Proposal for a building community resilience and addressing health inequalities in vulnerable groups

1. Background and evidence base

1.1. Health Inequalities

For a person to stay healthy they need good homes, good jobs, friends and an environment that makes healthy choices possible[i]. Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society, which arise from the conditions in which people are born, grow, live, work and age. These conditions influence opportunities for good health, and how people think, feel and act, and this shapes mental health, physical health and wellbeing. Health inequalities can therefore result in differences in:

- access to care, for example, availability of treatments
- quality and experience of care, for example, levels of patient satisfaction
- behavioural risks to health, for example, smoking rates
- wider determinants of health, for example, quality of housing
- health status, for example, life expectancy and prevalence of health conditions[ii].

Health inequalities are not inevitable and can be significantly reduced. Most effective actions to reduce health inequalities will come through action within the social determinants of health[iii]. However, attempts to reduce health inequalities have not always systematically addressed the background causes of ill health and have relied on tackling more proximal causes (such as smoking), through behaviour change programmes[iv]. Health inequalities are likely to persist between socioeconomic groups, even if lifestyle factors (such as smoking) are equalised, without addressing the fundamental causes of inequality[v]. Interventions aimed at changing individual behaviours such as smoking, alcohol, diet and exercise are more quickly and commonly taken up by the middle classes and those who already have positive attitudes towards health[vi], which can further exacerbate health inequalities.

'*10 years on from the Marmot review*'[vii] observes that the last decade has been marked by deteriorating health and widening health inequalities: 'Since 2010, in many places levels of deprivation and exclusion have intensified and accumulated. Throughout England there are communities and places, that have been labelled as 'left behind', where multiple forms of deprivation intersect and where deprivation has persisted for many years with little prospect of alleviation. Over the last ten years, these deprived communities and areas have seen vital physical and community assets lost, resources and funding reduced, community and voluntary sector services diminished and public services cut, all of which may have damaged health and widened inequalities'.

1.2. Social exclusion

Social inequalities exist across a wide range of domains: age, gender, race, ethnicity, religion, language, physical and mental health and sexual orientation. There are also some groups in society who are particularly disadvantaged: for example people who are homeless, refugees and asylum seekers, including those who receive no financial support and for whom absolute poverty remains a reality.

Social exclusion can be defined broadly as processes driven by unequal power relationships that interact across economic, political, social, and cultural dimensions[viii]. In the UK, the concept of inclusion heath has typically encompassed homeless people; Gypsy, Roma, and

traveller communities; vulnerable migrants; and sex workers [ix] but other groups can be included.

Social exclusion is associated with the poorest health outcomes, putting those affected beyond the extreme end of the gradient of health inequalities. Inclusion health groups commonly have very high levels of morbidity and mortality, often with multiple and complex needs including overlapping mental and physical ill-health, and substance dependency, creating complex situations that health services are not always equipped to deal with and that traditional population-based approaches generally fail to address[x].

Common experiences cut across inclusion health groups. Most have been or are exposed to multiple, overlapping risk factors, such as adverse childhood experiences, trauma, and poverty. Adding to this unfavourable start, many face multiple barriers in access to health services because of fear, language and communication issues or negative past experiences, such as being turned away[xi]. This results in overuse of some services, such as accident and emergency departments, and underuse of others, such as primary and preventative care, resulting in inefficiencies and extra costs. Many of these populations are also highly mobile, making it difficult to ensure access and continuity of care from services that are typically designed for fixed populations[xii].

These groups frequently face stigma, discrimination, and public misconception, and marginalisation can further be compounded by punitive social policies. Notably, inclusion health groups are not consistently recorded in electronic records, making them effectively invisible for policy and service planning purposes[xiii]. These experiences can create a vicious cycle of health and social deterioration for those affected.

