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West Northamptonshire Council

West Northamptonshire Health and Wellbeing Board

A meeting of the West Northamptonshire Health and Wellbeing Board will be held at the Francis Crick House, Summerhouse Road, Moulton Park, Northampton, NN3 6BF on Thursday 8 September 2022 at 1.00 pm

Agenda

1.	**Apologies for Absence and Notification of Substitute Members**
2.	**Notification of Requests to Address the Meeting** The Chairman to advise whether any requests have been received to address the meeting.
3.	**Declarations of Interest** Members are asked to declare any interest and the nature of that interest which they may have in any of the items under consideration at this meeting.
4.	**Chair's Announcements** To receive communications from the Chair.
5.	**Minutes from previous meeting 7th June 2022** (Pages 5 - 18) To agree the minutes from the previous meeting 7th June
6.	**Action Log** (Pages 19 - 20) To review actions from the previous meeting 7th June 2022
7.	**Northamptonshire Better Care Fund Plan 2022/2023** (Pages 21 - 74)

8.	**Health Equality Grant** (Pages 75 - 106)
9.	**NHS Northamptonshire Integrated Care Board update** (Verbal Report)
10.	**Integrated Care System PLACE Development** (Pages 107 - 316) 1. Integrated Care Strategy 2. Local Area Partnerships 3. Outcomes Framework and Joint Strategic Needs Assessment Update
11.	**West Northamptonshire Anti Poverty Strategy** (Pages 317 - 326)
12.	**Community Engagement Framework** (Pages 327 - 356)

Catherine Whitehead
Proper Officer
31 August 2022

West Northamptonshire Health and Wellbeing Board Members:

Councillor Matt Golby (Chair)

Chief Superintendent Ashley Tuckley
Sally Burns
Councillor Jonathan Nunn
Dr Jonathan Cox
Naomi Eisenstadt
Assistant Chief Fire Officer Dr Shaun Hallam
Russell Rolph
Colin Smith
Michael Jones
Dr Andy Rathbone
Professor Jacqueline Parkes
Chris Keirnan
Councillor Fiona Baker
Alan Burns
Anna Earnshaw
Colin Foster
Stuart Lackenby
Toby Sanders
Neelam Aggarwal
Jean Knight
Councillor Wendy Randall
Wendy Patel

Information about this Agenda

Apologies for Absence
Apologies for absence and the appointment of substitute Members should be notified to democraticservices@westnorthants.gov.uk prior to the start of the meeting.

Declarations of Interest
Members are asked to declare interests at item 2 on the agenda or if arriving after the start of the meeting, at the start of the relevant agenda item

Local Government and Finance Act 1992 – Budget Setting, Contracts & Supplementary Estimates
Members are reminded that any member who is two months in arrears with Council Tax must declare that fact and may speak but not vote on any decision which involves budget setting, extending or agreeing contracts or incurring expenditure not provided for in the agreed budget for a given year and could affect calculations on the level of Council Tax.

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Queries Regarding this Agenda
If you have any queries about this agenda please contact Cheryl Bird, Health and Wellbeing Board Business Manager via the following:

Tel: 0300 126 3000
Email: Cheryl.Bird@northnorthants.gov.uk

Or by writing to:

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One Angel Square
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Northampton
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WEST NORTHANTS
Health and Wellbeing Board
live your best life

WEST NORTHAMPTONSHIRE HEALTH & WELLBEINGBOARD
Minutes of the meeting held on 7th June 2022 at 11.00 am
Venue: Great Hall, Guildhall, Northampton, NN1 1DE

Present:

Councillor Matthew Golby (Chair)	Cabinet Member for Adults, Health and Wellbeing, West Northamptonshire Council
Neelam Aggarwal-Singh	BAME Representative
Cllr Fiona Baker	Cabinet member for Childrens, Families and Education, West Northants Council
Sally Burns	Interim Director of Public Health, West Northants Council
Anna Earnshaw	Chief Executive, West Northants Council
Naomi Eisenstadt	Chair Designate, Northamptonshire Integrated Care Board
Colin Foster	Chief Executive, Northamptonshire Childrens Trust
Polly Grimmett - substitute	Director of Strategy, University Group of Hospitals Northamptonshire
Dr Shaun Hallam	Assistant Chief Fire Officer, Northants Fire and Rescue
Michael Jones	Divisional Director, EMAS
Jean Knight	Chief Operating Officer, Northamptonshire Healthcare Foundation Trust
Stuart Lackenby	Deputy Chief Executive, Director for Adult Social Services, West Northants Council
Professor Nick Petford	Vice Chancellor, University of Northampton
Cllr Wendy Randall	Opposition Leader, West Northants Council
Russell Rolph	Chief Executive, Voluntary Impact Northamptonshire
Toby Sanders	Chief Executive, Northamptonshire Clinical Commissioning Group
Dr Darin Seiger	Chair, Northampton GP Locality
Colin Smith	Chief Executive, Northamptonshire Local Medical Committee

Dr Philip Stevens	Chair, Daventry and South Northants GP Locality

Also, Present

Cheryl Bird, Health and Wellbeing board Business Manager
Katie Brown, Assistant Director Safeguarding and Wellbeing Services, West Northamptonshire Council
Sarah Hillier, Chief Executive, Northamptonshire MIND
Chris Stopford, Interim Private Sector Housing Manager, West Northants Council

And no members of the public were in attendance.

13/22 Apologies

Chris Kiernan, Director of Childrens Services, West Northants Council
Dr Andy Rathborne, Primary Care Network
Assistant Chief Constable Ashley Tuckley, Northamptonshire Police
Alan Burns, University Group of Hospitals, Northamptonshire
Professor Will Pope, Chair Healthwatch Northamptonshire
Dr Jo Watt, Chair, NHS Northamptonshire Clinical Commissioning Group

14/22 Notification of requests from members of the public to address the meeting

None received.

15/22 Declaration of members' interests

None received.

16/22 Chairman's Announcements

As part of the ongoing work to support delivery of PLACE the Board are asked to endorse Dr Philip Stevens, Chair of the Daventry and South Northants Locality and Dr Darin Sieger, Chair of the Northampton Locality to become members of this Board

Cllr Wendy Randall is replacing Cllr Bob Purser as opposition elected member to the Board.

RESOLVED that: the following representatives are co-opted to membership of the Board:

- **Dr Darin Seiger**
- **Dr Philip Stevens**
- **Cllr Wendy Randall**

17/22 Minutes from the Previous meeting 3rd March 2022

RESOLVED that: minutes from the previous meeting held on the 3rd March 2022 were agreed as an accurate record.

18/22 Action Log

The Board reviewed the actions from the previous meeting:

- A letter of thanks be sent to Lucy Wightman on behalf of the Board. **Completed, this was sent on the 4th March.**
- The Director of Public Health to ask communications to emphasise that people must continue to wear face coverings in all health facilities. **Completed**, **this has been emphasised in communications.**
- The ICS Outcomes Framework presentation be circulated to the board for feedback and be brought back to the next meeting. **Completed this was circulated on the 4th March and will be discussed later in the meeting.**
- Membership of the board be mapped against the against the 10 domains in Live your Best Life. **Completed this will be discussed later in the meeting.**
- The draft Health Inequalities Plan will be brought back to the next Board meeting. **Completed this will be discussed later in the meeting.**
- The draft Anti Poverty Strategy will be forwarded to the Board and an agenda item at the next meeting. **Completed. This will be discussed later in the meeting**.

19/22 Clinical Group Strategy

Polly Grimmett gave a presentation on the process of engagement undertaken during development of the Clinical Group Strategy (CGS)and highlighted the following:

- The University Group of Hospitals Northamptonshire was formed in 2020, with Northampton General Hospital and Kettering General Hospital.
- Previously the hospitals had worked separately which had limitations, by forming the hospital group they can work together to provide clinical services resulting on sustainable improvements for patients care.
- The population in Northamptonshire is growing fastest than the national average, with pockets of health inequalities within the county.
- There is difficultly in recruiting and retaining some specialist staff within the two hospitals in the county, which leads to poor reliability of service provision to patients.
- Feedback from patients about their experiences across the two hospitals, was there was no join up with services, clinicians from one hospital couldn't view test results taken at the other hospital.
- Some patients are having to travel out of county for treatment when in theory this could be delivered in county.
- Engagement for the strategy began with hospital staff across the two hospitals, asking for views on how they felt working together could improve services for patients. 90% of staff who took part the engagement stated working together with collaborative services was a real opportunity to improve patient care. The ideas from this engagement were taken to the Hospital Group Board in November 2021 for agreement.
- Since November 2021 wider engagement has been undertaken with Integrated Care System partners, public and patients. This wider engagement involved over 600 staff, hosting 4 public events and circulating information on websites and social media.
- There was feedback about being net zero carbon and having environmentally friendly practices and which appears in the CGS.
- The CGS will focus on four themes:
  - Work with health and care partners to prevent ill-health and reduce hospitalisation. Working as part of an Integrated Care System (ICS) provides an opportunity to deliver seamless care, including across community services and primary care.
  - Develop Centres of Excellence across all services, starting with cardiology and cancer. It has been recognised that there will be a significant increase in terms of

care for those developing these long term conditions. Investment has begun on specialist equipment needed for these centres and patients can now have these specialist treatments in county. It is also hoped these centres will attract recruitment of talented people across the country.
  - Ring-fence elective capacity to reduce waiting list and variation between sites and increase efficiency. During the winter months elective care operations have to be postponed, one of our priorities over the next 12 months is to define and protect the elective capacity across the group**.**
  - Build on our University Hospital status to become a hub for innovation and research.
- The University Hospitals Group Northamptonshire Board were presented with the CGS in May and accepted that the document represented the feedback received during the engagement phase.
- On the 8th July there will be a cancer workshop with stakeholders where we can start to define what cancer care in the acute sector needs to look like.

Following questions from the Board, Polly Grimmett added the following:
- Over the next 6-12 months work will take place on identifying the actual deliverables, along with a Communities Engagement Plan to ensure there is a continuous engagement cycle.
- If there is evidence, we may suggest a change in where services are provided, but this would be in the best interests of patients.
- The next level of detail for service designs will consider the location of patients, what is their access and what are their health inequalities.

The Board discussed the CGS and the following was noted:
- There is a need to ensure this strategy will be complementary to the GP Clinical Strategy when this is developed.
- More clarification is needed on how people who live on the border on Northamptonshire will be able to access services.
- Patients need to have seamless services delivered at the point of need.
- It would be beneficial to discuss how this will align with the four collaboratives within the ICS.
- GPs will be keen to work on how to develop the new integrated cardiology services.

RESOLVED that the Board:

a) Notes the significant engagement that has taken place with staff, patients, the public and local stakeholders in developing the Group Clinical Strategy.

b) **Approves the document as a strategic direction of travel for acute hospital care in the county**.

20/22 COVID19 Update

The Director of Public Health gave an update on the latest COVID19 situation and highlighted the following:
- Most of the mandatory requirements for the management of COVID19, have been revoked and we are now in a 'Living with COVID19' phase.
- The Health Protection Team are working on a transition project involving partners from across the county.
- The all-age positivity case rate for Northamptonshire has drastically reduced to 75 per 100000 population which is a 22% reduction on the previous week.
- The levels of PCR and Lateral Flow testing being undertaken are also reducing.
- There are currently three active outbreaks across Northamptonshire, one in a Care Home in the West of the county, with the other two outbreaks in the North of the county.

- The role of Public Health Northamptonshire in relation to COVID19 has moved to managing outbreaks.
- COVID19 related hospital admissions have also drastically reduced.
- Due to to reduction in positivity, and hospital admissions the Director of Public Health proposes to bring a COVID19 update to the Board only if there is an escalation in cases.

The Chief Executive of the Integrated Care Board gave an update on the vaccination programme and highlighted the following:

- 1,568,142 total vaccines delivered in Northants as of 5th June 2021.
- Current focus is on Spring Boosters to over 75s; Care Homes, Housebound and Immunosuppressed and continued focus on 5-11 and 12-15 cohorts, with the following number of vaccines administered:
  - Over 80s – 24,614 with 7,200 remaining;
  - over 75s 21,544 with 6,481 remaining.
  - Care Homes – 95% visited (highest in the region) – remaining scheduled (outbreaks stopped visits)
- Guidance on the autumn campaign is expected. Currently JCVI cohorts 1-6 are covered but this could expand to 1-9 (over 50s, frontline HSCW and at risk patients). This will be c400,000 people in Northants with an expectation the programme will run from Sept-Dec 2022
- All eligible patients for the spring boosters are encouraged to come forward before the end of June. This is critical so that when the autumn campaign commences, they will have had a three month gap between vaccine doses.
- Some sites will be pausing COVID19 vaccination during the summer months as demand reduces.

The Board discussed the vaccination update, and the following was noted:

- There may be some reluctance amongst the population to have any further COVID19 vaccine boosters due to feeling unwell after receiving the vaccine or already having caught COVID19.
- As part of the transition project, local vaccination teams are using data to target areas of low vaccine uptake, by identifying champions in communities to increase uptake. There are 18 areas in West Northamptonshire which have low vaccine uptake.

The Director of Public Health discussed the Health Protection Plan and following was noted:

- This plan is an annual report reviewing the previous year and setting priorities for future years.
- The system response to COVID19 is not reported in this plan as this is covered by the Directors of Public Health Annual Report.
- As part of the transition project, Public Health Northamptonshire is trying to build on the health protection function moving forwards, as well as being prepared if there was a surge in COVID19 cases.
- There are 9 strategic priorities moving forwards:
  - Immunisation
  - Screening
  - Infection Prevention Control
  - Tuberculosis
  - Blood borne virus
  - Outbreak management
  - Environmental health
  - Training and Campaigns
  - Addressing health inequalities
- The Plan has been signed off by the Health Protection Committee and will be refreshed at the end of March 2023.

The Chief Executive of the ICB confirmed responsibility for vaccination programmes will transfer from NHS England to local ICB's from the 1st July 2022. There are also ongoing financial implications during 2022/2023 with COVID19 costs for acutes and providers which will continue until the end of June.

RESOLVED that the Board:

a) **Notes the local situation and vaccination updates**
b) **Notes Northamptonshire Joint Health Protection Plan 2022 – 2024**
c) **Agreed for COVID19 updates to be given at Board meetings if there is an escalation in cases or change in regulations.**

21/22 Better Care Fund End of Year Performance

The Assistant Director for Adult Social Services presented the Better Care Fund End of Year Report 2021/2022 and highlighted the following:

- The BCF End of Year Performance Template 2021/2022 was submitted to NHS England on the 31st May 2022, subject to approval from this Board.
- The national metric for avoidable admissions is not available, but there have been ongoing reductions in Northamptonshire, which relates to the work being undertaken by the iCAN programme.
- The percentage target for those in hospital post 14 days and 21 days was achieved in quarters 1 and 2, but slightly higher from October 2021. This was caused by COVID19 hospital admissions increasing and challenges with the provision of onward care.
- The percentage target of people discharged to their normal place of residence is not on track although the monthly average has been at 95% against the target of 95.6%. Quarter 4 performance has seen a decrease to 94% as there has been a reliance on bedded solutions to overcome pathway blockages and reduce hospital pressure.
- Still at home 91 days are hospital discharge, over this winter people have been discharged home with support with higher acuity needs, this results in a greater likelihood of re-admission and requiring additional support and services. Currently this is at 62% and the baseline target is 79%.
- There is significant work being undertaken with the iCAN programme particularly around pathway one reablement at home and bedded re-hab to support improvement in autumn and winter this year.
- The 2022/2023 BCF plan will be developed locally and is currently with leads from across the system, this will then transfer across to the ICB from 1st July. There is a working group chaired by David Watts who meet fortnightly, providing a real opportunity through the PLACE development programme to do things differently in relation to the collaboratives under the guise of the ICS.
- BCF guidance for 2022/2023 is expected from NHS England in July.
- The BCF 2022/2023 plan will come to the next Board meeting in September.

Following questions the Director for Adult Social Services added:

- Less complex cases are being stuck in hospital, which means we must take a less risk adverse approach with some people.
- Adult Social Services work with self funders the same way as other elderly people. With the introduction of a care pathway which can appropriate care on behalf of self funders, more support will be given to self funders, which we envisage will provide a better service for people. But this will have implications in resource and capacity within adult social services.

RESOLVED that the Board:

a) Approved the performance template for the Better Care Fund schemes (2021/22).

b) Noted the proposed timelines for the Better Care Fund plan for 2022/23

22/22 Disabled Facilities Grant

The Private Sector Housing Manager presented the Disabled Facilities Grant (DFG) Annual Report 2021/2022 and highlighted the following:

- The DFG Annual Report 2020/2021 showed a significant underspend due to the impact of COVID19 on the DFG service and construction trades.
- The grant from central government for DFG's is £2.5 million and £1 million was brought forward from 2021/2022, with £3.4 million committed spend on supporting residents to remain safe in their home. The carry forward from 2021/2022 to 2022/2023 is £120k.
- The impact of COVID on the service has continued during 2021/2022. Additional occupational therapy services have been put in place to support residents to get the assessments that they need. The construction trade is behind on the recovery plan due to the impact of their supply chains caused by COVID19.
- During 2021/2022 214 mandatory grants were approved. In April 2021, West Northants Council brought in a discretionary policy with a further 42 additional grants approved under this policy.
- The DFG service have worked with community occupational therapy teams and hospital occupational therapy teams within Northampton and Kettering General Hospitals, as well as presenting our DFG policies out to peripheral hospitals who support residents on the borders of south Northamptonshire.
- Five hospital discharge grants have been approved this year, designed to get people home safely in a sustainable manner.
- 19 palliative care grants have been approved with the local hospices, designed to get people home as part of their end-of-life plan.

Following questions from the Board, the Private Sector Housing Manager added the following:

- During 2021/2022 no grants were refused, but some applications were not continued through to completion.
- The DFG applications for hospital discharge and palliative care are fast tracked, supported by the occupational health teams at the acute hospitals and hospices.
- Trades costs are increasing, due to the inflation rises. Although the DFG service have an approved contract list and can obtain best value, this is resulting in prices for DFGs increasing.
- The DFGs covers from birth to end of life.
- The spend of £3.5 million during 2021/2022 included a high number of latent cases due to the COVID19 pandemic. The DFG applications are now back to 2018/19 figures.
- The DFG spend is monitored monthly and if it is looking like an overspend the Director of Adult Social Services is informed and a request for additional funding made.

