them to agencies, for example to women's' safety units, who can intervene to reduce the chances of further harm; auditing hotspot locations for violence such as particular bars and nightclubs; being committed to decreasing community violence as well as treating the injured; initiating and participating in local safety campaigns, working with local media (Shepherd, 2007).

6.3 Example from HELP, C2 or similar projects
REACH, the Redruth Enabling Active Community Health, is an example of close collaboration between a community project using the C2 approach from which HELP is derived, and an emergency service. It was a partnership between the Redruth North Partnership and the South West Ambulance Service. Its aim was to provide easy community access to a known and trusted practitioner (an emergency care practitioner/paramedic), while reducing the numbers of inappropriate 999 calls. The initiative won an NHS Health and Social Care Award for reducing health inequalities in July 2006. Outcomes included 210 patients treated between 2004-2006 on site, a 30% drop in incidence of under-age problem drinking and an 18% reduction in emergency call outs (Stuteley, 2007).

6.4 Indicator/s
A&E attendance

6.5 Average incidence in a population of 5,000
1516 per 5000

6.6 Baseline from Smiths Wood, Solihull figures (5000 base)
09/10 1565 per 5000

6.7 Average cost
Per A&E attendance £86.90

6.8 Illustrative 5% additional saving attributable to CD
78 cases, £6,779

7. Crime and the fear of crime
7.1 Community Development Effect
Concern about crime is among the first priorities of many communities; and this is reflected in successive HELP Listening Events. Lower crime is associated with social capital which is positively associated with health. There is also a link between fear of crime and health: levels of fear of crime are not always consistent with actual crime in a community. It is therefore beneficial to health to reduce crime and the fear of crime.

7.2 Research Base
Those areas with stronger social networks experience less crime (Skogan, 1986), and less delinquency (Sampson et al, 1997).

In a Chicago study, overall, neighbourhood social capital - as measured by reciprocity, trust, and civic participation - was associated with lower neighbourhood death rates, after adjustment for neighbourhood material deprivation (Lochner et al, 2003).

The fear of crime refers to the fear of being a victim of crime as opposed to the actual probability of being a victim of crime (Hale, 1996; Farrall et al, 2007).
Individuals with high fear of crime are twice as likely to suffer from depression. Fear of crime is associated with decreased physical functioning and lower quality of life (Stafford et al, 2007).

7.3 Examples of relevant CD activity
See examples above of work to improve social capital. Positive trends in crime reduction in Beacon (Falmouth), Camborne, Redruth North, Townstal.

- Large scale youth dance activities run by Camborne Neighbourhood Police Team, using the HELP approach to work with 325 children, many of them linked, as perpetrators or victims, to anti-social behaviour or crime. This has been subject to qualitative evaluation, with a finding that relationships between children and police were substantially improved (Camborne (2006)

- Two caretakers employed in one of the most problematic blocks of flats: better relationship with the tenants means that housing association felt confident to install an expensive security system again without fear of the repetitive vandalism that was occurring - Townstal, Dartmouth.

- Police Community Support Officer set up free local football session with youth between 14-16 – after week 6 there were 30 attendees – continuing with joint funding, supported by two staff from the Fire Service (Townstal, Dartmouth).

7.4 Indicator/s
Reported crime

7.5 Average incidence in a population of 5,000
2009/10, England: 394 per 5,000.

7.6 Baseline from Smiths Wood, Solihull figures (5000 base)
2009/10: 1,104 crimes. Rate 1289/5000.

7.7 Average cost
Est. cost of individual crime in Smiths Wood (based on local pattern) £1,318.

7.8 Illustrative 5% additional saving attributable to CD
Reduction of 55 crimes, £72,490

8. NEET (Not in education, employment or training between the ages of 16 and 18)

8.1 Community Development Effect
Work with young people at risk to promote social inclusion, including work on confidence, resilience, social skills.

8.2 Research Base
Major predictor of later unemployment, low income, depression, involvement in crime and poor mental health (Places database, DfE)

8.3 Example from HELP, C2 or similar projects
See youth activity examples in 7.3 above.

- Greenfingers project in Redruth North aimed at unemployed disaffected young people, (NEET) (partnership between Redruth North Partnership and Cornwall College, offering NVQ level 1 in horticulture, while improving estate gardens of older people and those with disabilities) in return for free driving lessons. Now higher levels of participation in NVQ and other learning, a fall in youth unemployment and the creation of gardens and open space.
- Life skills courses, IT skills training (Beacon, Falmouth)
- Response to service cuts through Community Partnership: school in Townstal hosting Connexions outreach for young people (previously removed from Dartmouth); youth club continues after withdrawn by Youth Service, staffed by police out of uniform (Townstal, Dartmouth)

8.4 Indicator/s
Number of NEET (population denominator a problem in small geographical areas).

8.5 Average incidence in a population of 5,000
6.7% of residents aged 16-18 (2008, England)

8.6 Baseline from Smiths Wood, Solihull figures (5000 base)

Number: 52 in April 2011 (2010 figure requested). 14% of total in N Solihull regeneration zone

8.7 Average cost

Public finance cost of NEET, £7,986 per head (Coles et al 2010).

8.8 Illustrative 5% additional saving attributable to CD

Reduce by 3: £23,958.