Inclusion Health[xiv] highlighted a number of challenges which illustrate the need for commissioners to tackle this issue in a robust way, and most of these still stand today:

	Challenges
Clients	• complex needs and chaotic lifestyles make it difficult for socially excluded people to access services and navigate systems • many socially excluded clients have low health aspirations, poor expectations of services, and limited opportunities to shape their care • they often report feeling 'invisible' or discriminated against
Practitioners	• many practitioners (especially in non-specialist settings) lack awareness, skills and training to cope effectively with the most excluded • in many mainstream settings, there is a tendency to focus on treating presenting symptoms – rather than supporting recovery and sustained behaviour change • specialist practitioners often work in isolation or lack the support networks and supervision to deal effectively with high need clients
Providers	• there is a limited evidence base on what works for these clients, and sometimes a lack of capacity/capability to evaluate • services often lack the flexibility to respond to complex needs and chaotic lifestyles • few incentives to promote partnership working around clients with complex needs

	• it is easy for clients to fall between the gaps of different services • there are key gaps in and barriers to provision (e.g. access to mental health services for those with dual diagnosis) • there is an artificial divide between clinical and social models of care
Commissioners	• there is considerable variation of provision of specialist services between different areas of the country • socially excluded clients often do not show up on needs assessments • some groups are very small or geographically dispersed, and there are important differences between and within groups • often there is limited join-up between PCTs, LAs and the Third Sector in sharing • knowledge about the most excluded clients • limited focus on health promotion, prevention and recovery
Leaders	• there is no national voice for the socially excluded and the diverse range of professionals who work with them • health care for socially excluded groups is of low priority and the needs of these • groups tend not to be at the forefront in strategic planning • health and wellbeing outcomes do not adequately reflect the specificity and complexity of socially excluded clients' needs and circumstances

1.3. Community based approaches to addressing health inequalities

'Community' as a term is used as shorthand for the relationships, bonds, identities and interests that join people together or give them a shared stake in a place, service, culture or activity. Distinctions are often made between communities of place or geography and communities of interest, identity or affinity, as strategies for engaging people may vary accordingly. Nevertheless, communities are dynamic and complex, and people's identities and allegiances may shift over time and in different social circumstances[xv].

Communities are important for physical and mental health and well-being. The physical and social characteristics of communities, and the degree to which they enable and promote healthy behaviours, all make a contribution to social inequalities in health[xvi]. The Marmot Review provided evidence that in order to reduce health inequalities in England, we must improve community capital and reduce social isolation across the social gradient.

'Social capital' refers to the relationships and social networks available that bind and connect people within and between communities. It provides a source of resilience which is critical to physical and mental well-being. Networks can also support more practical needs including, including help for people find work, or get through economic and other material difficulties. The extent of people's participation in their communities and the added control over their lives that this brings has the potential to contribute to their psychosocial well-being and, as a

result, to other health outcomes. Therefore it is **vital to build social capital at a local level** to ensure that approaches are shaped and owned by local communities.

A radical shift is needed to put communities at the heart of public health[xvii] and there is growing evidence which supports the case for this shift to more person and community-centred approaches to health and wellbeing[xviii]. They involve:

- using non-clinical methods
- using participatory approaches, such as community members actively involved in design, delivery and evaluation
- reducing barriers to engagement
- utilising and building on the local community assets
- collaborating with those most at risk of poor health
- changing the conditions that drive poor health
- addressing community-level factors such as social networks, social capital and empowerment
- increasing people's control over their health.

Actively involving citizens in prevention programmes and strengthening community assets is a key strategy in helping to improve the health of the poorest fastest. Community assets include:

- the skills, knowledge, social competence and commitment of individual community members
- friendships, inter-generational solidarity, community cohesion and neighbourliness
- local groups and community and voluntary associations, ranging from formal organisations to informal groups, or mutual aid networks such as babysitting circles
- physical, environmental and economic resources
- assets brought by external agencies including the public, private and third sector[xix].