The Chief Executive of Northamptonshire Childrens Trust confirmed the use of DFG's prevents children going into the care system.

The Director for Adult Social Services advised in future annual reports will include more granular detail, to be able to fully assess the impact of DFGs, as well as different types of indicators around timeliness of activities. Also included will be information on the work with Northampton Partnership Homes, Grand Union and Future to ensure that properties are not just about accessibility but how we can collectively support people in their own homes. There is an aspiration to have an adapted property register, with these three social housing

providers listing properties with significant adaptions.

RESOLVED that:
a) The Board noted the report.
b) The detailed spend for individual grants will be circulated to the Board.
c) Granular data and more detail on how DFGs are used for children and young people and this impact of this is to be presented in future DFG Annual Reports. and will be added in the annual report for 2022.2023.

23/22 Health Inequalities Plan

The Director of Public Health presented the final Health Inequalities plan and highlighted the following:

- The final Health Inequalities Plan is still a work in progress.
- There was a Health Inequalities Plan workshop held in April with approximately 80 attendees. Feedback from this workshop was the passion for this topic, to ensure communities are not left behind. The challenge that came out of the workshop was communities wanted to know what we are going to do.
- There will be a Health Inequalities Delivery Group to address how this plan can be embedded into the Integrated Care Strategy and Outcomes Framework.
- Public Transport is a problem for rural areas in the county, making it difficult for lower paid families who are unable to get into employment.
- Another workshop is organised for the 21st July at Moulton Community Centre to discuss the action plan.
- The Health Inequalities Plan is also about addressing inequity as well as inequalities, there is challenge when delivering a service to understand who is accessing the service and why.

The Board discussed the Health Inequalities Plan and following was noted:

- The ICB have a task and finish group looking at the impact of health inequalities.
- The financial implications of not tackling health inequalities need to be formally recorded.
- West Northants Council are looking at how public transport can get out to rural and disconnected communities and is part of the anti poverty strategy.

RESOLVED that:
a) The Board endorsed the Health Inequalities Plan
b) Colleagues to email expressions of interest to be on the Health Inequalities Oversight Group.

24/22 Director Public Health Annual Report 2020/2022

The Director of Public Health presented the Directors of Public Health Annual Report 2020/2022 and noted that the report describes the journey through the COVID19 pandemic, highlighting all the work by partners, voluntary sector and communities to address the pandemic. The positives from the report are collaborative working assets and communities, how to harness this moving forward.

The Designate Chair of the ICB asked if future reports could contain comparisons with our statistical partners in wealth. Also the higher the risk the fewer people are affected and this needs to be taken into consideration.

RESOLVED that: the Board endorsed the Director of Public Health Annual Report 2020-2022.

25/22 Integrated Care System

The Designate Chair of the ICB gave an update on development of the ICB and the following was highlighted:

- There are now four nonexecutive directors appointed, two from inside the local health and care system and 2 from outside.
- There have been two shadow ICB meetings taken place, one more shadow meeting is scheduled before the ICB becomes a statutory body on the 1st July 2022.
- The Outcomes Framework is looking to identify what are the key issues to agree for the core function.
- The ICB constitution has been approved by NHS England.
- NHS Northamptonshire Clinical Commissioning Group will cease to exist on the 1st July when the ICB becomes operational.
- The Designate Chair of the ICB thanked partners and NHS Northamptonshire CCG for the collaborative working that has taken place to prepare for the transition to an ICB and Integrated Care Partnership.

The Director for Adult social Services gave a presentation on development of the Integrated Care Partnership (ICP) and PLACE in West Northants and highlighted the following:

- The West Northants and North Northants Health and Wellbeing Boards can feed into ICP which will enable us to deliver different types of service and interventions in the context of PLACE.
- The first shadow ICP meeting took place on the 31st May including members from the both Health and Wellbeing Boards and the ICB.
- This Integrated Care Strategy will be the strategy which pulls the North and West HWBBs strategies as well as the ICB Five Year Plan into a single point which allows us to reflect on how we can improve lives and outcomes for children, young people and their families. Sitting behind this needs to be a Resource strategy and mobilisation strategy.
- Although this will be an inclusive approach, there are time constraints for development of the strategy, so it is likely to be a high level strategy highlighting what we already know about the system.
- The Outcomes Framework will be developed in parrarrell with the Integrated Care Strategy, this will focus around the 'Live your best life' 10 domains. This will be constructed as a high level Outcomes Framework which will then drill down into specific key performance indicators.
- North Northamptonshire will also be adopting the 'Live your best life' 10 domains to provide the level of consistency required across the county. Each PLACE will differ slightly but have a consistent approach to system wide core outcomes.
- The role of the Health and Wellbeing Boards will orient around the work programme and one of its first functions will be to oversee the development of PLACE. A report showing the construct of PLACE including Terms of Reference (ToR) for this Board is being presented to West Northants Cabinet on the 14th June, then Full Council on the 30th June. West Northants Full Council will follow governance procedures in nominating its representative for the ICB. Cabinet will be asked to agree the geography of the local area partnerships (LAPs) for the West.
- The ToR for this Board will be reviewed on a 6 six monthly basis, as the role, function and membership of the Board may have to change as PLACE develops.
- In West Northants there will be 9 Local Area Partnerships (LAPs), each with a population range of between 30-55k, attributed to two Health Wellbeing Forums, Northampton and Daventry and South Northants. Within the LAPs we have tried to algin geographical

rural areas with a level of commonality, there will be complexities around the context of GP Practices, Primary Care Networks, school admission areas which all needs to be worked though.

- Public Health Northamptonshire analyst team will support development of local area profiles to aid work of local area partnerships.
- A LAP will oversee and understand the local area profile, as well as a local asset map, this will provide the ability to see the gaps in resources in a particular area. Need to consider wider determinants of health alongside traditional health and social care services, to have shared aspirations.
- Activity across the 9 LAPs, and 2 Health and Wellbeing Forums will report into this Board, which has the overall responsibility in the West for taking forward the delivery of 'Live your best life' 10 domains. This will also link in with the activity of the ICB and the work taken place within the North of the county.
- Currently organisations have their individual communication and engagement policies, there is an expectation to have one across the system, which allows us to capitalise on the good practice and level of engagement for PLACE.

The Board discussed the update, and the following was noted:

- From the 1st July NHS England will be represented at this Board by the representatives from the ICB.
- The aim is for the ICP to meet twice a year, with main work being completed by the two HWBBs and ICB.
- There is a need to develop engagement with organisations to support them having the right representatives attend meetings to take forward the purpose and scope of each meeting and avoid duplication. If membership is not right, then that affects the different layers of PLACE, and it is paramount to define what does PLACE leadership look like at different levels of place.
- There is a lack of capital investment to look at the planning needs for new developments.
- There are 5 Integrated Care Systems across the East Midlands who come together to discuss how to commission specialist services at a larger regional level.
- LAP is an opportunity for elected members to be a part of the bigger picture and be local champions in communicating and spreading the word of the work taking place
- Working from the bottom-up approach in local area will be beneficial and get better results for the local population and staff.

RESOLVED that:

a) **The Board noted the update and progress toward the Northamptonshire ICS and supported its planned implementation as described within the report.**
b) **The Board approved the Terms of Reference for the Health and Wellbeing Board for the ICS from the 1st July 2022 which will be put forward for approval at West Northamptonshire's full council meeting on the 30th June 2022**
c) **The Board noted the chairing arrangements for the ICP.**
d) **The Board approved the proposed governance structure for the ICP (West Place) which were approved at the Shadow ICP meeting on the 31st May 2022**
e) **The Board noted the proposed LAP's for the West Place as part of the ICP following consultation with stakeholders**
f) **At the next meeting included in the ICS update will be joint work with the 5 Integrated Care Systems across the East Midlands.**

26/22 Prevention Concordat

The Chair of Northamptonshire MIND gave a presentation on the Prevention Concordat and highlighted the following:

- Members of the Mental Health and Learning Disability Collaborative have a desire to make an application for the Prevention Concordat, which will be a whole system commitment. Work on the Prevention Concordat is linked the Population Health and Prevention Pillar within this collaborative.
- Good mental health improves people's lives, increases their life chances and impacts positively on families and communities
- Mental health does not only impact on the individual, but also those around them.
- Prevention of, and recovery from, mental ill health relies on people having hope, control, choice and opportunity in their lives
- Pre-Covid, mental health problems were responsible for over a fifth of the burden of disease in England
- COVID-19 pandemic has worsened mental health and wellbeing in the general population. Increased mental distress from cumulative pandemic waves (UK Household Longitudinal Study) adults reporting a clinically significant level of psychological distress increased (20.8% in 2019 up to 29.5% in April 2020 and 24.5% in March 2021)
- 1 in 6 children have at least one mental health disorder. Around half of all mental health problems start before 14
- 1 in 6 adults experience a common mental health disorder. More common in women, people living in deprived areas, as well as people in poor physical health, living alone, and/or not employed. People with Severe Mental Illness (SMI) die on average 15 to 20 years earlier than the general population, mostly from preventable physical illnesses.
- The National Prevention Concordat for Better Mental Health is focused on promoting positive mental health and prevention to improve mental health and wellbeing, and addressing health inequalities:
  - Shared commitment to improve mental health and wellbeing
  - Partnership working and coproduction at all levels
  - Evidence based planning and commissioning
- The advantages of a prevention concordat are
  - Framework for local coordinated planning and actions
  - Shared commitment across the system to improve mental health and wellbeing for all and help with identifying funding and other resources to support this.
  - Identifies the areas and priorities local partners and communities agree to collectively support, through enhancing existing approaches and initiatives and developing new ones.
  - Recognition that good mental health and wellbeing for all, builds on existing partnership work and will help further develop joint working with a focus on:
    - People, places (councils, 'neighbourhoods', communities) and partnerships to support wellbeing, self-help, and self-care
    - Better integration to provide joined-up community-based services that are responsive to individual needs
    - Collaboration to sustain high quality specialist services and ensure good access and outcomes for everyone
- Prevention Concordat for Better Mental Health is based on the Five Domain Framework for Local Action
  - Understanding local need and assets
  - Working together /partnership and alignment
  - Acting on prevention/promotion of mental health, and to reduce mental health inequalities
  - Defining success/measuring outcomes
  - Leadership and Direction

The group discussed Prevention Concordat and the following was noted:

- The Board needs to publicly support the Concordat application.
- This could be taken forward as part of the work by the LAPs.
- Primary Care Networks have a budget to appoint mental health practitioners, but recruitment is difficult.
- Need to consider a wider recruitment strategy within mental health, looking at alternative qualifications rather than ma nursing background.
- This commitment will be about prevention rather treatment, to build resilience in the community.
- Need to consider how men and women access services differently.
- In terms of prevention we need to start young, neo natal health issues, support for children and families under the age of 5. To review evidence-based work of frequent callers to identify what causes potential mental health issues later in life.
- Looked after children and the most vulnerable in society.
- Frequent callers have a lot of personality disorders, which are already picked up by community mental health services such as the crisis cafes. There is a good working relationship with EMAS and the Integrated Mental Health Response Hub.
- NHFT provide 0-19 services at a county level and NHFT are seeing a burgeoning need to get support to help young people stop spiralling into crisis, there are a significant proportion of children requiring additional tier 3 and tier 4 mental health support.

Resolved that:

a) The Board agreed to support the Prevention Concordat application
b) The Prevention Concordat report be circulated to the Board.
c) The Prevention Concordat be brought back to a future Board meeting for a more in-depth discussion.

27/22 Northamptonshire Suicide Prevention Strategy

The Director of Public Health gave an update on the refresh of the Suicide Prevention Strategy and highlighted the following:

- As a system there is a requirement to have a local Suicide Prevention Strategy in place.
- In Northamptonshire there is a strong and well attended Suicide Prevention Partnership Board.
- The Chief Executive of Northamptonshire MIND has led the re-freshing of the Suicide Prevention Strategy.
- The work for this strategy falls within the Mental Health, Learning Disability and Autism Collaborative, under the Population Health and Prevention Pillar.
- Public Health Northamptonshire had a dedicated officer that concentrates solely on suicide prevention which is funded by health.
- There is a link from the Prevention and Population Health Pillar to the Children and Young People Collaborative, Healthy Minds, Healthy Brains group.
- The Suicide Prevention Strategy is an all-age strategy,
- There were 5224 deaths attributed to suicide in England and Wales in 2020, and the cost of each suicide is appropriately £1.6 million.
- Those at a higher risk of suicide tend to be men, those with long term mental health problems and within the Eastern European communities.
- In Northamptonshire approximately 6 people commit suicide every year which is under the national average.
- Public Health Northamptonshire works with the coroner to look for trends in communities and method of suicide.
- West Northamptonshire 2018-2020 has a suicide rate of 8;3 per 100000 population,

- There is a lag in Public Health Northamptonshire being able to report the data due to coroner needing to give a verdict of suicide but work with the Coroner's office occurs before the verdict is given.
- Some of the headline achievements since 2017 are:
  - Working in partnership – well attended with the right colleagues in attendance
  - Good at looking at data,
  - Good relationship with the coroner's office
  - Improved information sharing amongst partners and services
  - Improved online information for partners and service users of local services and support
- There is an ongoing audit of suicide cases, where the history of the person is reviewed to see if there was anything that could be done to prevent the suicide.
- Reducing the risk of suicide in key high-risk groups:
  - Training delivered to frontline staff working in secondary care, know how to refer and recognise warning signs.
  - Have secured funding of £180k for additional training and methods.
  - There is a challenge around self harm and the link between self harm and suicide, evidence indicates in 50% of cases there was evidence of self harm. Focus on understanding self harm data and bring in support to address this.
  - Specialist Perinatal Service delivered by NHFT
  - Regional Wave 3 programme funding for prevention of suicide in high-risk groups (middle-aged men), bereavement
  - support and improve secondary mental health services
- Priority areas in refreshed strategy:
  - Reduce the risk of suicide in key high-risk groups
  - Tailor approaches to improve mental health in specific groups
  - Reduce access to means of suicide
  - Provide better information and support to those bereaved or affected by suicide
  - Support the media in delivering sensitive approaches to suicide and suicidal behaviour
  - Support research, data collection and monitoring
  - Reducing rates of self-harm as a key indicator of suicide risk

Resolved that the Board:

a) Endorsed the Northamptonshire Suicide Prevention Strategy 2022-2025 and Action Plan

b) Endorsed the recommendation that the Suicide Prevention Steering Group lead the implementation of strategy, working closely with local partners and communities

c) Endorsed the recommendation that the Mental Health Learning Disability Autism (adults), and Healthy Minds and Healthy Brains (children and young people) Collaboratives maintain strategic oversight of the implementation of strategy

d) Endorsed the recommendation that the Mental Health Learning Disability Autism Executive Board signs of strategy.

28/22 Any Other Business

The Anti Poverty Strategy will come to next meeting.

The Chair advised this is the last meeting for Nick Petford and Jo Watt and thanked them for their service to the Board.

There being no further business the meeting closed at 1.33 pm.

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West Northamptonshire Health and Wellbeing Board Action Log

Action No	Action Point	Allocated to	Progress	Status of Action
070622/01	The detailed spend for individual grants will be circulated to the Board.	Chris Stopford	Awaiting update from Chris Stopford.	

Actions completed since the 7th June 2022

Action No	Action Point	Allocated to	Progress	Status of Action
070622/02	The Prevention Concordat report be circulated to the Board.	Cheryl Bird		Completed

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West Northamptonshire Council

Item no: 07

West Northamptonshire Health and Wellbeing Board
8th September 2022

Report Title	**Better Care Fund Update**	
Report Author	**Stuart Lackenby, Executive Director for Adults, Communities and Wellbeing, stuart.lackenby@westnorthants.gov.uk**	
Contributors/Checkers/Approvers		
Other Director/SME	**Ashley Leduc**	**Assistant Director Commissioning and Performance**

List of Appendices

Appendix 1: Proposed Schemes
Appendix 2: Narrative to support BCF schemes

1. Purpose of Report

1.1. To update the Health and Wellbeing Board on the Better Care Fund (BCF) 2022/23 plan for West Northants including schemes.

2. Executive Summary

2.1 The Better Care Fund (BCF) is one of the government's national vehicles for driving health and social care integration. It requires Integrated Care Boards (ICBs) and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB). These are joint plans for using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006).

2.2 The policy framework, for 2022/23, has not been published yet. As a result, the proposed schemes are in draft form pending confirmation of the national framework criteria for 2022/23. An update will be provided to the Health and Wellbeing Board once the 2022/23 Policy Framework has been published.

2.3 The BCF plan and schemes for 2022/23 has been submitted to comply with the statutory deadline on 1st September 2022.

2.4 North Northamptonshire Council are acting as hosts for the Better Care Fund pooled budget on behalf of both unitary councils. This arrangement is subject to review for 2023/24.

3. Recommendations

3.1 It is recommended that the West Northamptonshire Health and Wellbeing Board:

a) Note that the final approval of the financial plan in conjunction with the Chair/Deputy Chair in consultation with a nominated representative from NHS Northamptonshire Integrated Care Board and West Northamptonshire Council has been agreed as part of the delegated decision making agreed at the previous Health and Wellbeing Board.

b) Note that detailed plans have been submitted to NHS England for moderation.

c) Note that West Northamptonshire Council and North Northamptonshire Council have undertaken a review of the schemes to better align the BCF to the Integrated Care Across Northamptonshire (iCAN) programme and these proposals have been agreed with Northamptonshire Integrated Care Board as set out in recommendation 3.1a above.

d) Note that the mechanism for paying the iCAN delivery partner will be via the BCF pool, however the funding of those payments will need to be matched by corresponding income from constituent partners to pay the delivery partner against agreed milestones.

3.2 **Reason for Recommendations**

3.3 To review the narrative plan and BCF schemes and confirm agreement.

4. Report Background

4.1 **Funding**

4.2 The policy framework is yet to be published. Once published, a further update will be provided to confirm that the proposed schemes and funding are in line with the policy framework.