Community-centred approaches are about mobilising assets within communities, promoting equity, and increasing people's control over their health and lives. However, not all groups have equal access to community assets. Those who are socially excluded often do not have a voice in local decisions and are not given as many opportunities to participate in community life as others. Participatory approaches can directly address marginalisation and powerlessness that underpin inequities and can therefore be more effective than professional-led services in reducing inequalities. Effective participation in which individuals and communities define the problems and develop community solutions is required to shift power towards individuals and communities to address health inequalities[xvi].

PHE has developed a 'family of community-centred approaches' as a framework to represent some of the practical and evidence-based options that can be used to improve community health and wellbeing. It includes four strands of community-centred approaches for health and wellbeing, including:

- strengthening communities: building on community capacities to take action together on health and the social determinants of health
- volunteer and peer roles: enhancing individuals' capabilities to provide advice, information and support or organise activities around health and wellbeing in their or other communities.
- collaborations and partnerships: approaches that involve communities and local services working together at any stage of the planning cycle, from identifying needs through to implementation and evaluation.

- access to community resources: connecting people to community resources, practical help, group activities and volunteering opportunities to meet health needs and increase social participation.

During the COVID-19 pandemic communities have shown and built their resilience. Neighbours are connecting and looking out for each other more than usual, informal support groups in local areas have organised to support people in need. ONS weekly research into social impacts of COVID-19 has seen a steady increase in community spirit. However, it has also likely exacerbated some of the issues faced by those who are isolated and excluded as n not everyone can contribute to or benefit equally from neighbourhood action[xx].

The pandemic has not only highlighted the importance of communities. In order not to lose these gains as we recover from the pandemic it is vital to maintain the centrality of communities and continue to strengthen community resilience through our ongoing efforts to improve health and wellbeing.

2. Health inequalities in Northamptonshire

To understand local needs Public Health have conducted a rapid desktop needs assessment, looking at vulnerable groups in Northamptonshire. In January 2020 Public Health held a Health and Wellbeing Board Development Session, which also started to gather information on vulnerable groups and what the current local assets and needs are (through local Voluntary and Community Sector and other service representatives who were in attendance). Public Health are also conducting an engagement activity from 1 – 28 September to gain feedback on the proposals for this approach to addressing health inequalities to inform the development of the service specification. However, we also recognise that a key element to any community development approach is to engage with communities to develop relationships and a shared understanding of the issues and to work in partnership to co-design and co-deliver interventions. This will be the first phase of the programme.

2.1. Local needs and areas to focus on

In 2015-17 the life expectancies of Northamptonshire males and females were slightly lower than the England average (males: 79.5 vs. 79.6 years; females: 82.8 vs. 83.1 years). There was a 6.6 year gap between the most and least deprived quintile for males, and a 5.3 year gap for females.

Table 2: Inequalities between the most deprived and least deprived quintile in Northamptonshire in 2015-17

	Male	Female
Life expectancy in most deprived quintile of Northamptonshire (yrs)	75.3	79.4
Life expectancy in least deprived quintile of Northamptonshire (yrs)	82	84.6
Absolute gap in life expectancy between most and least deprived quintile (yrs)	-6.6	-5.3

The top 3 broad causes of death that contributed the most to the life expectancy gap between the most and least deprived areas across the seven districts and boroughs were:
• Circulatory disease
• Cancer
• Respiratory disease