4.3 For West Northants the total funding for 2022/23 is £50,087,680 (please see Appendix A for the full breakdown).

4.4 **BCF national conditions and metrics for 2022/23**

The national conditions for the BCF in 2022/23 are:

1. a jointly agreed plan between local health and social care commissioners, signed off by the HWB
2. NHS contribution to adult social care to be maintained in line with the uplift to ICB minimum contribution
3. invest in NHS-commissioned out-of-hospital services
4. a plan for improving outcomes for people being discharged from hospital

4.5 **National condition 1:**
A jointly agreed plan between local health and social care commissioners and signed off by the HWB has been completed and submitted.

4.6 **National condition 2:**
NHS contribution to adult social care has been maintained in line with the uplift to ICB minimum contribution.

4.7 **National condition 3:**
Invest in NHS commissioned out-of-hospital services.

4.8 Expenditure plans in appendix 1 show the schemes that are being commissioned from BCF funding sources to support this objective.

4.9 Please see appendix 2 which sets out the approach to delivering this aim locally, and how health and local authority partners will work together to deliver it.

4.10 **National condition 4:**
Plan for improving outcomes for people being discharged from hospital.

4.11 Expenditure plans in appendix 1 show the schemes that are being commissioned from BCF funding sources to support this objective.

4.12 Please see appendix 2 which sets out the approach to delivering this aim locally, and how health and local authority partners will work together to deliver it.

There is a requirement that the joint BCF plan should focus on improvements in the key metrics below:

1. reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days.
2. improving the proportion of people discharged home using data on discharge to their usual place of residence. Further details on measuring discharge are set out in the BCF planning requirements and reflected in the BCF narrative in appendix 2.

4.13 **Metrics**

4.14 Beyond this, areas have flexibility in how the fund is spent over health, care and housing schemes or services, but need to agree ambitions on how this spending will improve performance against the following BCF 2021/22 metrics:

- Discharge Indicator set
- Avoidable admissions to hospital
- Admissions to residential and care homes
- Effectiveness of reablement

4.15 Plans under national condition 4 (discharge) should describe how HWB partners will work with providers to improve outcomes for a range of discharge measures, covering both reductions in the time someone remains in hospital, and effective decision making and integrated community services to maximise a person's independence once they leave hospital.

4.16 Systems have been asked to set expectations for reductions in avoidable admissions (classified as the rate of emergency admissions for ambulatory sensitive conditions) and for metrics related to discharge from quarter 3.

4.17 Further details of this is set out in Appendix 2.

4.18 **Planning and assurance of BCF plans for 2022/23.**

4.19 This plan has been developed locally by the local authority and ICBs. This has been aligned with other strategic documents and plans including those of the ICS and wider programmes such as Ageing Well. The plan has been submitted for moderation to NHSE.

5. Issues and Choices

5.1 As per the delegation from the previous board the discussions with local partners to determine financial allocations was agreed and approved by the Chair of the Health and Wellbeing Board and lead officers from both West Northants Council and the ICB

6. Implications (including financial implications)

6.1 **Resources and Financial**

6.1.1 Please see appendix 1 for the final breakdown of schemes and financial allocation.

6.2 **Legal**

The council constitution makes provision for working groups to undertake activity on behalf of the board.

6.3 **Risk**

6.3.1 None

6.4 **Consultation**

6.4.1 No consultation was required.

6.5 **Consideration by Scrutiny**

6.5.1 This report has not been considered by scrutiny.

6.6 **Climate Impact**

6.6.1 There are no know direct impacts on the climate because of the matters referenced in this report.

6.7 **Community Impact**

6.7.1 There are no distinct populations that are affected because of the matters discussed in this report, however those that access care and health services more frequently than the general population will be impacted more by any improvements associated with activity undertaken.

7. Background Papers

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BCF Planning Template 2022-23

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2022-23. It will be pre-populated with the minimum NHS contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.

2. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

3. Please use the comment boxes alongside to add any specific detail around this additional contribution.

4. If you are pooling any funding carried over from 2021-22 (**i.e. underspends from BCF mandatory contributions**) you should show these on a separate line to the other additional contributions and use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

5. Allocations of the NHS minimum contribution (formerly CCG minimum) are shown as allocations from ICB to the HWB area in question. Mapping of the allocations from former CCGs to HWBs can be found in the BCF allocation spreadsheet on the BCF section of the NHS England Website.

6. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

5. Expenditure (click to go to sheet)

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Conditions 2 and 3 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend under National Condition 3. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2022-23:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2022-23 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2022-23. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2022-23.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2022-23. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2020)
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Exact script used to pull pre-populated data can be found on the BCX along with the methodology used to produce the indicator value:
https://future.nhs.uk/bettercareexchange/viewdocument?docid=142269317&done=DOCCreated1&fid=21058704
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2021-22, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2022-23 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

3. Residential Admissions (RES) planning:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

4. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2022-23 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2022-23 Template

2. Cover

Version 1.0.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2022-23.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.
- Where BCF plans are signed off under a delegated authority it must be reflected in the HWB's governance arrangements.

Health and Wellbeing Board:	West Northamptonshire	
Completed by:	Anna Earnshaw	
E-mail:	Anna.earnshaw@westnorthants.gov.uk	
Contact number:	07766 204789	
Has this plan been signed off by the HWB (or delegated authority) at the time of submission?	No	
If no please indicate when the HWB is expected to sign off the plan:	Thu 08/09/2022	<< Please enter using the format, DD/MM/YYYY
If using a delegated authority, please state who is signing off the BCF plan:	Stuart Lackenby Executive Director for People	

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Cabinet members for Adults Community and Wellbeing
Name:	Cllr Matt Golby

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Matt	Golby	matthew.golby@westnorthants.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Toby	Sanders	toby.sanders1@nhs.net
	Additional ICB(s) contacts if relevant		Jan	Thomas	Jan.thomas@nhs.net
	Local Authority Chief Executive		Anna	Earnshaw	Anna.earnshaw@westnorthants.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Stuart	Lackenby	stuart.lackenby@westnorthants.gov.uk
	Better Care Fund Lead Official		Anna	Earnshaw	Anna.earnshaw@westnorthants.gov.uk
	LA Section 151 Officer		Martin	Henry	martin.henry@westnorthants.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	No
7. Planning Requirements	No

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: West Northamptonshire

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,558,938	£2,558,938	£0
Minimum NHS Contribution	£29,346,053	£29,346,053	£0
iBCF	£10,069,033	£10,069,033	£0
Additional LA Contribution	£1,370,179	£1,370,179	£0
Additional ICB Contribution	£7,098,094	£7,098,094	£0
Total	**£50,442,297**	**£50,442,297**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£8,339,473
Planned spend	£19,048,998

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£7,273,483
Planned spend	£9,285,808

Scheme Types

Assistive Technologies and Equipment	£3,728,780	(7.4%)
Care Act Implementation Related Duties	£609,479	(1.2%)
Carers Services	£776,119	(1.5%)
Community Based Schemes	£14,736,709	(29.2%)
DFG Related Schemes	£2,558,938	(5.1%)
Enablers for Integration	£274,223	(0.5%)
High Impact Change Model for Managing Transfer of C	£2,646,789	(5.2%)
Home Care or Domiciliary Care	£4,339,868	(8.6%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£0	(0.0%)
Bed based intermediate Care Services	£4,806,974	(9.5%)
Reablement in a persons own home	£9,405,866	(18.6%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£1,210,000	(2.4%)
Residential Placements	£5,065,165	(10.0%)
Other	£283,387	(0.6%)
Total	**£50,442,297**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)			

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)			

Residential Admissions

		2020-21 Actual	2022-23 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	321	549

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	78.9%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	No
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2022-23 Template

4. Income

Selected Health and Wellbeing Board: West Northamptonshire

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
West Northamptonshire	£2,558,938
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,558,938**

iBCF Contribution	Contribution
West Northamptonshire	£10,069,033
Total iBCF Contribution	**£10,069,033**

Are any additional LA Contributions being made in 2022-23? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
West Northamptonshire	£1,370,179	Community Equipment
Total Additional Local Authority Contribution	**£1,370,179**	

NHS Minimum Contribution	Contribution
NHS Northamptonshire ICB	£29,346,053
Total NHS Minimum Contribution	**£29,346,053**

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	Yes

Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS Northamptonshire ICB	£7,098,094	ICAN, VHE, P2 Pilot & DTA beds
Total Additional NHS Contribution	**£7,098,094**	
Total NHS Contribution	**£36,444,147**	

	2021-22
Total BCF Pooled Budget	**£50,442,297**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2022-23 Template

5. Expenditure

Selected Health and Wellbeing Board: West Northamptonshire

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,558,938	£2,558,938	£0
Minimum NHS Contribution	£29,346,053	£29,346,053	£0
iBCF	£10,069,033	£10,069,033	£0
Additional LA Contribution	£1,370,179	£1,370,179	£0
Additional NHS Contribution	£7,098,094	£7,098,094	£0
Total	**£50,442,297**	**£50,442,297**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£8,339,473	£19,048,998	£0
Adult Social Care services spend from the minimum ICB allocations	£7,273,483	£9,285,808	£0

>> Link to further guidance

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Carers Support Services (CCG Contract)	This Service provides Carers health support ensuring that they can	Carers Services	Respite services		Other	Northamptonshire Carers	CCG			Private Sector	Minimum NHS Contribution	£374,351	Existing
2	Carers Support Services WNC Contract	Council Contracted Service hosted by North Northants on behalf of	Carers Services	Other	Assessment & Advice services	Other	Northamptonshire Carers	LA			Private Sector	Minimum NHS Contribution	£401,768	Existing
3	Continuing Healthcare	LD Health care at home/CHC/domiciliary care	Community Based Schemes	Multidisciplinary teams that are supporting		Continuing Care		CCG			Private Sector	Minimum NHS Contribution	£9,348,114	Existing
4	Hospital Discharge Programme	Nationally funded programme of services and Interventions reduce	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	Additional NHS Contribution	£659,394	New
5	LD Service Delivery	LD service delivery- community based health support	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£3,978,595	Existing
6	ICAN - community Resillience	Transformation programme - implementation of best	Community Based Schemes	Integrated neighbourhood services		Other	Integrated programme & subject matter	LA			Private Sector	Additional NHS Contribution	£1,410,000	New
7	ICAN - Flow & Grip	transformation of acute hospital patient management and reduce	High Impact Change Model for Managing Transfer	Early Discharge Planning		Other	Integrated programme & subject matter	LA			Private Sector	Additional NHS Contribution	£1,210,000	New

8	ICAN - Frailty, Escalation and Front Door	Transformation to support the development of the	Prevention / Early Intervention	Other	Admission avoidance and same day Care	Other	Integrated programme & subject matter	LA			Private Sector	Additional NHS Contribution	£1,210,000	New
9	Integrated Discharge Teams	Social Care Hospital based teams supporting Integrated Discharge	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum NHS Contribution	£777,395	Existing
10	Specialist Care Centres (SCC) Step and Step Down	Specialist Care Centres (SCCs) x 52 beds with a mix of Nursing	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Local Authority	Minimum NHS Contribution	£2,900,974	New
11	Telecare and Assistive technology	Assistive technology and call lifelines designed to help keep people safe in	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Local Authority	iBCF	£448,000	Existing
12	Intermediate Care Teams (ICT)	Community health reablement team supporting discharge	Reablement in a persons own home	Reablement to support discharge - step down		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£5,064,551	Existing
13	Community Equipment (Health)	Jointing commissioned and funded Health and social care provision of	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Private Sector	Minimum NHS Contribution	£991,901	Existing
14	Community Equipment (Social Care)	Jointing commissioned and funded Health and social care provision of	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Private Sector	Additional LA Contribution	£1,370,179	Existing
15	Community Reablement Team	Team providing reablement support post discharge home or from	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			Local Authority	Minimum NHS Contribution	£2,979,124	Existing
16	Older People's Mental Health / Dementia	Holistic Intermediate Care Team (HICT) service - This is a specialist	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			Local Authority	Minimum NHS Contribution	£285,047	Existing
17	Community Occupational Therapy	Community Occupational Therapy Teams - The	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,077,144	Existing
18	Disabled Facilities Grants	The DFG provides funding through local councils to make	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£2,558,938	Existing
19	Clinical cover for SCCs	GP & Pharmacy cover across the three specialist care centres to	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Local Authority	iBCF	£216,000	Existing
20	Safeguarding (Assurance) Teams	quality and safeguarding team responsible for monitoring the quality of	Care Act Implementation Related Duties	Other	Privider Quality, Advice and improvement	Primary Care		LA			Local Authority	Minimum NHS Contribution	£609,479	Existing
21	Commissioning & Intelligence Capacity	Provision of commissioning capacity and expertise to support	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	Minimum NHS Contribution	£274,223	Existing
22	Demographic and care cost pressures	Ongoing underlying care cost pressures (volume, complexity and cost	Residential Placements	Care home		Social Care		LA			Local Authority	iBCF	£5,065,165	Existing
23	Domiciliary Care	Additional Market Capacity to meet the ongoing additional	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		LA			Local Authority	iBCF	£4,339,868	Existing
24	Virtual Health Enviornment	Technology to support the extenson of Virtual Wards	Assistive Technologies and Equipment	Telecare		Acute		CCG			NHS Acute Provider	Additional NHS Contribution	£918,700	New
15	Pathway 2 Intermedite care pilot	Staffing costs to support pilot for single integrated bedded	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		Joint	30.0%	70.0%	NHS Community Provider	Additional NHS Contribution	£1,690,000	New
16	Contingency	Unallocated	Other		Contingency	Other	Contingency	CCG			CCG	Minimum NHS Contribution	£283,387	Existing

Further guidance for completing Expe

National Conditions 2 & 3

Schemes tagged with the following will count towards th

- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribu

Schemes tagged with the below will count towards the p

- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, o
- **Source of funding** selected as 'Minimum NHS Contribu

2022-23 Revised Scheme types

Number	Scheme type/ services
1	Assistive Technologies and Equipment
2	Care Act Implementation Related Duties
3	Carers Services
4	Community Based Schemes

5	DFG Related Schemes
6	Enablers for Integration
7	High Impact Change Model for Managing Transfer of Care
8	Home Care or Domiciliary Care
9	Housing Related Schemes

10	Integrated Care Planning and Navigation
11	Bed based intermediate Care Services
12	Reablement in a persons own home
13	Personalised Budgeting and Commissioning
14	Personalised Care at Home

15	Prevention / Early Intervention
16	Residential Placements
18	Other

nditure sheet

ıe planned **Adult Social Care services spend** from the NHS min:

ution'

planned **Out of Hospital spend** from the NHS min:

nly the NHS % will contribute)
ution'

Sub type
1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other
1. Carer advice and support 2. Independent Mental Health Advocacy 3. Safeguarding 4. Other
1. Respite Services 2. Other
1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other

1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other
1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other
1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other
1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other

1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other
1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other
1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other
1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other

1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other
1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other

Description
Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'

The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
Provides support in your own home to improve your confidence and ability to live as independently as possible
Various person centred approaches to commissioning and budgeting, including direct payments.
Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of ‘home ward’ for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.

Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: West Northamptonshire

8.1 Avoidable admissions

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population	Indicator value	995	954	1,038	928	it should be noted that the denominator value for our population is incorrect as this still shows the whole county not west northants. This has been reported to Khalid and we are awaiting advice . We are unable to submit the plan figures in the first draft submission as we are still trying to ascertain the correct figures as many of	
	Denominator	757,200	757,200	757,200	757,200		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
(See Guidance)	Indicator value						
	Indicator value						
	Denominator						

>> link to NHS Digital webpage (for more detailed guidance)

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Quarter (%)	94.9%	95.2%	94.7%	93.6%	We are unable to submit the plan figures in the first draft submission as we are still trying to ascertain the correct figures as many of the personnel previously involved have moved on, so it is taking some time to work out what was done last time and replicate it with confidence. we will send a revised template when we have this.	
	Numerator	7,908	7,699	7,370	6,493		
	Denominator	8,329	8,083	7,781	6,937		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
(SUS data - available on the Better Care Exchange)	Quarter (%)						
	Numerator						
	Denominator						

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	320.5	936.3	432.6	549.0	'2021-22 estimated' estimated figures on the planning template based on our SALT returns population figures not the BCF ones. The figure for 8.4 (cell H48)has been adjusted due to the slight difference in population used for SALT and those built	we continue to focus on pathway 1 and 2 as the preferred options with the best outcomes for patients. Recent years have proved challenging though with a high incidence of hospitals discharging to care homnes and D2A places and the council
	Numerator	443	699	323	418		
	Denominator	138,216	74,657	74,657	76,142		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	73.9%	79.2%	83.8%	78.9%	Analysis was carried out but due to the erratic nature of this indictors monthly/quarterly % the forecasting used that relies on prior months/quarters figures creates a forecast that's very different to the prior year SALT return final	Our ambition based on the ICAN work to re-egineer and redesign pathways 1 and 2 is that 85% to 90% of people are still at home after 91 days, but this is currently challenging as flow in pathway 1 has been slowed by a lack of step down capacity and
	Numerator	420	240	119	116		
	Denominator	568	303	142	147		

Please note that due to the demerging of Northamptonshire, information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

Better Care Fund 2022-23 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: West Northamptonshire

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between ICB(s) and LA; been submitted? Has the HWB approved the plan/delegated approval? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	No	All local partners and stakeholders leisted have been involved in the development of the plan and are engaged in all the ICAN work and programme as shown in page 1 of the narrative plan.		THE West Northants HWBB meeeting is on 8th September where the draft plan and expenditure will be approved.
	PR2	**A clear narrative for the integration of health and social care**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally • The approach to collaborative commissioning • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these. The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.	Narrative plan	Yes			
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes			
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution?**	Does the total spend from the NHS minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Implementing the BCF policy objectives	PR6	**Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?**	Does the plan include an agreed approach for meeting the two BCF policy objectives: - Enable people to stay well, safe and independent at home for longer and - Provide the right care in the right place at the right time? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? •Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided? • Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care? • Does the plan include actions going forward to improve performance against the HICM?	Narrative plan Expenditure tab C&D template and narrative Narrative plan Narrative template	Yes	see page 10 of the narrative plan and demand and capacity template		

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 31 – 43 of Planning Requirements) (tick-box) • Has the area included a description of how BCF funding is being used to support unpaid carers? • Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plan Narrative plans, expenditure tab and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching ambitions been agreed locally for all BCF metrics? • Is there a clear narrative for each metric setting out: - the rationale for the ambition set, and - the local plan to meet this ambition?	Metrics tab	Yes	We have been as ambitious on residential admissions given the past challenges we faced with an over reliance on bedded solutions post COVID and that we have less hospital		

Department of Health & Social Care | Department for Levelling Up, Housing & Communities | Local Government Association | NHS England

1. Health and Wellbeing Board(s)

West Northants Council

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

- West Northants Council Adults Services
- Northamptonshire ICB
- Northamptonshire Health Foundation Trust (NHFT)
- Northamptonshire Universities Group Hospital
- ICAN Patient Advisory Group – Voluntary sector and patient Group (including Healthwatch)
- West Northants Community and Opportunities (Housing services, DFG services, care and repair)

2. How have you gone about involving these stakeholders?

The BCF plan 2022-23 and ambitions for 2023-24 have been discussed, developed, and agreed through our shared joint weekly health and care Chief Executives group, Chief Operating Officers group and as part of extensive conversation across all the stakeholders listed above as part of the ongoing work that our ICS is doing on its development of collaboratives.

One of these ICS collaboratives is the ICAN (integrated Care Across Northamptonshire) which is overseeing all our transformation work on all of our BCF out of hospital services and to improve our performance in relation to BCF metrics and national conditions. Within the ICAN BCF activities we are bringing services together across our community partners, primary care, hospitals front and back door activity and intermediate care services to make major improvements in outcomes, flow and efficiency. These have all been redesigned with a focus on keeping **more people well at home for longer and ensuring over 65s get the right care in the right place**, aims aligned to the BCF national objectives.

The ICAN BCF programme and budgets are overseen by joint health and care governance arrangements with all of the above partners engaged in monthly boards, weekly reviews and regular reporting to the ICB, HWBB and executives of all the partners listed. The programme is also working towards major improvement in KPIs across admission avoidance, reduced scalations, length of stay reduction, improved longer term outcomes and financial benefits, which are reported monthly and reviewed bi-monthly in a gateway review meeting attended system Directors of Finance and by NHSEI.

3. Executive summary

Priorities for 2022-23 & Key changes since previous BCF plan

Our main objective in 2022-23 is to build on the transformation work done in 2021-22 and progress our integrated out of hospital delivery Model, described later in this plan. This will mean bringing together health and care and voluntary services, resources, assets and BCF and other funding sources into a single collaborative working within a single integrated delivery structure. In 2022-23 we continue to work towards this design through our ICAN programme which is targeting key improvement and transformation as well as formalising collaborative arrangements with delegated budgets and single outcomes contract for delivery. We have targeted several key and specific improvements in the over 65s cohort as part of ICAN BCF schemes and these are

- Reducing unplanned hospital admissions
- Reducing escalations to Acute care
- Reducing length of stay in Acute hospitals including reductions in patients with no reason to reside and stranded patients
- Reducing the Length of stay in community hospitals and rehab
- Improving our community offer & intermediate care
- Reducing the reliance on and use of long-term Care
- Delivering significant finance benefits to the system

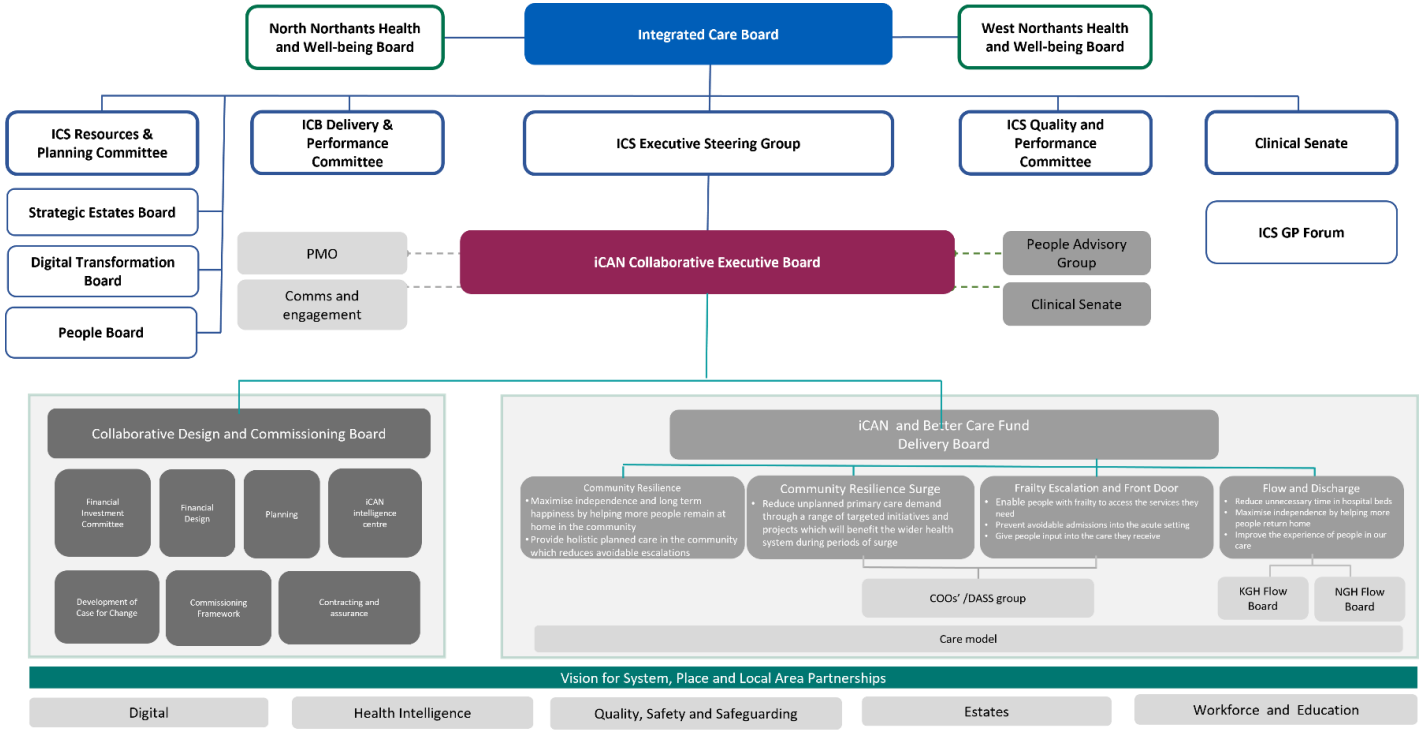
We are targeting over 65s within the BCF and ICAN and these specific improvements are designed to help us address our challenging demographic. Overall, the 2021 census showed that West Northants grew by 13% against a national average growth of 6%. But in the over 75s, West Northants saw growth of 58% compared to 37% nationally. Frailty increases with age, therefore having more people over 75 creates a disproportionate demand for support services.

We agreed as system that this cohort should be a priority for ICAN BCF schemes in order to mitigate the potential impacts of this growth on both cost and the quality and safety of care. While ICAN is a five-year programme we expect to make a significant difference against these priorities through these new ways of working and BCF schemes. The baseline we have and the improvements and changes we expect to see are summarised above.

While we are looking to bring in some additional services (like district nursing) into the 2023-24 BCF to align to our plans and remove some schemes (like mental health) where they are better aligned to other collaboratives, the BCF schemes for 2022-23 remain unchanged.

4. Governance

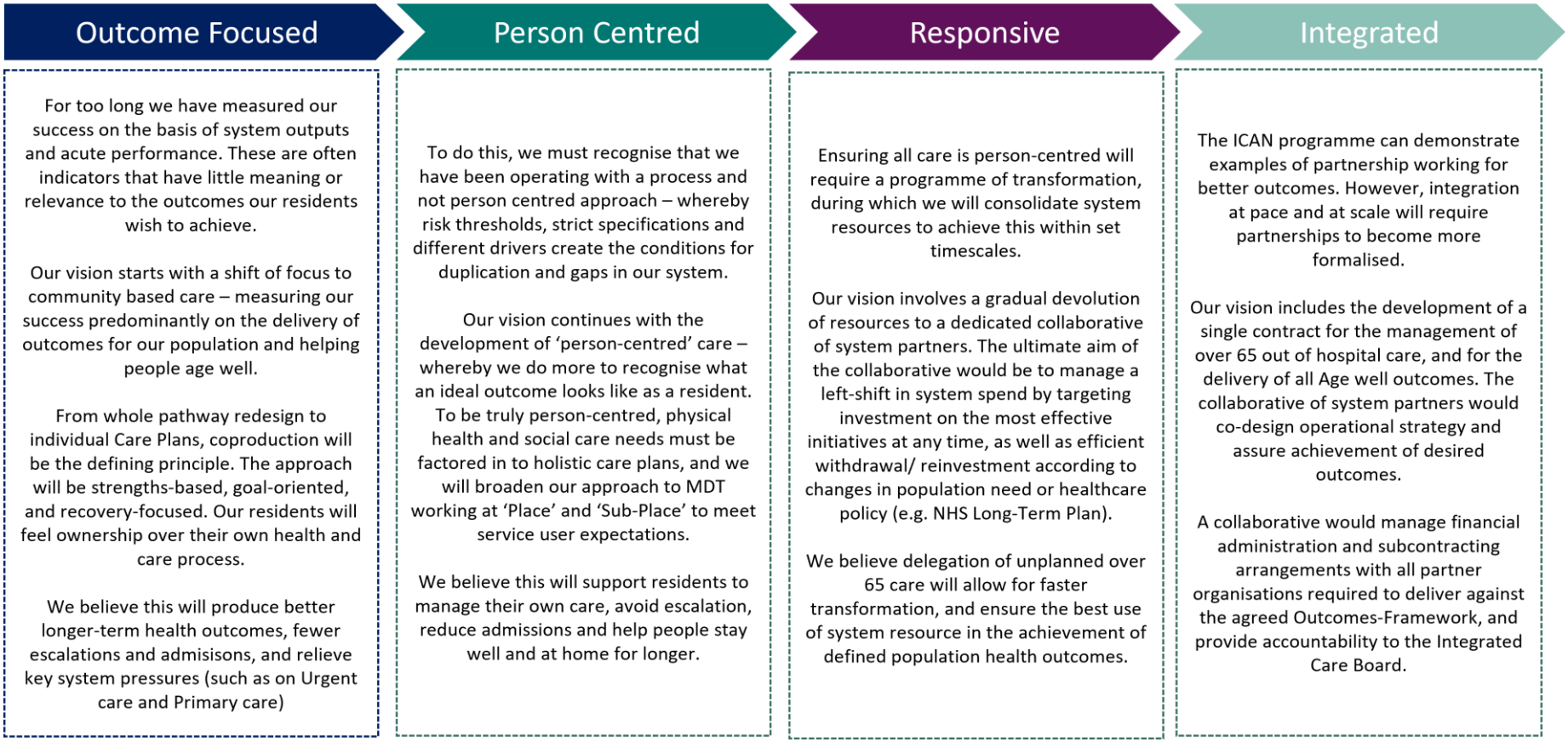
To deliver our ambitions, we have put in place the governance structure below that helps us oversee the BCF ICAN performance metrics and deliverables while also helping us transition ICAN from a transformation programme to an integrated service delivery model within a collaborative. This governance forms part of the ICB governance structures and ensures that the BCF performance is monitored via the ICS Planning and Resources Committee (for BCF finances) and through the Delivery & performance Committee (in terms of service delivery and BCF metrics)



5. Overall BCF plan and approach to integration

5.1 Outline of Joint priorities for 2022-23

Our priorities for 2022-23 builds on our work in 2021-22 and supports an overall move to more outcome focused and person-centred services that are both responsive and integrated. While we have immediate and significant challenges to reduce the occupancy levels in our Acute Hospitals and improve timely discharge, our ICAB BCF schemes are focused on a left shift of care to community-based care and away from increasing unplanned care. The changes we are making, the reason for those changes and the outcomes we are seeking are described below and involve moving to a truly integrated community offer.



The priorities for our 2022-23 ICAN BCF transformation programme funded through the PCF are:

Reducing unplanned hospital admissions & escalations to Acute care by left shifting to more care in the community:

- **Community Resilience** - We are continuing to expand our work within the community through the use of community MDTs combining community health, social care, the voluntary sector and GP Age well teams to help people manage long term conditions and reduce the risks associated with frailty (for example falls). We now have frailty leads in all PCNs and are undertaking comprehensive care plan reviews using the MDTs and working with patients, carers and professionals to proactively prevent and mitigate the risks of frailty. Our work includes befriending services to reduce isolation, memory clinics and preventative support like balance classes (see further detail below). Multi-disciplinary and voluntary sector Welfare teams are also in place to support people stay well or follow up after a crisis or hospital visit and avoid readmissions.

"My mum would have ended up in a care home if it wasn't for her extended GP review" – Daughter of person who had a GP-led review

- **Remote Monitoring** – One our iCAN BCF objectives is to help older people stay well in the community, and remote monitoring will enable earlier identification of changes in presentation which could indicate an emerging issue. we have increased the level of remote monitoring instances both through the Virtual Ward programme for respiratory illness but also in peoples own homes. We have put in place the first large scale joint remote monitoring hub with combined council and nursing staff using an array of equipment to keep people safe. This project has introduced equipment to do the monitoring of patients' clinical observations and well-being remotely, by a team of senior clinicians. They then monitor and respond to the data that the equipment is feeding back. The Virtual Clinical Care Team is operating from 8am to 8pm daily and has the ability to respond within two hours to any significant abnormal data the system receives given clinical advice and guidance to manage the situation within the community.

- **Emergency Community Response** – our new Rapid Response pathways seek to increase the number of people using Rapid Response rather than attending hospital. As well as the success we have had in the community with an average of 35 referrals a day and 80% of calls needing a 2-hour response meeting targets, we are also now taking calls from the EMAS stack directly and from 111 more recently. At maximum throughput, this trajectory expects 6 additional EMAS referrals per day and 2 additional 111 referrals per day. One example of our successes is that 90% of long-wait fallers have already been supported to stay at home and the new pathway has saved an estimated 8.5 days of time where people would have been waiting on the floor.

Our first EMAS referral saved someone from waiting on the floor for 9 hours and inevitably avoided an attendance to hospital

Reduced admissions as a result Frailty Escalation clinics and Front Door screening:

- **Frailty Units and Same Day Emergency Care** - our aim is to create a high performing and specialised team at the front door of our hospitals to support frail people to go home rather than be admitted into hospital. Both Hospitals now have frailty units in place with skilled teams who seek to screen, assess, and then discharge (with support if needed) and reduce the need to admit unnecessarily. It aims to discharge home 78% of patients referred. Despite a slow start with COVID the scheme is now meeting its target for referrals.

Reducing Length of Stay In hospital through our flow and Grip work with:

Great feedback from the clinical director for medicine: "We have seen improvement on this, it's working well... we're empowering the ward sisters "

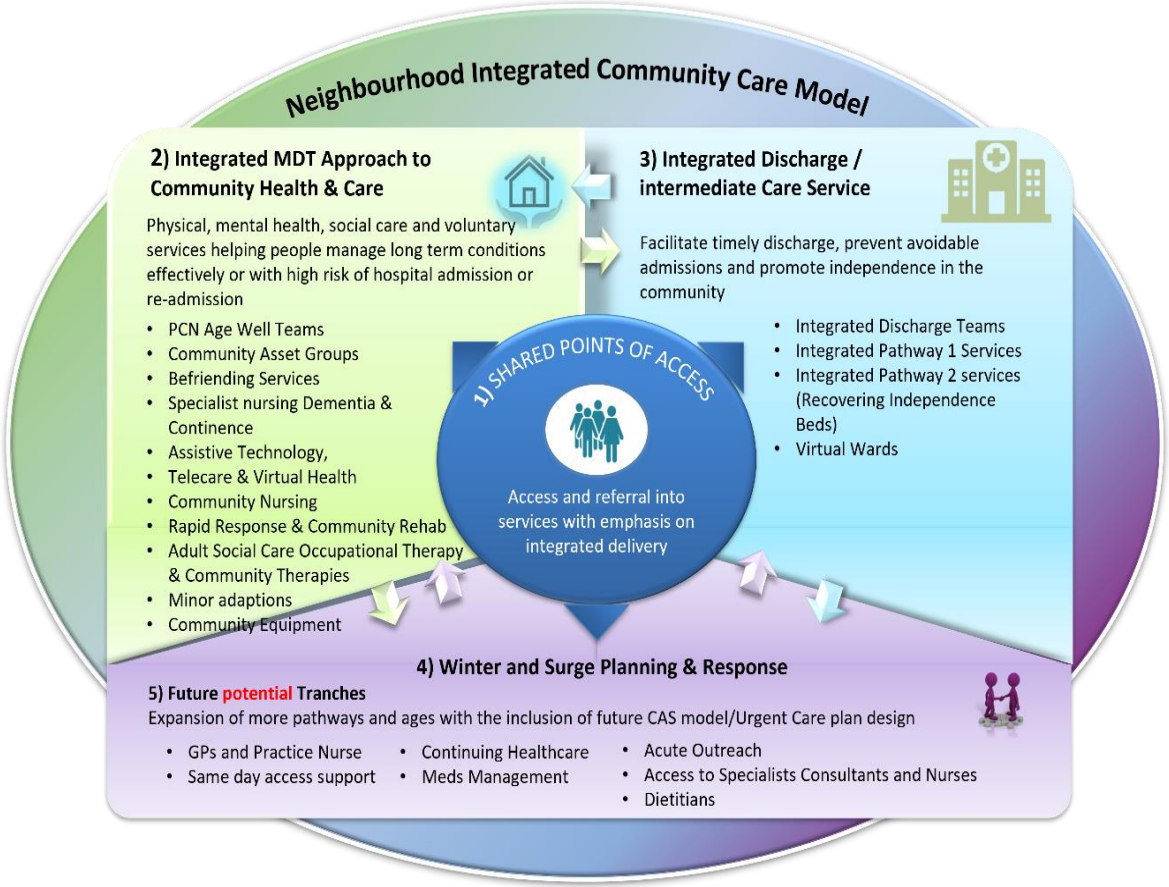
- **Board Rounds & Timely discharges -** Adopting new processes such as board rounds based on discharge best practice to enable a smooth and speedy flow through the hospital for our patients. The work here includes the development of an integrated Discharge Hub, improved early discharge expectations and a sustained focus on home first pathways.
- **Improved timeliness of diagnostics and use of community IV solutions –** past assessments have shown we over-use some diagnostic tests and delays occur when people wait for tests and during which time they decondition. We are now maximising the utilisation of all diagnostic systems and are now sending more people home with oral antibiotics or community IV rather than relying, as we have in the past, on hospital based IV solutions.
- **Trusted Assessments -** New forms are now being used in all wards replacing our PDNA forms that were over prescriptive and did not always represent the patient causing issues with Trusted assessments – the new 'What Matters to Me' focus creates a strength based, home first focus on all patients so they don't stay in hospitals when they no longer need acute care.