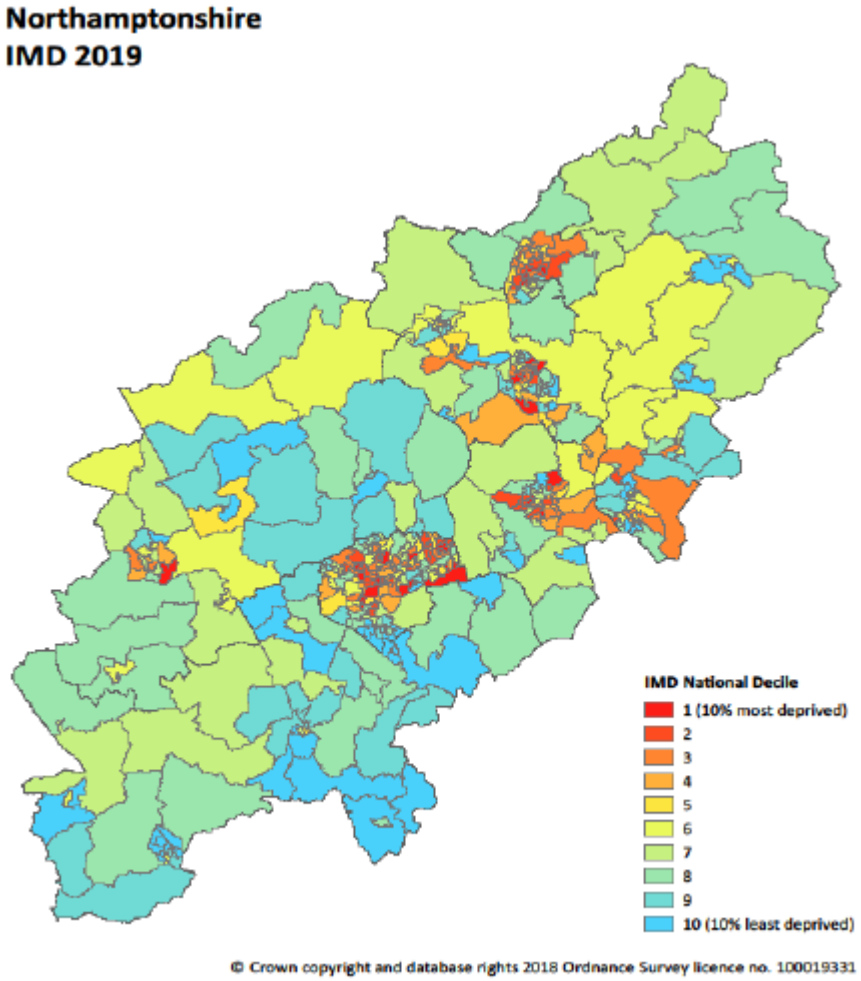
The districts/ boroughs with the greatest inequalities in life expectancy compared to the England average are:

1. Corby (2.8 years lower than England for males and 2.7 years for females)
2. Northampton (1.1 years lower than England for males and 0.6 years for females)
3. Wellingborough (0.7 years lower than England for males and 0.9 years for females)
4. Kettering (0.5 years lower than England for females)

For further detail please view
https://www.northamptonshire.gov.uk/councilservices/health/health-and-wellbeing-board/northamptonshire-jsna/Documents/Health%20Inequality%20in%20Northamptonshire.pdf

2.2. Indices of multiple deprivation

24 LSOAs in Northamptonshire are amongst the top 10% most deprived in England and 38 fall within Decile 2 nationally. Thus, 62 (14.7%) of the LSOAs in Northamptonshire are amongst the top 20% most deprived nationally. See the table below for the 20 most deprived LSOAs.



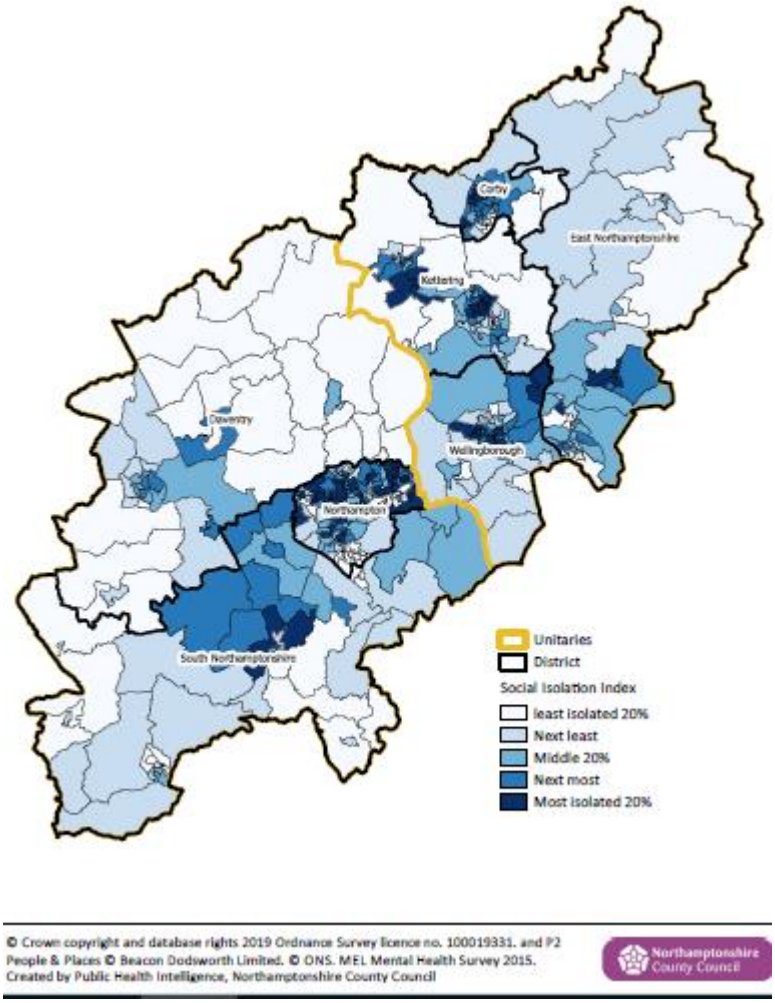
LSOA 2011	Name	Proposed Unitary	LSOA 2011 Descriptive Name	IMD 2019 : Overall National Rank	IMD 2019 : Overall National Decile	IMD 2019 : Overall County Rank
E01027140	Northampton 011A	West	Billing : Fieldmill Road area, Billing Aquadrome	185	1	1
E01026968	Corby 006G	North	Kingswood : Dunedin Road, Vancouver Close, Kenilworth	440	1	2
E01027127	Kettering 005D	North	Kettering : Kathleen Drive, Washington Square	748	1	3
E01027235	Northampton 026C	West	Briar Hill : Ringway, Southwood Hill	1139	1	4
E01026965	Corby 006D	North	Kingswood : Saxilby Close, Buxton Close	1181	1	5
E01032979	Northampton 021F	North	Town Centre : Rail Station, St James Retail Park, St Peter's Way, Drapery	1372	1	6
E01027244	Northampton 017E	West	Kings Heath : Park Drive, West Oval	1398	1	7
E01027239	Northampton 017A	West	Dallington : Dallington Road, Merthyr Road	1520	1	8
E01027334	Wellingborough 002E	North	Wellingborough : Finedon Road Ind Est, West Farm Cres, Fulmar Lane	1736	1	9
E01027199	Northampton 007D	West	Blackthorn : Blackthorn Primary School, Pikemead Ct, Hopmead Ct	1803	1	10
E01027083	Kettering 005C	North	Kettering Buccleuch, Walnut Crescent	1859	1	11
E01026960	Corby 006B	North	Maplefields School, Leighton Road, Turner Road, Constable Road area	1919	1	12
E01027310	Wellingborough 007B	North	Wellingborough : Minerva Way, Kiln Way	2182	1	13
E01027168	Northampton 012A	West	Eastfield Park, Grange Road	2238	1	14
E01027110	Kettering 007B	North	Kettering : Northfield Avenue (South), Silver Street	2269	1	15
E01027318	Wellingborough 008B	North	Wellingborough : Jubilee Crescent	2296	1	16
E01027013	Daventry 008D	West	Borough Hill, Trafalgar Way, Tovey Dr area, Long March, High March	2375	1	17
E01027153	Northampton 021C	West	Semilong & Barrack Rd : Marriot Street, St George's Street, Deal Street, Sheep Street	2420	1	18
E01027131	Kettering 009D	North	Kettering : Northumberland Road, Kettering Business Park	2492	1	19
E01026950	Corby 005B	North	Burghley Drive, Recreation Ground area	2643	1	20