5.2 Approaches to joint/collaborative commissioning

The ICAN BCF programme and services are jointly commissioned by health and care and ICAN is one of the four Northamptonshire ICS priorities and collaboratives being developed. Investment in the ICAN BCF improvement programme has been provided by all partners and is monitored through the ICB governance arrangements. The ICAN collaborative will see all the services shown in the operating model below (funded by the BCF) placed into a formal collaborative in 2023-24 and we are acting in a shadow form currently. The ICAN BCF collaborative has just received ICB approval of its vision, scope and planned operating model and during the second half of 2022-23 we will be formulating and agreeing via the ICB, the outcome based collaborative contract

we will work to, with agreed KPIs and incentives for improvement and the final delegated budgets to be included. Delivery of out of hospital ICAN BCF services will be undertaken through a formally commissioned alliance contract covering services provided by the local authority, community health partner, Primary care age well teams and the voluntary sector.

The operating model for our collaborative will build on our ICAN BCF work to date with tranche 1 including all the services detailed in sections 1 to 4 of the diagram opposite to:



- **create formal commisioned integrated structures** and shared ownership of pathways
- **develop more trusted assessor approaches** with shared referral points in hospitals and from the community
- **operate an integrated intermediate care model** with Pathway 1 and Pathway 2 services with shared SLAs, less hand-offs and shared outcomes
- **increase avoided escalations to hospitals** with step up services to be developed working with GPs
- **develop a flexible shared workforces** that can respond to surges/Winter using data to inform joint interventions
- **expand ICAN pilots and integrate more prevention and wellbeing services** that can help avoid escalation for e.g. falls, supporting independence
- **work within the Neighbourhoods** and emerging Local Area Partnerships of our ICPs to join up wider services that effect the wider determinants of health and help prevent escalation, reduce unplanned care and improve population health outcomes.

5.3 BCF support for integration and changes to services commissioning through the BCF from 2022-23.

The new shared remote monitoring hub

The hub went live in 2022-23 we have implemented a centralised monitoring hub that combines the existing response service provided by the local authority, monitoring lifeline responses and people with other assistive technology devices with the development of the use of telehealth across the county. This hub provides preventative and proactive engagement and response to people with low level assistive technology through to clinical decision making based on proactive monitoring of clinical data that people are providing from home.

We have rolled out the monitoring of telehealth in a number of care homes. The data is inputted by the staff from the care home and clinical team analyse the data, give advice and if necessary, seek further clinical input. The main objectives are to reduce GP input, admissions to hospital and to identify at the earliest opportunity any changes in clinical presentation to enable proactive intervention. Over the next 6 months the next areas of implementation are:-

- Virtual ICT ward of 20 patients. These are identified as having previous multiple admissions and re admissions to an acute setting.
- 600 people living in the community that are identified by GP's as having conditions/co morbidities that could be better monitored by telehealth equipment and the hub
- Utilising the hub team to proactively call all lifeline customers to identify where additional preventative support is required. This will be linked to the welfare teams in PCN's and the leads for the frailty clinics.
- Working with the MHLDA collaborative to see if the use of telehealth can improve health checks for people with an LD

Currently the service provides monitoring support to 5481 people plus the care homes monitored through telehealth.

Redesigned intermediate care - pathway 1 services

Our ICAN BCF reablement services have faced significant challenges with demand and available capacity not aligned and as a result we have seen blocks in acute discharges and an overreliance on bed-based solutions that don't offer the optimum outcome for patients. The home care market challenges also effect the exit routes from Pathway 1. In 2022-23 the ICAN programme has been targeting significant improvements in performance and integration across the BCF pathway 1 services including working on local footprints to improve ICT/Reablement co-ordination and local improvement cycles to improve

capacity, the operating model and shift patterns of the workforce, process/Patient journey improvement and a harmonisation of ways of working – e.g., potential in assessment processes and on-going visit co-ordination / MDTs. During 2022-23 we ae specifically targeting:

- Capacity Improvement: Working through contracting and scheduling to align workforce to demand (see West reablement schedule variation right). Redesigned model in Reablement West would see weekly hours of care delivered increase from 491 to c. 1200.
- Length of Stay: Keeping a grip on length of stay and reducing days spent in service once optimised awaiting on-going packages of care – particularly a risk if taking more complex individuals into the services.

New redesigned intermediate care - pathway 2 Pilot.

This ICAN BCF pilot aims to improve Pathway 2 step down service availability, supporting patients to be discharged promptly to the right intermediate care, and with the right wrap-around support to achieve their ideal long-term outcomes. We are moving towards a single integrated bed base of around 140 beds across the community hospitals, West Northants "Thackley Green" specialist care centre (SCC) and additional therapy based beds being set up in North Northants . We are calling these "**Recovering Independence Beds**" (RIB) because our focus will be to return people home. They will be overseen by a single management team led by our community health partners NHFT and will be staffed by joint health and care teams with a single point of access across the locations. The key elements of our model will be:

- **Single Point of Access** for referrals, with admissions seven days a week
- **Joint staffing model** of nursing, therapy and support staff allows flexibility of support around people as their levels of independence increase
- **Multi-disciplinary working** with joint plans, improving outcomes and reducing handovers and delays
- **Goals-based therapy focus**, allowing people to step out from RIBs at the appropriate point for them, not based on standard time periods
- **A culture of holistic support targeted at Recovering Independence**, with all staff members supporting the rehabilitation and recovery process
- **Beginning discharge planning from Day 1**, helping to reduce delays vs current settings
- Specialist Care Centre (SCC) sites include units with secure access, which is ideal for those with acute confusion/delirium
- Several rooms set up as individual flats –helping people achieve independence better than traditional hospital settings

We believe this will increase availability and flexibility of bed base and overcome the past challenges of underutilisation and blocks as the bed base available didn't exactly match the patients ready for discharge. We will also be targeting Length of stay improvements and P1/on-going care availability with smooth transitions.

Who would the Integrated sites support?

- **Medical/Nursing needs** - Those individuals who are undergoing reablement/rehabilitation but also have medical needs requiring nursing support. These patients would typically currently be supported in community hospitals (or some Nursing bed discharges e.g.. CHC pathways).
- **Residential Rehabilitation** - Those individuals who are undergoing reablement/rehabilitation who are not yet able to return home. These people are currently served by both community hospitals, SCCs and D2A residential beds.

Nursing and rehab cohorts would form most RIB bed patients – both cohorts could include step-up access as well as hospital discharges and potentially dementia and delirium patients. The pilot will run from September 2022 to March 2023 and will be closely monitored against range of KPIs including referrals, length of stay and returns home. The longer-term business case and funding model will be reviewed while the pilot is running and if successful the new model is likely to form part of ICAN BCF collaborative services in 2023-24.

6. Implementing the BCF Policy Objectives (national condition four)

6.1 Enable people to stay well, safe and independent at home for longer/Steps to personalise care, deliver asset-based approaches

In Northamptonshire we have implemented a holistic, strengths-based approach to creating care and support plans through the ICAN BCF and Age well plans. These are centred on 'what matters to me' principle rather than a traditional, often health led, 'what is the matter with me' desktop MDT approach. By placing the person at the centre, goals are created which are meaningful and achievable for the individual and their support network. We have adopted the 'no discussion or decision about me without me' core value from mental health and have embedded this into all our Ageing Well work.

Patient testimonial from our asset groups: "In the past if I go to bed and do not wake up then it's okay really, now I have hope. The MDT was such a relief because someone cared. Now I go to be with a smile on my face"

We utilise the framework of the Ardens Frailty Template but tailored for the individual situation; recognising that not every older person requires a full geriatric assessment but, by engaging with our population earlier in their ageing journey, we build a richness of shared information with the person. The baseline created enabled us to measure outcomes and changes in need over time. Our two key outcomes are improvement in person's self-reported wellbeing and how long their frailty level can be maintained at current (or better) level.

The power of social inclusion and peer support, especially amongst those with shared lived experience (person and carer), is recognised in Northamptonshire. Using our 2017 award winning community asset programme for people with COPD (Breathing Space) we have extended this to provide asset groups for Heart Failure, Diabetes and Dementia. These are all facilitated and run by our Voluntary Sector partners with specialist input and masterclasses provided on a rolling basis by a range of professional health, care and specialist advisors e.g. Financial Advisors, Bereavement Counsellors etc. Feedback from those attending and the staff delivering continues to be excellent reinforcing the oft heard view that small things make a massive difference to a person's wellbeing. "it's great to feel I am not alone and there are others just like me".

We have supplemented this with targeted strength and balance, fitness classes for those with frailty and / or cognitive impairment, identifying a gap in provision. These operate on a 'screen-in' rather than 'screen-out' attendance approach.

It is our 2023/2024 ambition that every older person will have the opportunity to choose to, and the wherewithal to physically attend, an asset-based support group within their local area (five to seven miles).

6.2 implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care

Whilst the themes we hear through coproduction are consistent around what good looks and feels like to age well, we know that the bespoke solutions are required to meet the diverse spread of the people we serve. Asset groups in town centre venues well serviced by public and voluntary transport are great but do not provide a viable option for the many older persons living in our rural areas where pop-up or rotating session programmes work better. We also ensure a choice in mix of face to face and on-line group support.

Our West Northamptonshire Public Health Team have, with the support of Optum this year, established learning sets helping us to use triangulated multi partner data sources to ensure our offers are both meeting identified need but are also engaging with all of our communities. As an example of this we chose to launch our Heart Failure Asset Group in Daventry this year as this was identified from our PHM analysis as a PCN with high ratio of older person registered population living with heart failure.

We work with our partners across all of our BAME and Protected Characteristic groups to ensure that solutions are meaningful. This can be fostering wider community integration e.g., having an older person fitness class for all delivered from a local Hindu Association Temple complex or by employing, through partnership with our Black Communities Together Group, staff who are recognised by communities and able to engage in first language where this isn't English as we are currently doing with our pathfinder work to support our Older Asian Communities in Northampton.

We review all of our activity data to test whether use of our new solutions is reflective of the population served e.g. are we seeing an expected share of persons from BAME communities in our GP Led Extended Review Clinics and our Group programmes and is their experience and outcomes comparable. Using our GP list demographic, we can triangulate and where a shortfall is identified we work with community groups and leaders to coproduce solutions.

Within our iCAN partnership team we have leaders from our LGBTQIA communities providing conduits for coproduction in the design and development of our Ageing Well Programme.

For 2023/2024 a priority focus for us is through our partnerships with Alzheimer's Society and Dementia UK to develop our support offer for persons with cognitive impairment associated with age, recognising the lower volume of persons from minority communities seeking timely help. Working with families to change our dialogue and our content where Dementia is not a recognised term or condition and helping to remove stigma will be essential as we know that early support can massively improve outcomes for many years, significantly reducing demand for long term care services.

Our ICAN BCF schemes and funding are supporting the rollout of new models of care and our June 2022 update showed that

- 128 patients had extended GP led reviews – with 854 patients cumulatively seen since we commenced the programme
- 14 of 16 of our PCNs are now delivering patient present multi-disciplinary team reviews of care plans
- A further 370 patients are now supported by PCN Age Well teams
- Attendance at community asset groups continues to grow, supported by roll out of Memory Hubs

6.3 multidisciplinary teams at place or neighbourhood level.

In 2018 we created our first PCN Integrated Age Well Team comprising team members from voluntary sector (Northants Carers, Age UK, Alzheimer's Society), Adult Social Care, Community Health and Primary Care. All staff, regardless of which organisation they are employed by, work under the day to day leadership of their team lead employed by the PCN and have same core training and skills development e.g. all can take basic patient observations, assess for, order and supply low level equipment, complete PQ9 and GAD mental health assessments, provide advice on benefits, attendance allowance etc

but most importantly all have been empowered to work with the individual person to sort what matters to them at that moment. The teams are able to fulfil the tasks that often fall into the gaps of someone's responsibility, but nobody knows whose.

During 2021 /2022 we have expanded to create eleven PCN Age Well Teams covering all sixteen of our PCNs. Age Well Teams cover circa 70,000 GP list size which is around 14,000 persons over 65 for each team.

Through our partnership ICAN BCF programme we have now secured a dedicated Frailty GP Lead(s) for every Age Well Team, supported by the PCN Pharmacist, Advanced Nurse Practitioner and other specialists including social care as needed are able to provide extended GP led reviews, the majority of which take pace in person's own home through Microsoft TEAMs call with the Age Well Coordinator being with the person. Our learning to date is that around 25% of new referrals require the extended clinical team input. Our Adult Social Care (AEW) team members are linked to their local ASC Teams and are able to identify from duty lists and low-level safeguarding concerns received, persons who would benefit from the Age Well Team input.

The Age Well Team approach adopted is of warm transfer and never cold onward referrals to another service which avoids leaving the person confused on what will happen next and unsupported.

All Age Well staff are trained and provided with NHS laptops and smartphones enabling them to directly update the person's health record providing the GP and primary care team with much greater awareness of the holistic person, their living circumstances, areas of confidence, causes of concern but also ensuring through our digital interoperability solutions that this same level of information is visible to those responding to the person at point of crisis or escalation.

Our 2022 /2023 priority is to extend the capacity of the team; at present there is limited resilience as no cover for leave or unplanned sickness and the volume of referrals is increasing and to further embed remote monitoring and assistive technology as core tools to aid independence and confidence of the person / carer.

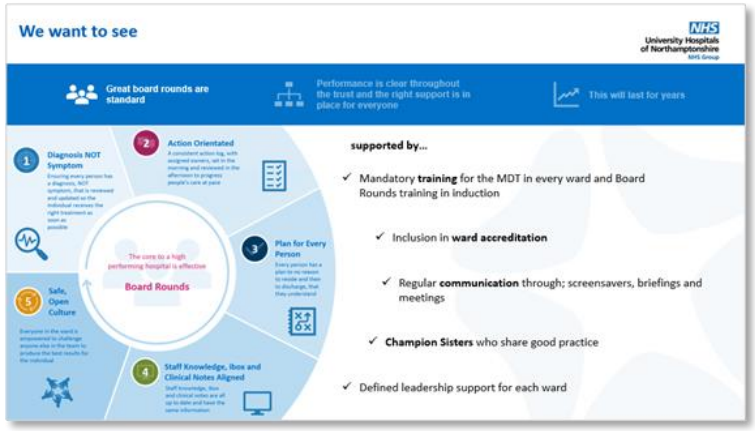
We are already seeing several of our PCNs moving to the next level of integration with their Care Home Coordinators attending shared team meetings with the Age Well staff and in some cases people with dual roles supporting people in their own home and a care home in their area. By having Age Well staff it has supported the PCNs to focus their Social Prescriber capacity onto those persons under 65.

Our learning has been shared with the NHSE/I team nationally leading on Anticipatory Care and has helped to inform the scope and ambition of the eagerly awaited Anticipatory Care Specification.

As part of the development of our Integrated Care Partnerships (ICPs) we are creating 9 local Area Partnerships (LAPs) across West Northants. These LAPs will be based on populations of between 30,000 – 50,000 and will be small enough to provide personal care through integrated neighbourhood teams, but big enough to make sure residents can use the range of services they need. Each LAP will provide support to neighbourhood teams by aligning additional services often related to health and wellbeing to the neighbourhood teams, this includes housing, debt advice, mental health services and leisure services.

Provide the right care in the right place at the right time

6.4 Support safe and timely discharge



As set out in section 5.1, we have made improvements across our discharge processes starting with the target that all patients will receive a letter on admission about their expected discharge expectations. In addition, we have moved to a best practice model of 'What Matters to Me' when discussing expectations with patients. This creates a strength based, home first focus on all patients so they don't stay in hospitals when they no longer need acute care

The ward referral and transfer of care hub processes to improve the speed of the discharge decision making processes. Most of our delays in discharge queues, for both bedded and home-based intermediate care, are either when patients are waiting for capacity to become available, or when a patient becomes not medically fit, but the referral process is kept open. As far as possible we try to avoid moving people to other bedded settings purely while they wait for the appropriate pathway to be available. Reducing the need for this is one of the raesns we have redesigned pathway 1 and 2 services as set out in section 5.3 abive to ensure that there is a graeter likelihood of people returning home and/or to independence.

Going forwards, we are improving the visibility of queues and wait times for each pathway, using data from both Transfer of Care Hubs and the Pathway Services. This will enable targeted continuous improvement and data-led decisions on capacity, and when to e.g., use spot purchase or alternative pathways as the best option to maintain hospital flow. We will continue to try to improve referral to discharge time, which will be most impacted by capacity improvements in services.

We can confirm that our approach addresses all the key criteria set out in the High Impact Change Model. The one area of the model where we require further work and workforce development is the **seven-day working, weekend working and extended hours for services across health and social care can deliver improved flow of people through the system**

6.5 Collaborative commissioning of discharge services to support this.

ICAN is an ICS system wide commissioned, funded and resourced programme supporting ageing well and admission avoidance but also timely discharges based on home first principles (where possible) and joint health, care and VCS "Welfare teams" who follow up on discharges to ensure we reduce the likelihood of readmissions. As set out in section 5.1 to 5.3 above this incudes jointly commissioned new intermediate care services using shared resources including:

Pathway 1 capacity – the council reablement service is currently undergoing significant HR and scheduling changes to improve the capacity of the service from providing c. 500 hours per week to a targeted 1100 hours. This increase will both cover the capacity currently delivered by the H2H service which was covered by D2A/ temporary funding, and then provide further starts capacity on top – aiming for the service to be able to move from c. 67 starts to c. 122 starts per month.