For further detail please view https://www.northamptonshire.gov.uk/councilservices/health/health-and-wellbeing-board/northamptonshire-jsna/Documents/IMD%20Profile%20NORTHAMPTONSHIRE%20-%20Oct%202019.pdf

Social isolation

Isolation (a lack of social contact) and loneliness (the subjective feeling of lacking social contact) are affecting people of all ages and in all situations. People who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. Some marginalised or socially excluded groups, including those from migrant communities or those with poor mental health or substance misuse issues often do not have a voice in local decisions and are not given as many opportunities to participate in community life as others. [xxi]

Public Health Northamptonshire developed a social isolation index based on methodology used by Gloucester County Council using Acorn demographic segmentation produced by CACI Ltd. The figure below shows social isolation by LSOA. It is expected that people feeling socially isolated will have been exacerbated by COVID and the social distancing restrictions, particularly for those who are vulnerable and/ or shielding.



Vulnerable migrants and asylum seekers

Health problems of vulnerable migrants are frequently related to destitution and lack of access to services, rather than to complex or long-standing ill-health. Vulnerable migrants may be dissuaded from accessing care because they fear charges or coming to the attention of immigration authorities. Refugees and asylum seekers may have high levels of psychological ill-health, which is not necessarily due solely to their experiences of conflict and related traumatic events but is also likely to reflect the socio-political conditions in host countries that create discrimination and marginalisation. Migrants' high risk of homelessness and destitution creates circumstances that further exacerbate their already fragile mental health.[xxii]

In Northamptonshire:

- In 2019 23 asylum applicants were claiming 'section 95 support'.

While Northamptonshire as a county doesn't have a particularly high rate of asylum applicants it also doesn't have any particular organisations dedicated to working with vulnerable migrants and so their needs may not be met.

Homelessness

The average age of death for homeless people is just 43 for women and 47 years for men, and is associated with reduced quality of life caused by multi-morbidity. Homelessness is an

independent risk factor for premature mortality and is associated with extremes of deprivation and multi-morbidity. Chronic homelessness is an associated marker for tri-morbidity, complex health needs and premature death. Tri-morbidity is the combination of physical ill-health with mental ill-health and drug or alcohol misuse. Oral health problems are very common amongst homeless populations. 32% of people who are homeless report dental pain, and have a greater number of missing and decayed teeth and fewer filled teeth.[xxii]

In Northamptonshire:

- 140 rough sleepers were accommodated during COVID-19 outbreak, and 80 have now been moved on to settled housing.
- In 2018 there were an estimated 3,026 people who were homeless: 1286 homeless households, 91 rough sleepers, 1649 hidden homeless, 590 temporary accommodation and 7761 overcrowded households

Sexual exploitation and sex workers

Sex workers are likely to experience poor health because of the risks associated with their work. Female sex workers in London have a mortality rate that is 12 times the national average. Up to 95% of female sex workers are problematic drug users. 68% of female sex workers meet the criteria for post-traumatic stress disorder – this is in the same range as victims of torture and combat veterans undergoing treatment. A comparatively low percentage of female sex workers have had routine health checks such as cervical screening, or attend antenatal checks when pregnant. Psychological and institutional barriers to accessing healthcare include: fear of criminalisation, institutional factors (e.g. opening hours, location), stigmatisation and discrimination. [xxii]

In Northamptonshire

- No local data. Estimated total number of sex workers in the UK 72,800, equal to 1.72 per 1,000 population, applied in Northants this is around 1,021

Gypsy Roma Traveller Communities

“Gypsies and Travellers” is a commonly used catch-all term that includes people from a variety of groups, all of whom were – or are – nomadic. These include: Romany (English/ Welsh) Gypsies (the majority group in England and Wales), Scottish Gypsies/Travellers, Travellers of Irish heritage (Irish Travellers), Roma, Fairground and Show people, Circus people, New Travellers, and Bargee and water craft/canal boat Travellers. An estimated two-thirds of Gypsies and Travellers in the UK today live among the “settled community” in permanent housing, with a further significant portion living on permanent sites, either privately or publicly provided. Others, due to national shortages of sites, live on unauthorised sites (as of 2011, approximately 20% of Gypsy/Traveller caravans are stationed “unlawfully”, rendering the occupants technically homeless.[xxii]

Gypsies and Travellers have significantly poorer health outcomes compared with the general population of England and with other English-speaking ethnic minorities. They are frequently subject to racial abuse and discrimination, and many Gypsies and Travellers reluctant to disclose their identity due to fears of prejudice, and a deeply ingrained mistrust of authority. Many Gypsies and Travellers are not literate. [xxii]

A 2012 report by the Ministerial Working Group on tackling inequalities experienced by Gypsies and Travellers confirmed that they have the lowest life expectancy of any ethnic group in the UK and continue to experience high infant mortality rates (18% of Gypsy and Traveller women have experienced the death of a child), high maternal mortality rates, low

child immunisation levels (particularly where specialist Traveller Health Visitors are not available), and high rates of mental health issues including suicide, substance misuse issues and diabetes, as well as high rates of heart disease and premature morbidity and mortality. [xxii]

There is often a poor take-up of preventative healthcare by Gypsies and Travellers, particularly among men, with conditions usually well advanced before any type of healthcare is sought. Targeted services are needed to increase male engagement in preventative healthcare and to fast-track Gypsies and Travellers to preventative services supported by peer/community health promotion workers. [xxii]

In Northamptonshire:
Permanent traveller sites and pitches:

	Data from 2019				Data from 2017		
	Corby	Kettering	East Northants	Welling-borough	Daventry	South Northants	North-ampton
Private sites	2	13	3	2	4	1	
Pitches	7	69	72	62	28	3	
Public sites	2	2		1			1
pitches	18	22		3			35

Number of households meeting the planning definition of gypsy traveller:

	Corby	Kettering	East Northants	Welling-borough	Daventry	South Northants	North-ampton
Meet the definition	8	25	0	2	0	5	0
Undetermined	4	15	67	29	24	0	10
Do not meet definition	12	20	6	2	2	4	27

Source Documents:
North Northamptonshire Gypsy and Traveller Accommodation Assessment (GTAA) Final Report March2019. **West Northamptonshire Travellers' Accommodation Needs Study** Final Report January 2017

What do we want to achieve?

Public Health Northamptonshire want to take a community based approach to address health inequalities in Northamptonshire. The outcomes we want to achieve are:

- To build resilience within local communities so that they are empowered to take action together on health and the social determinants of health. The approach required to address this includes community development, asset based approaches, social action and social network approaches and comes from the 'strengthening communities' strand of the family of community based approaches.
- Reduce the health inequalities faced by those who are most disadvantaged or excluded.

Outcomes

Outcomes should be developed as part of the development of the program, but the types outcomes we want to see include:

- Improved wellbeing

- Increased social connections
- Improved neighbourhood environment

These protective factors can help buffer against risk factors like smoking, obesity, and drug and alcohol use[xxiii] as well as mental health, and these are also areas which the programme could expect to seem an impact on.