Pathway 2 model – Collaboration between NHFT and the two councils to pilot a new integrated care model in pathway 2 across 102 Recovering Independence Beds (RIBs) in the system over Winter. This would see a broader spectrum of staffing and people utilise the RIB beds, and with the right culture and holistic support to enable more people to return home and maximise their independence. Community Hospitals are also working on length of stay improvements to drive more capacity and starts per month – aiming for c. 10% improvement in length of stay through reducing equipment delays and implementing more goals-based discharge approaches.

7. Supporting unpaid carers.

As a system Health and Care invest over £1m of our BCF funding annually in Northamptonshire carers as the main provider of Care Act Carers assessments, support and advice for carers, respite breaks for both adult and child carers and wider services to help support unpaid carers in their key role. One in ten people on Northamptonshire is a Carer or Young Carer and they care for over another tenth of the population. We have commissioned services that seek to ensure carers are recognised and valued and that they can access the right support/advice/information at the right time, that they can enjoy a life outside their caring role and that carers own health and wellbeing is a priority

We aim achieve this by providing high quality, easily accessible information, advice and support which is timely and appropriate, delivering a range of preventative services that will delay, prevent or reduce the need for more intensive support for Carers and carrying out quality statutory Carers assessments to identify eligible support needs and a support plan that enables the Carer to maintain their caring role on a long term basis as required

Ensuring feedback is sought from Carers which is independent, impartial and meaningful is important to us and from the outset of the ICAN transformation that we engaged the view of patients and carers in our design and the development of our offer.

The PAG (patient Advisory Group) is led by No9rthamptonshire carers and gives the people group (including those who will benefit from the use of services or who care for people who use them) oversight of the developments that occur within the iCAN programme. Meeting monthly, the PAG also promotes, aids and helps to develop co-production of services. Membership is formed of patients, carers and service users, and includes key professionals and service leads will also on occasion be invited to present to, or update the group on key issues.

8. Disabled Facilities Grant (DFG) and wider services

The BCF DFG plans and approaches within the plan has been agreed by West Northants Council as a Housing Authority and brings together Housing, DFGs, occupational therapy and social care come to ensure that DFG funding is used effectively to help people stay I their own homes longer. From a housing and accommodation perspective our health, care and housing leads have worked together to increase the capacity we have across the county that can support independent living through several lenses. Our occupational therapy teams are now working alongside the housing DFG teams as part of plans to invest in improving accommodation earlier, removing waiting lists and considering more significant conversions that can support complex care and be used by future residents. While we saw backlogs for adaptions in 2021-22 we have cleared this and we are now utilising all of our budgets. We have also introduced some new elements of service including:

- Introducing a fast-track process
- Removing financial assessments for Disabled Facilities Grants under £5,000
- Maintaining a register of accessible homes for people to move into
- Introducing a new service to make minor repairs and
- Continuing our care and repair service to support discharges

We are working together with health across a range of housing services to ensure that people can remain independent longer, these include

- Extra Care – we have several extra care facilities supporting older people to stay independent and the CCG are also commissioning some of the flats as facilities for complex medical rehabilitation and step down for non-weight bearing patients leaving hospital.
- Supported living We have opened our first Learning disabled supported living village "Oak Rise" in 2021 which is based on a national best practice model and is jointly funding through the CCG and Councils to provide a community supported living facility for some of our most complex shared patients. This helps them remain independent and out of residential and hospital care for longer and live the best life they can, protected by on site care staff.
- Specialist living - We opened our community based complex Mental Health and Physical disability supported living facility, Morray Lodge in 2021 This has 20 flats equipped with assistive technology and equipment and provides a level of independence with on site specialist support and is our first shared step down facility for decades for these cohorts.

9. Equality and health inequalities

Since 2021-22 we have been working as a system on developing our population health outcome framework. This is designed to help us gauge the effects of interventions accurately and rapidly, and at a range of different population levels, allowing the tailoring of interventions and incentives to deliver both the highest impact and best use of resources. The main aims of the framework will be to Improve the health and wellbeing of the population and address health and care inequalities.

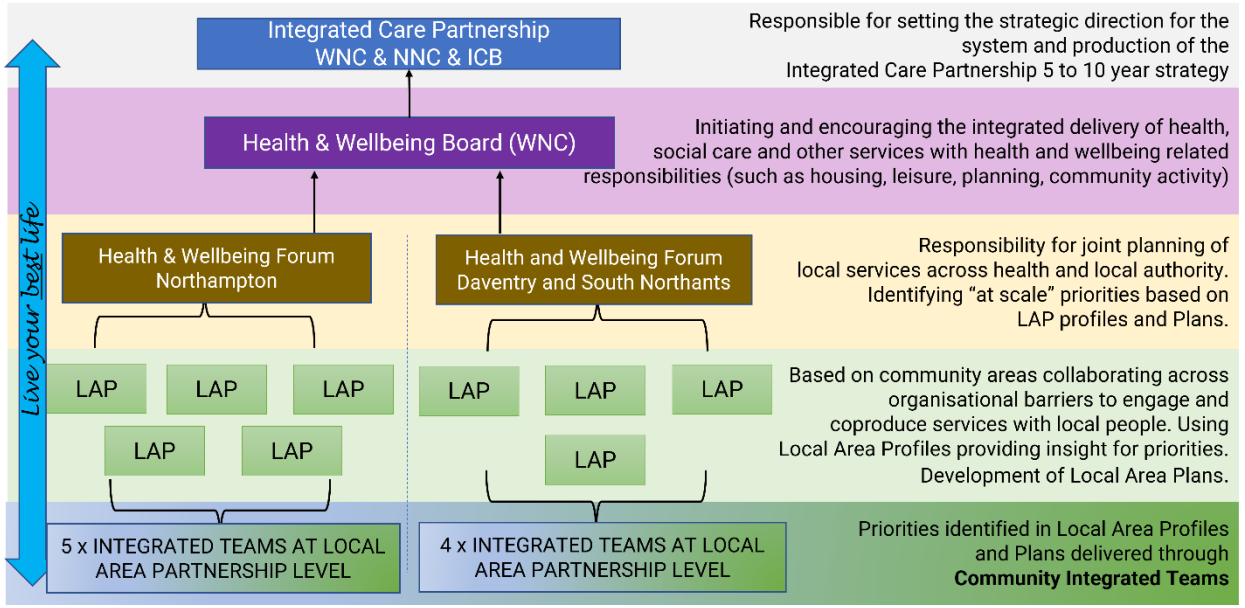
We have agreed 10 domains as part of our overall approach about people "**living their best life**" (LYBL) against which we will measure ourselves and identify and target identified inequalities.

Best start in Life	To feel safe in their homes and when out and about
Access to the best available education and learning	Connected to their families and friends
Opportunity to stay fit, well and independent	The chance for a fresh start, when things go wrong
Employment that keeps them and their families out of poverty	Access to health and social care when they need it
Housing that is affordable, safe and sustainable in places which are clean and green	To be accepted and valued simply for who they are

In relation to the ICAN BCF schemes the key inequalities measure is Access to health and social care when they need it. Linked to this we have set out a clear set of outcomes that reflect our plans to reduce hospitalisations, ensure people are discharges in a timely way and where possible to their home. The focus of our schemes is providing the right care in the right place and ensure that all over 65s can live their best life.

As ICAN BCF services are targeting the frail and elderly the main inequality we are seeking to address is the variable outcomes and inconsistent services that over 65s have experienced in the past. In 2022-23 the ICB will be formalising the framework which will then form the basis for contracting and commissioning services that will also deliver to a range of national metrics and service level agreements.

More widely as part of the West Northants ICP development we have agreed that we will adopt an operating model with the **Objective that** Health services, care services and wider determinates of health services are integrated at a local level to focus on the needs of the community. We have also agreed that we will across nine geographical Local Area Partnerships (LAPs).



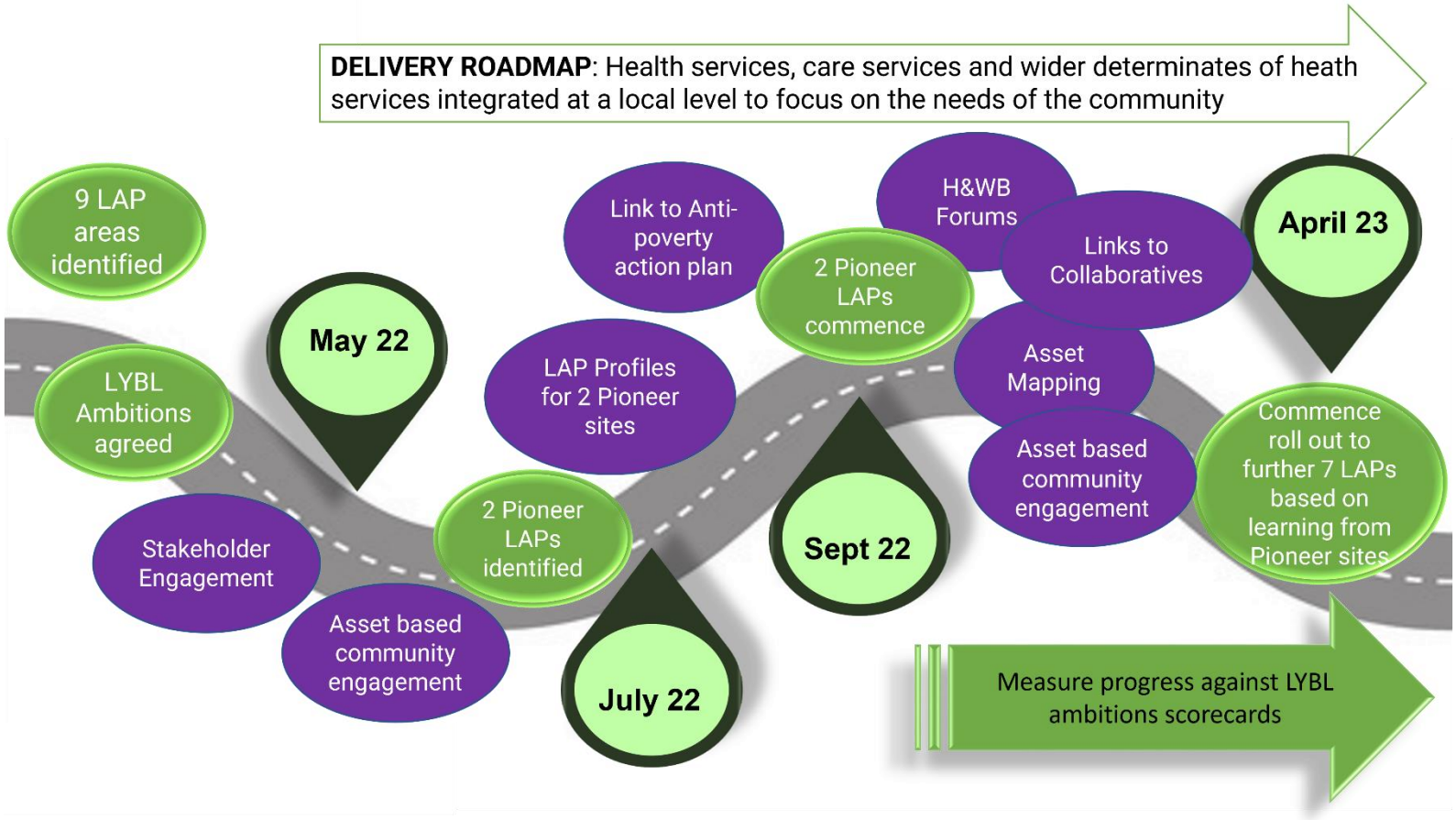
These LAPs will have specific intelligence based local area profiles that set out how the local population measures against the wider determinants of health as well as wider national standards. It will also include the mapping of local assets, community groups and public and voluntary services in the area.

This information will allow us to map and share data insights and local and national data by GPs/PCN and LAP helping us target the specific needs of the community. It will also allow us to see the prevalence of certain conditions, inequities or need and target services, assets and shared resources at improvements. This recognises the unique nature of an area and circumstances of its residents and will ensure we are providing appropriate interventions to improve health outcomes and address inequity of access.

Our plan extends beyond health and care and we have also mapped adults social care services, voluntary sector services, police beats, housing teams, iCAN welfare support teams, buildings, anti-poverty work, anti-social behaviour teams and housing a debt services to each LAP. By doing this we can ensure that services can be aligned, and actions taken to reduce crisis, for example we know that debt and housing issues often underpin mental health issues.

The LAP model and use of local area profiles will commence in September 22 and will start with two "pioneer areas" selected specifically to test the model in very different areas. One is in Northampton with high deprivation, poverty, crime, mental health issues and significant childrens services presence to

meet need. The second is in South Northants and Daventry which is more rural, has an older population and has more issues with isolation, a lack of childrens centres but high falls. Both Pioneer areas have the full engagement of GPs in the areas, and we are building a full data profile on which the Health and Wellbeing board and health and care partners can agree the services that will best address the needs of residents and improve outcomes against the 10 live Your Best Life (LYBL) measures. The roadmap for the rollout of this across all 9 LAPs in the Health and Wellbeing board area is below.



WEST NORTHANTS Health and Wellbeing Board live your best life

Item no: 08

WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

Report Title	**MOU between the Integrated Care System (ICS) and the Voluntary, Community and Social Enterprise Sector (collectively known as the VCSE)**
Report Author	**Russell Rolph, Chief Executive, Voluntary Impact Northamptonshire**

List of Appendices

Appendix A – MOU (ICS and the VCSE)
Appendix B – NHS Guidance on Embedding the VCSE into the ICS

1. Purpose of Report

1.1. This report tables an MOU between the ICS and the VCSE, an important element of NHS Guidance for all ICSs across the UK.

2. Executive Summary

1.2. There is a requirement for all ICSs to embed the VCSE into their system, both at a strategic and Placed Based level. As part of this process each ICS should adopt an MOU (Memorandum of Understanding) between the system in all its component parts and the VCSE sector. The MOU is a set of high-level principles which both the system and the VCSE should adhere to. It does not prevent any other Terms of Reference which may be required in any other specific part of the system. The MOU should be reviewed annually by the Health and Wellbeing Board.

3. Recommendations

That the Health and Well Being Board ratify and adopt the MOU.

4. Report Background

4.1 The Integrated Care System went live in Northamptonshire on the 1st of July 2022. As part of the ICS framework there is a requirement (laid down by NHS Guidance) that the system embeds the

VCSE into its work. NHS England believe that the VCSE is vital to ensuring that the ICS delivers effective and economic services into communities and in that regard is an equal partner. Voluntary Impact Northamptonshire is the systems appointed choice as NHS VCSE Broker into the ICS and is the recipient of Health Equality Grant funding (known as Connect Northamptonshire) which amounts to £448K over the next three years. As NHS VCSE Broker, VIN is bringing the system wide MOU with the VCSE for consideration and endorsement.

5. Issues and Choices

5.1 The MOU establishes a set of high-level principles which the system and the VCSE should work to. The success of the ICS in respect of the wider determinants of health will require new and intuitive ways of working to deliver different results for communities, and the VCSE has a role in supporting this as engagers, brokers and in the delivery of services. The VCSE is already represented in three of the four clinical collaboratives (Mental Health, ICAN and CYP) and has a VCSE Assembly populated with 380 members and 11 Thematic Groups. Over and above this, other networks have access to a further 1600 VCSE organisations and the value to Northamptonshire is considerable. By adopting the MOU, the Health and Wellbeing Board ratifies a commitment to working with the VCSE around a set of shared principles and undertakings. The board has several choices:

- To adopt the MOU.
- To adopt the MOU with amendments.
- To reject the MOU.

Rejection of the MOU will have implications on the relationship between the system and the VCSE, on which it might, could or should rely to deliver services, engage with communities, provide intelligence, assess impact, and support development and growth programmes.

6. Implications (including financial implications)

6.1 Resources and Financial

There are no resources or financial implications arising from the proposal.

6.2 Legal

There are no legal implications arising from the proposals.

6.3 Risk

There are no significant risks arising from the proposed recommendations in this report.

6.4 Consultation

6.4.1 This MOU has been circulated to the ICB Chair and ICS CEO, the Directors of Place, and the Directors and Deputy Directors of Adult Social Services. It has also been circulated to all partners

engaged in the Health Equalities Grant Phase 2 submission with the Lottery, in addition to the wider VCSE which includes the VCSE Assembly Board and the Assembly Thematic Groups.

6.5 **Consideration by Overview and Scrutiny**

6.5.1 None

6.6 **Climate Impact**

6.6.1 None

6.7 **Community Impact**

6.7.1 The MOU will help the community engagement process within the Local Area Partnerships as it sets the tone for relationship between statutory partners and the VCSE.

7. Background Papers

7.1 PAR905 NHS Guidance on **Building Strong Integrated Systems Everywhere (or Appendix B).**

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Northamptonshire Integrated Care System (ICS) Memorandum of Understanding

Appendix A

This document is a written understanding between the Statutory, Voluntary and Community Sectors and other partners about how they will co-operate within the ICS construct and at point of place delivery through Local Area Partnerships. It has been compiled by Voluntary Impact Northamptonshire, VCSE NHS Broker for the ICS and Recipient of the Health Equality Grant Phase 2 on behalf of Northamptonshire community organisations (known as Connect Northamptonshire) and those members involved in the VCSE Assembly. This document is dated **12.07.2022** and should be **reviewed annually** by respective Health and Wellbeing Boards who are expected to endorse these aspirations and undertakings. The Health and Wellbeing Boards in both the West and the North will endorse this MOU, and all statutory partners and VCSE organisations should show commitment to it.

The Vision of an Integrated Care System:

To put local people at the heart of the services we design and deliver, helping local people to realise their potential; to live healthier, happier lives; and to stay well and independent in their families, homes, and communities for as long as possible. Voluntary and Community organisations make a major and literally incalculable contribution to the social, cultural, and economic life of Northamptonshire. They act as pathfinders for the involvement of our population in the design and delivery of services and often act as advocates for those who otherwise have no voice. In doing so, they promote both equality and diversity. They help to alleviate poverty, reduce health inequalities, improve the quality of life, and empower socially excluded people. The Voluntary and Community sector also makes an important direct economic contribution to the area. The Voluntary and Community sector in Northampton shire can operate most effectively if it has the understanding and support of the statutory sector, and vice versa.

The purpose of an MOU:

A 'Local Memorandum of Understanding' is a written understanding between the Statutory, Voluntary and Community Sectors and other partners within any given locality about how they will co-operate. It should recognise the contribution that Voluntary and Community groups make and acknowledge their independence, and the moves in central government and wider society towards empowering the voluntary sector and communities. It is crucial to the governance and wellbeing of communities in Northamptonshire, as elsewhere, working through engagement of volunteers, to promote an active population, promotion of debate, questioning and new ideas, and providing services. If the Memorandum of Understanding is effective, it will support the development of Voluntary and Community sector capacity to increase and improve the impact of the sector and benefit the population of Northamptonshire: Community health resilience is the ability of a community to use its assets to strengthen public health and healthcare systems and to improve the community's physical, behavioural, and social health to withstand, adapt to, and recover from adversity and reduce inequalities. The Voluntary and Community sector in Northamptonshire is wide-ranging, richly diverse, and resilient. There is continued recognition of the Voluntary and Community sectors independence, skill, and professionalism. Statutory organisations and the Voluntary and Community sector share many aspirations. These include the pursuit of inclusiveness, dedication to public life, and support for the development of healthy and safe communities. VCSE

organisations often provide unique solutions to difficult issues and have a reach into communities and cohorts that others do not. If the sectors work well together, the population of Northamptonshire will benefit as they will be empowered and will receive better services.

Shared Principles:

Some principles are fundamental to the relationship which exists between the Statutory sector and other partners such as the VCSE. All sectors need to:

- Ensure that we are transparent in all we do and remain committed to the principles of co-production. Co-production is an essential element of any ICS.
- Ensure that we are both solution- focused and bold in our decision making, and that all conflicts or potential conflicts are declared and resolved accordingly.
- That we respect each other's views and allow partners the courtesy of being listened to and heard.
- That voluntary or social action is an essential component of a democratic society.
- That an independent and diverse Voluntary and Community sector enriches society and is fundamental to its well-being.
- Accept that in the development and delivery of public policy and services, statutory organisations and the Voluntary and Community sector have distinct but complementary roles but in coming together they have collective strength for the good of communities.
- Strive to work with partners to ensure excellent services.
- Accept that partnership is effective if it works towards common goals and achieves benefits for service users and communities.
- Accept that Statutory organisations and the Voluntary and Community sector have different forms of accountability and are answerable to different stakeholders: But common to both is the need for integrity, objectivity, accountability, openness, honesty, leadership, and inclusivity.
- Accept that Voluntary and Community organisations are entitled to campaign within the law to advance their aims with or without support from statutory bodies, and to promote equality of opportunity for all people regardless of race, age, disability, gender, sexual orientation, religion or any other discriminatory or oppressive criteria and elimination discriminatory or oppressive practice.

Undertakings by the VCSE and the Statutory sectors:

- To advance a positive relationship with Voluntary and Community bodies, Statutory organisations signing up to the Northamptonshire ICS MOU will adopt these undertakings:
- Recognise and support the independence of Voluntary and Community bodies as equal partners, including their right within the law to campaign, to comment on and to challenge policy within the law, irrespective of any resource focus relationship that might exist, and to determine and manage their own affairs.
- Take account of the need for greater proportionality, targeting, consistency and transparency in frameworks and to promote strategic resource focus, enhancing the capacity of Voluntary and Community organisations.
- Recognise the importance of infrastructure to the voluntary sector and volunteering and, where appropriate, to support its development at a unitary and place level.

- Seek to appraise new policies and procedures, particularly at the developmental stage, to identify as far as possible potentially damaging implications for the sector.
- Consult and ensure shared decision making is carried out with the voluntary sector, subject to considerations of urgency, sensitivity, or confidentiality, or on issues that are likely to affect it. Such consultation should be timely and allow reasonable timescales for response, considering the need of organisations to consult their users, beneficiaries, and stakeholders.
- Consult and co-design a fluid engagement strategy that can respond to the needs of the communities impacted by change.
- Take account positively of the specific needs, interests and contributions of those Voluntary and Community bodies which represent women, minority groups and socially excluded people.
- Ensure that statutory sector staff are informed on the nature and importance of the Voluntary and Community sector.
- Recognise and acknowledge the skills and knowledge the voluntary sector retain.
- Undertake regular mapping exercises with the Voluntary and Community Sector to identify gaps and overlaps in service provision and areas of potential support.
- Promote effective working relationships, consistency of approach and good practice between Statutory partners and the VCSE.
- Work to develop a shared data asset register to support local needs assessments to target approaches in reducing inequalities.

Undertakings by the Voluntary and Community Sector:

In developing their relationship with the statutory sector, Voluntary and Community sector organisations agree the following undertakings: Voluntary and Community organisations will:

- Maintain high standards of governance and conduct and meet reporting and accountability obligations to funding bodies and users.
- Respect and be accountable to the law, and in the case of charities observe the appropriate guidance from the Charity Commission, including that on political activities and campaigning.
- Acknowledge responsibilities and constraints placed on the statutory sector, including the democratic responsibility and legitimacy of elected representatives.
- Develop quality standards appropriate to the organisations.
- Ensure that service users, volunteers, members, and supporters are informed and consulted, where appropriate, about activities and policy positions.
- Promote effective working relationships with other agencies and across the Voluntary and Community sector.
- Involve users, wherever possible, in the development and management of activities and services.
- Put in place policies for promoting best practice and equality of opportunity, including employment, the involvement of volunteers and users, and in building service provision.
- Work to develop a shared data asset register to support local needs assessments to target approaches in reducing inequalities.
- Build positive, effective, and lasting relationships with Statutory partners and communities.

Next steps:

The publication and endorsement of this Northamptonshire ICS MOU will not, in isolation, change or alter exponentially the relationships which exist between sectors for the benefit of communities. Whilst there are some excellent examples of co-production, engagement and joint working, positive and lasting change will depend on several essential and critical factors agreed on and committed to by all partners. These are:

- Ensuring that the priorities agreed upon for both the wider ICS and the LAPS are consistent and make sense to all, not least the communities that they intend to benefit.
- Ensuring that the wider determinants of health remain as important as the agreed clinical priorities.
- Ensuring that the Population Health Data is used wisely and consistently well as a mechanism for change in communities.
- Ensuring that community assets (VCSE organisations, buildings, people, services, and skills) remain an important conduit for the ICS and for preventing health inequality.
- Ensure that the VCSE is properly represented within the structures of the ICS.
- That solutions are truly tailored to community need.
- That reporting mechanisms focus not only on statistics but socially account for changes in people's lives.
- That Public Outcome Frameworks possess an element of Social Return on Investment.
- That feedback and engagement loops are inclusive.
- That this MOU is treated with respect and is reviewed annually in line with changing circumstances at both the West and North Health and Wellbeing Boards.

Classification: Official

Publications approval reference: PAR905

Building strong integrated care systems everywhere

ICS implementation guidance on partnerships with the voluntary, community and social enterprise sector

NHS England and NHS Improvement may update or supplement this document during 2021/22. Elements of this guidance are subject to change until the legislation passes through Parliament and receives Royal Assent. We also welcome feedback from system and stakeholders to help us continually improve our guidance and learn from implementation. The latest versions of all NHS England and NHS Improvement guidance relating to the development of ICSs can be found at ICS Guidance.

Version 1, 2 September 2021

ICS implementation guidance

Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area.

They exist to achieve four aims:

- **improve outcomes** in population health and healthcare
- **tackle inequalities** in outcomes, experience and access
- enhance **productivity and value for money**
- help the NHS support broader **social and economic development**.

Following several years of locally-led development, and based on the recommendations of NHS England and NHS Improvement, the government has set out plans to put ICSs on a statutory footing.

To support this transition, NHS England and NHS Improvement are publishing guidance and resources, drawing on learning from all over the country.

Our aim is to enable local health and care leaders to build strong and effective ICSs in every part of England.

Collaborating as ICSs will help health and care organisations tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

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About this document

This guidance is for health and care leaders from all organisations in ICSs that are developing partnerships across local government, health, housing, social care and the voluntary, community and social enterprise (VCSE) sector. The ICS design framework sets the expectation that integrated care board (ICB) governance and decision-making arrangements support close working with the VCSE sector as a strategic partner in shaping, improving and delivering services, and developing and delivering plans to tackle the wider determinants of health. This guidance provides more detail on how to embed VCSE sector partnerships in ICSs.

Key points

- The VCSE sector is a key strategic partner with an important contribution to make in shaping, improving and delivering services, and developing and implementing plans to tackle the wider determinants of health
- VCSE partnership should be embedded in how the ICS operates, including through involvement in governance structures in population health management and service redesign work, and in system workforce, leadership and organisational development plans.

Action required

- By April 2022, ICBs are expected to have developed a formal agreement for engaging and embedding the VCSE sector in system-level governance and decision-making arrangements, ideally by working through a VCSE alliance to reflect the diversity of the sector.
- These arrangements should build on the involvement of VCSE partners in relevant forums at place and neighbourhood level.

Other guidance and resources

- ICS design framework
- Guidance on ICSs working with people and communities
- Guidance on the functions and governance of the ICB

Foreword: communities at the heart of health and care systems – the essential role of the VCSE

The COVID-19 pandemic has given society its biggest challenge of the past 70 years. It has shown that people need support joined up across local councils, the NHS and voluntary organisations. Initiatives to bring support to people in their communities have been most successful when partners have bridged traditional divisions between health and care and the voluntary sector. The pandemic has highlighted the value of this work.

Some of the most exciting and innovative work I have seen has been in the voluntary, community and social enterprise sector (VCSE). A strong focus on health and wellbeing, social connection and having fun!

In Wigan, we created a social contract between citizen and state – The Wigan Deal – bringing communities and local partnerships together.

As part of this, we took an 'invest to save' approach to strengthen the role of the VCSE sector in prevention and community resilience. We set up a community investment fund for VCSEs and gave council officers freedom to work with communities in an innovative way.

Council cost–benefit analysis estimates that for every £1 spent through the fund, £2 of fiscal value is created. This includes direct savings to social care, crisis savings and benefits payments.

Our approach was to join the dots around people and place, cutting through the complex proliferation of initiatives and departmental solutions.

This is what we learned:

- Find out what's important to residents and listen closely to communities. They will make the right decisions about their own lives with the right support.

- Invest in local community grassroots organisations and relationships with families to truly help people and reduce demand for expensive, ineffective and clunky state solutions.
- Give the freedom to test new approaches in integrated place-based teams, such as the self-organised Buurtzorg model in neighbourhoods. Trust public servants to work with people.
- Reduce time and money spent on passing people around the system for further assessment and referrals to another agency to deal with part of their problems.

It is important to understand that many VCSE organisations are struggling financially because fundraising has been adversely affected by the pandemic, at a time when demand for their services and support has never been greater. Positive engagement with the VCSE sector now can ensure that their knowledge, expertise and networks are protected, for the benefit of the whole community.

Frontline workers in VCSE sector organisations, together with their public sector colleagues, want to help people and improve their lives. We need to tap into their creativity and resilience and set them free to cut across the artificial organisational barriers of health, care, housing and criminal justice. If we do, the future is much more exciting!

Professor Donna Hall, CBE
Chair New Local Government Network and Bolton NHS Foundation Trust

Why do we need VCSE partnerships in ICSs?

The VCSE sector brings specialist expertise and fresh perspectives to public service delivery and is particularly well placed to support people with complex and multiple needs. It has a long track record in promoting engagement and finding creative ways to improve outcomes for groups with the poorest health, making it an essential partner in combating the inverse care law.[1]

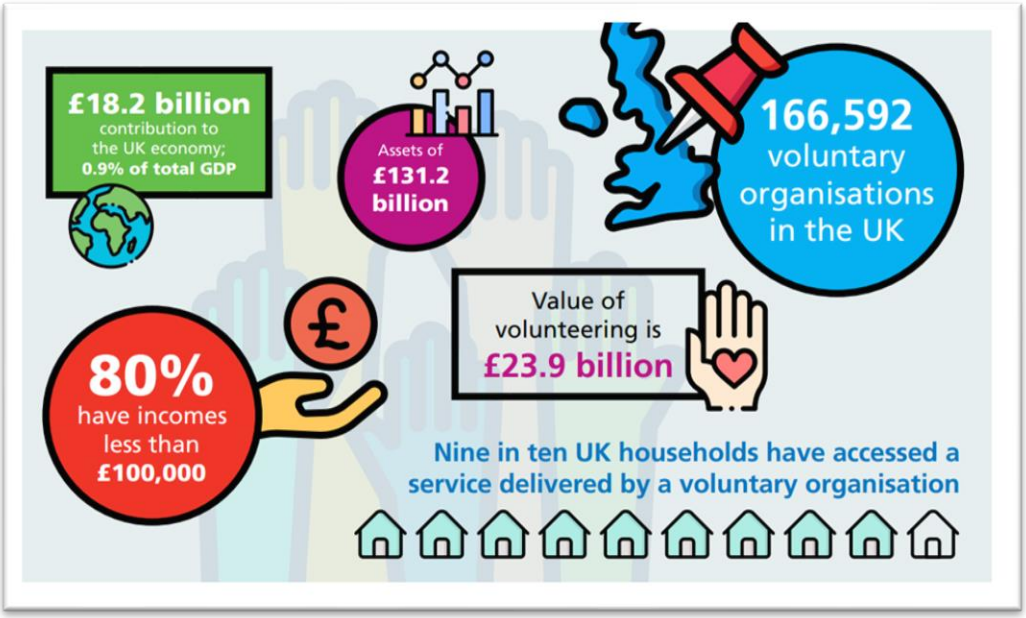
With its focus on early action, preventative services and wider social value, the sector provides good value for money. It brings insights, voice and assets into partnerships to support health and wellbeing, including expertise in service redesign and delivery, insight into inequalities, and access to volunteers and premises.

> "Voluntary and community sector organisations – from large national charities to small local ones – are involved in care pathways covering a wide variety of services, including disease-specific care, and in co-ordinating care for those with multi-morbidity across different parts of a pathway."
> (King's Fund[2])

Those working in the sector make up a significant proportion of the health and care workforce (Figure 1). Social enterprises alone employ over 100,000 staff – and have a turnover of more than £1.5 billion.[3] Around three million people volunteer in health and care, making an important contribution to people's experience of care.[4]

[1] The inverse care law highlights that disadvantaged populations need more healthcare than advantaged populations, but tend to receive less.
[2] Communities and health | The King's Fund
[3] Social enterprises: part of the NHS family – an explanatory guide for the wider NHS » Social Enterprise UK
[4] Volunteering in health and care | The King's Fund

Figure 1: The voluntary sector in numbers (Source: The UK Civil Society Almanac, 2020)



The VCSE sector has, and continues to, play an important role in keeping people connected during the COVID-19 pandemic, responding quickly to meet communities' needs. Organisations across the sector modified their services to support people and communities in the most vulnerable situations.

Table 1: Examples of some of the benefits when there is close partnership working between the VCSE sector and statutory partners

Achievement	Description
Improving outcomes in population health and healthcare	
Faster and more joined-up mental healthcare in Somerset	The Open Mental Health partnership is a new approach to mental health care designed by partners from all sectors with the involvement of people who use services at all stages. The care model includes a 24-hour helpline and has tightly linked the VCSE sector to the NHS through a shared scheme for recovery and care planning.
Better prevention and treatment of eye care problems in West Yorkshire and Harrogate	The charities Vision UK, Thomas Pocklington Trust and the Macular Society are involved in a comprehensive review of eye care services, alongside NHS commissioners, hospitals and community services, opticians and local authorities. The aim is to improve all eye care services from prevention through to rehabilitation, building in shared decision-making and personalisation. Carers Wakefield is now using

Achievement	Description
	the Eyes Right Toolkit to improve prevention of vision problems among the local unpaid carer population.
Tackling inequalities	
Improved vaccination take-up for homeless people in Brighton	Arch Healthcare Community Interest Company, the main provider of primary care for people experiencing homelessness in Brighton, built on its pre-existing relationship with and knowledge of the local homeless community. It developed a mobile vaccination service, partnering with St John Ambulance and going to temporary accommodation hostels rather than inviting patients to a surgery or a mass vaccination site. It vaccinated more than 800 people in eight weeks, with around 38 people vaccinated per day in the community.
Better support for carers in Herefordshire and Worcestershire	Statutory health and care partners worked with local VCSE carers organisations, NHS staff and unpaid carers to improve support. Work included developing a carer's CV to support employment prospects for carers; a 'Carer Assist' service to support carers in the NHS workforce; and training and development for staff across the system on awareness and support for unpaid carers.
Enhancing productivity and value for money	
Out-of-hospital support for COVID-19 patients in Hertfordshire	Local charity Communities 1st worked with hospitals to establish 'virtual wards', where patients with COVID-19 are managed at home and they use oximetry to monitor their own oxygen levels. The primary aim of some of these wards is supported early discharge, freeing up hospital staff and beds; others are referring patients directly from emergency departments and primary care.

Challenges to VCSE and ICS partnership working

There can be as many as 16,000 VCSE organisations in the largest ICSs, ranging from big social enterprises employing a large workforce to informal grassroots groups supporting people in their local community. Support may relate to a specific condition, such as mental health, disability or cancer care, or it may be organised around a geographical or virtual community or local organisation or group.

The diversity of the VCSE sector is a strength to be recognised and celebrated – but it also means it can be daunting for ICSs, particularly at system level, to engage in a systematic way. Equally, VCSEs face challenges in working in a complex landscape and overcoming funding and time constraints. Statutory partners need to carefully consider how to equitably resource the involvement of VCSE partners in a way that respects their time and resource.

However, within many ICSs, partners have already created VCSE alliances to support engagement with the diversity of the sector. In addition, at place level, VCSE infrastructure organisations (often called CVSs or Voluntary Action) usually exist and provide a co-ordinating function for the sector. NHS bodies and local government already commission VCSE organisations and work with them at different scales, and the COVID-19 response has, in many cases, accelerated collaboration and deepened relationships, providing good foundations to build on.