Key Principles of the programme

A whole-system approach

People are complex: everyone's life is different, everyone's strengths and needs are different. The issues and systems that respond to these issues are complex: the range of people and organisations involved in creating 'outcomes' are beyond the management control of any person or organisation.[xxiv] Therefore a holistic approach is needed to engage people with multiple needs that is based on an understanding that the people being supported are part of a wider system. For example**,** homelessness is rarely the result of a single lifestyle choice, but rather the outcome of numerous systematic failures and problems.

To empower communities we need to work across partnerships and sectors to maximise impact and remove system barriers[xxv]. Community action is a necessary component of place-based approaches to reduce health inequalities, alongside and as part of, healthy public policy and prevention services. Joint working between the civic, service and community sectors is needed to enable the whole to become more than the sum of its parts[xxvi].

This commission community based approach will be part of a system wide approach to address these issues, which will be led by Public Health. It is anticipated that a system wide programme board will be set up to ensure that key stakeholders can work together to address some of the systemic issues that result in the poorer health outcomes and inequalities faced by those who are vulnerable or marginalised.

For many disadvantaged groups, clinical encounters and contact with service providers are characterised by suspicion, indifference and occasionally hostility, rather than dignity and respect. [xxvii] Working in partnership with commissioners and provider services to identify and address some of the barriers to accessing service will be a really important part of the programme.

Outcomes focussed

We need to develop outcomes that people care about, and that are produced by whole systems rather than individuals, organisations or programmes[xxviii]. A key part of phase 1 of the programme will be to identify what is important for communities and how we can best address and measure these outcomes.

Genuine co-design and co-delivery

It is vital to involve members of the community in setting priorities, monitoring and evaluating services and initiatives, as well as delivery. Working co-productively leads to improved outcomes for people who use services and carers, and has a positive impact on the workforce.

Delivery model

Community based

We recognise the importance and value the Voluntary and Community Sector has, through their knowledge and connections with local communities. Therefore this program of work will be led by those who have good links with local communities. There will some budget allocated to grants which will seed fund new local projects.

The proposal to deliver the service should include the use of community development workers, ideally from local communities, who can work with communities to understand their needs, local assets and develop interventions to improve health outcomes.

Sustainability of services is key and it is important the service results in more social capital and community resilience to enable an exit strategy.

Areas of focus

It is expected that the service development and delivery will be based on local needs and areas of focus, but there is an expectation that the main areas of focus will be to work with people who are affected by:

- Social isolation
- Homelessness
- Excluded and vulnerable groups, as listed above.

Procurement approach

This contract will be procured through an open competitive tender process. Due to the different areas of focus and the needs led, community based approach it is planned that the contract will be through a lead provider who will oversee delivery and coordinate the programme of work and will subcontract to other providers as and when required, as well as overseeing a grants programme. It is planned that the contract will be split into four lots which are aligned to the four Primary Care Localities, and this is the same way that the Northamptonshire Social Prescribing Social Impact Bond contract is structured, as it is key that we work together on this programme to complement one another. Therefore, the proposed geographies are:

- Northamptonshire North
    - Kettering and Corby
    - East Northants and Wellingborough
- Northamptonshire West
    - Northampton
    - Daventry and South Northants

Structuring the contract in this way will be a more efficient use of resources in terms of the commissioning and oversight of the contract, but using the lead provider approach will mean that there is flexibility to adapt services as required on a much more local level.

Delivery of the contract

Phase 1: engagement with local communities to map assets, understand the local issues, and identify shared outcomes and to coproduce solutions

Phase 2: development of the 'service' – co-produced and co-delivered with local communities.
Phase 3: service delivery- in partnership with communities to empower and enable them to continue after the end of the project
Phase 4: exit and sustainability

Location

The service will be place based, focusing on areas of highest need.

Timescales

Phase 1 will start in April 2021. The contract is proposed to be for 3 years, with an optional 1 year extension.

Funding

The annual budget will be.

Funding stream	North	West	Total
Social wellbeing	£429,307	£470,693	900,000

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