> "The voluntary sector can at times be competitively minded because it has needed to be. But now with collaborations in integrated care systems, we're more able to think about what unites us and how we can collaborate."
> (Beccy Wardle, Head of NHS partnerships, Rethink Mental Illness)

Case study: A VCSE Assembly in Norfolk and Waveney ICS

The Norfolk and Waveney Health and Care Partnership and its local VCSE organisations have developed a VCSE Assembly as a way to improve health and care by connecting the VCSE sector with statutory partners in the ICS. NHS, county councils and VCSE sector partners work in partnership to develop the Assembly and link it to the Health and Wellbeing Board, to ensure it represents and meets the needs of communities and the voluntary sector, and that the voices of smaller groups are heard.

Core requirement and good practice for building VCSE partnerships in ICSs

Core requirement

By April 2022 integrated care partnerships (ICPs) and the ICB[5] are expected to have developed a formal agreement for engaging and embedding the VCSE sector in system-level governance and decision-making arrangements, ideally by working through a VCSE alliance to reflect the diversity of the sector.

- The detail of partnership arrangements will depend on existing local infrastructure and approaches.
- Partnership arrangements should include agreed ways of working such as a memorandum of understanding and sets of principles.
- There is a national ICS and VCSE sector partnership programme to support this work.

> "As with all partnerships, ICSs need to invest time and money to build strategic relationships with the VCSE, creating, supporting and working with alliances. VCSE alliances are very knowledgeable about their communities, and everyone benefits from them being in the room."
> (Charlotte Augst, Chief Executive, National Voices)

The questions below, based on learning of 'what good looks like', are intended to stimulate thinking on how best to embed the VCSE sector in the ICB's governance and partnership arrangements.

[5] The ICS Design Framework referred to this organisation as the ICS NHS Body. However, since the second reading of the draft legislation in parliament we have adopted the name integrated care board (ICB).

Embedding the VCSE sector in the ICBs governance and partnership arrangements – a check list
Is there VCSE sector involvement in system-wide workstreams, service redesign, place-based partnerships, neighbourhood teams, primary care networks and provider collaboratives?
Have you mapped VCSE stakeholders and the contribution and resources brought by the VCSE sector to the ICS?
Are you working with VCSE groups relevant to the priorities you are tackling, and the population groups you are trying to support?
Are you building on existing structures and networks, such as VCSE representation on health and wellbeing boards and local VCSE infrastructure organisations?
Can data sharing agreements be made between health, care and VCSE partners?
Do you have a co-ordinated system approach to developing and sustaining effective social prescribing, developed with input from VCSE sector leaders, local authority and health commissioners, primary care networks, referral agencies and the health and wellbeing board?
Do you actively support NHS anchor institutions to work in partnership with the VCSE sector and involve the sector in networks to take joint action on the social determinants of health?
Does the ICS support a sustainable VCSE sector through market development, strategic grants and investment in VCSE infrastructure and alliances, including understanding where communities are not served or advocated for by the VCSE?
Are you being proactive in commissioning VCSE organisations to deliver services, including with innovative approaches to population health management and service transformation?

Can you develop non-financial support for VCSE organisations, such as their inclusion in leadership and quality training, workforce diversity and wellbeing initiatives, secondments and supported leadership opportunities on system workstreams?
Do you have a consistent approach to measuring the impact of VCSE partnerships as part of a wider social value approach?
Does the ICS have a strategy to support and increase volunteering in both public and VCSE sectors?

Case studies: Supporting broader economic and social development in the north west

Parts of the Lancashire coastal town Fleetwood are significantly disadvantaged Healthier Fleetwood helps residents improve their health and wellbeing. The starting point was 'connecting' all the great work going on in Fleetwood so that residents could engage with the services and support available. A strong network of partners is now providing expertise and facilities alongside the enthusiasm and energy of the residents, turning ideas into reality.

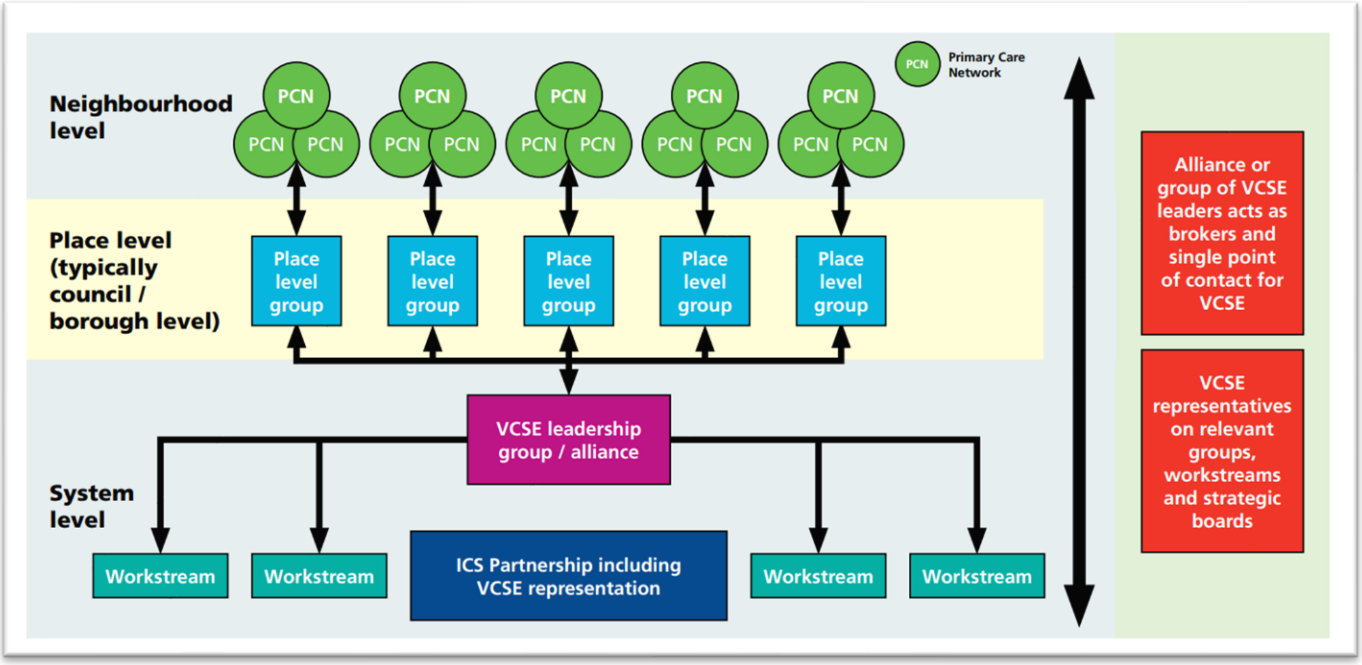
Local authorities, NHS providers, clinical commissioning groups and VCSE organisations across Cheshire and Merseyside signed up to a social value charter. They are using the shared social value approach to unlock the potential for local public sector organisations to use their purchasing power to contribute to better economic, environmental and social outcomes locally, making connections to local business and supported by a network of social value champions.

Working with the VCSE sector across the ICS

VCSE sector alliance model

Many ICSs have already developed alliance models to support the involvement of the diversity of the VCSE sector. Partnership at system level is likely to focus on strategic opportunities across the footprint and can build on existing arrangements at place. The model below (Figure 2), based on emerging work in ICSs, shows a potential approach to VCSE partnerships across the ICS that will support relationships to deliver better health and care for local people. NHS England and NHS Improvement are working with national VCSE partners on a development programme that supports systematic partnership with the VCSE sector in ICSs through an alliance model.

Figure 2: Approach to VCSE partnerships across the ICS



Case study: Building VCSE sector leadership and representation in Lancashire and South Cumbria

Lancashire and South Cumbria has strengthened its engagement processes by clarifying the lines of accountability and channels of communication. New voluntary sector leadership groups in its five integrated care partnership areas or places, each chaired by an elected representative, have jointly agreed a mechanism for transparent representation and voice. Representatives of each of the five areas and other voluntary organisations across the ICS area are also included in the Voluntary, Community and Faith Sector Leadership Alliance. This provides a single point of contact for public sector leaders and others in the VCSE sector.

VCSE partnerships at place

People access most of the health and care services they use in the 'place' in which they live, including advice and support to stay well and joined up treatment when they need it. The arrangements for partners to jointly plan and deliver health, social care and public health services alongside other services that promote health and wellbeing in a defined place have a long history. They involve the NHS, local government and providers of health and care services, including the VCSE sector, people and communities.

'Places' are also where most voluntary sector funding is allocated (usually by local council area) and where the sector can be increasingly embedded in decision-making and strategic planning. Experience shows that the greatest opportunities to improve care by redesigning services are often at place. Provider collaboratives (see below) are expected to link closely with place-based partnerships of health and social care partners, including the VCSE.

There is an expectation that the VCSE sector will be an integral part of the place-based partnerships developed in ICSs. This can build on existing structures and networks such as VCSE representation in health and wellbeing boards and local VCSE infrastructure organisations.

Case study: joined up work between all sectors to improve health and housing in Wakefield

Wakefield CCG and other NHS and local authority partners work with Wakefield District Housing, a social enterprise, to fund a number of schemes to improve housing and tenants' and community health. Mental health navigators take referrals on problems like hoarding, poor tenancy management and anti-social behaviour. In addition, a service based on local hospital wards is helping people get home from hospital sooner, by addressing barriers such as broken heating, cold homes or the need for new mobility equipment.

VCSE partnerships at neighbourhood

In neighbourhoods, local teams can work across organisational boundaries to give seamless care closer to people's homes, improve population health and prevention, and co-ordinate NHS support to those living in care homes. Primary care networks (PCNs) are a key part of this work, bringing together general practices, pharmacists and others.

ICSs are encouraged to consider how VCSE organisations can be included in multidisciplinary neighbourhood teams along with statutory partners, to improve the support to high-risk users and high-intensity service users.

An important connection for the VCSE sector in neighbourhoods is the social prescribing link worker, one of the new roles in PCNs. Link workers provide a bridge between health and community by connecting people to local activities and services for practical and emotional support. They work closely with the VCSE sector to identify and nurture local community groups and support. Much of the support that link workers refer to is provided by the VCSE, and often link workers are employed by the sector as well.

Provider collaboratives and the VCSE sector

NHS trusts and foundation trusts and provider collaboratives commission services from the VCSE sector as part of wider care pathways; for example, 'hospital at home' services, support for unpaid carers, community transport and community mental health services. This enables people and communities to benefit from the innovation that is often driven by the VCSE sector. It is expected that provider

collaboratives will continue to leverage the expertise of VCSE organisations to support co-design and delivery of health and care services.

Conclusion

The voluntary, community and social enterprise sector is key to the creation of successful integrated care systems. NHS England and Improvement are committed to supporting systems to build effective local partnerships everywhere. We hope this guidance will help local leaders to strengthen their arrangements, building on learning from around the country.

Appendix A: Further resources and information

About the VCSE sector

Local VCSE infrastructure organisations (LIOs, or Councils for Voluntary Services/Voluntary Actions) provide support and leadership for the local VCSE sector and can help statutory partners reach large numbers of charities and community groups in their area. These organisations are often aligned to local government areas such as counties or metropolitan boroughs. They facilitate networks of organisations that bring communities of interest, place and experience together, enabling them to play a key role in co-production and engagement. NAVCA's Find a member site lists LIOs for all areas.

The UK has a network of 46 accredited Community Foundations. These organisations invest in communities and people, matching donors and partners to local need. They often cover wider geographical areas that are a good match with ICSs and can support strategic grant making, capacity building and engagement.

Dedicated support from NHS England and NHS Improvement

The national voluntary partnerships and system transformation teams advise ICSs on strategic engagement with the VCSE sector. The VCSE leadership programme provides resources and facilitated support to develop or strengthen VCSE alliances in all ICSs.
england.voluntarypartnerships@nhs.net

The social prescribing team advises on best practice in working with the VCSE sector, primary care networks and partners to develop social prescribing.
england.socialprescribing@england.nhs.net

More information

Integrated care: www.england.nhs.uk/integratedcare/
ICS Design Framework

NCVO: Creating Partnerships for Success details examples and case studies from the STP/ICS VCSE Leadership programme

NHS Confederation: How health and care systems can work better with VCSE partners

The role of VCSE organisations in care and support planning: National Voices

Community organisations and primary care networks: National Voices
Inclusion health self-assessment tool for primary care networks
Social prescribing: NHS England Social Prescribing Summary Guide
National Voices, Rolling Out Social Prescribing
RSA and NCVO: Meeting as equals; Creating asset-based charities which have real impact

Appendix B: Glossary

Integrated care system (ICS): In an ICS, NHS organisations in partnership with local councils and others take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve.

Subject to legislation, the statutory ICS arrangements will include:

- an integrated care partnership, the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS
- an integrated care board, bringing the NHS together locally to improve population health and care.

Within ICSs, it is expected that several place-based partnerships will be agreed. The number of 'places' will depend on the geography of individual ICSs. The footprint of places should be defined based on what is meaningful to local people, such as a town, city, borough or county.

Neighbourhood: The smallest and most local area that services are organised at.

Primary care network (PCN): Local collaboration of GP practices covering 30,000 to 50,000 people working towards integrated primary and community health services.

Provider collaborative:[6] Partnership arrangements involving two or more trusts (NHS trusts or foundation trusts) working at scale across multiple places, with shared purpose and effective decision-making arrangements, to:

- reduce unwarranted variation and inequality in health outcomes, access to services and experience
- improve resilience (eg by providing mutual aid)
- ensure that specialisation and consolidation occur where this will provide better outcomes and value.

[6] Working together at scale: guidance on provider collaboratives

Voluntary and community sector: Made up of organisations which have a social purpose and exist not to make profit. Those with incomes of over £5,000 must register as a charity. Community organisations are generally smaller, operate in a particular community of geography or interest, and may be formally constituted with a management committee.

Social enterprise:[7] Like traditional businesses, social enterprises aim to make a profit, but reinvest or donate those profits to create positive social change.

[7] www.socialenterprise.org.uk

For more information on integrated care systems visit: www.england.nhs.uk/integratedcare/

Find us on LinkedIn: www.linkedin.com/showcase/futurehealthandcare/

Sign up to the Integrated Care bulletin: www.england.nhs.uk/email-bulletins/integrated-care-bulletin/

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WEST NORTHANTS Health and Wellbeing Board
live your best life

Item no: 10

WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

8th September 2022

Report Title	ICP Outcomes Framework (Iteration 1)
Report Author	Rhosyn Harris, Consultant in Public Health

Contributors/Checkers/Approvers		
Other Director/SME	Sally Burns Director of Public Health West Northants Council	30th August 2022

List of Appendices

Appendix A – ICP Outcomes Framework (Iteration 1)

1. Purpose of Report

1.1. The purpose of the Integrated Care Partnership (ICP) Outcomes Framework is to outline priority outcomes, based on the needs identified in the joint strategic needs assessments, agreed by all actors within the integrated care system.

1.2. The Outcomes Framework should provide focus to the integrated care strategy and provide a mechanism by which the partnership can measure joint efforts in driving progress on the most important outcomes for the local population.

2. Executive Summary

2.1 The ICP Outcomes Framework has been shaped around the ten "Live Your Best Life" ambitions agreed by the partnership when it was in its shadow form.

2.2 The ambitions are that people in Northamptonshire should be or have:

- the best start in life
- access to the best available education and learning
- the opportunity to be fit and well
- employment and support to keep people and their families out of poverty
- housing that is affordable, safe and sustainable in places that are
- safe in their homes and when out and about

- connected to their families and friends
- the chance of a fresh start when things go wrong
- access to health and social care when they need it
- accepted and valued for who they are

2.3 For each of these ten ambitions we have identified between two and five priority outcomes.; therefore 34 outcomes in total for the partnership to focus on. For all but three of these priority outcomes, metrics for which data is currently available have been proposed. A total of 78 metrics are included in this first iteration of the outcomes framework.

2.4 The last three outcomes, for which metrics have not yet been proposed relate to the ambition that "people are accepted and valued simply for who they are". We suggest that as this ambition is qualitative in nature and relates to people's feelings of being accepted and valued that we should develop measures for these outcomes with the community.

2.5 This first iteration of the outcomes framework, and wider integrated care strategy is being developed at pace in order to inform the development Integrated Care Northamptonshire's first five year plan. However, the development of shared partnership outcomes is expected to be an iterative process refined overtime.

3. Recommendations

3.1 For Health and Wellbeing Board to endorse the first iteration of the ICP Outcomes Framework to present for approval to the Integrated Care Partnership Board.

4. Report Background

4.1 Statutory guidance published by the Department of Health and Social Care (DHSC) on the development of integrated care strategies (please see supporting documents section below) suggests that a core feature of strategies should be agreement of "shared outcomes"

4.2 This guidance also notes that DHSC will set out further detail on shared outcomes, as described in 'Health and social care integration: joining up care for people, places and population', by April 2023. This will consider the relationship of this work to integrated care strategies.

5. Issues and Choices

5.1 In compiling the list of priority outcomes in the framework the team used both the findings of the Summary JSNA, alongside feedback from subject-matter experts across partnership agencies.

5.2 In compiling the list of metrics that best measure the outcomes listed in the framework, a significant issue has been identifying suitable metrics. For some outcomes it was recognised that the data required to measure the outcome adequately is not currently collected or recorded locally.

5.3 For all outcomes it was recognised that pure numeric/quantitative metrics will not be sufficient to measure progress and that each outcome area will need qualitative data or narrative summaries to describe what is happening locally.

6. Implications (including financial implications)

6.1 **Resources and Financial**

6.1.1 The outcomes framework itself does not directly have financial/budget implications but instead identifies priorities that should shape future budget setting.

6.2 **Legal**

6.2.1 There are no legal implications arising from the proposals.

6.3 **Risk**

6.3.1 There are no significant risks arising from the proposed recommendations to endorse this first iteration of the outcomes framework.

6.4 **Consultation**

6.4.1 Consultation was undertaken in the development of this first iteration of the outcomes framework with partners across the local authorities, NHS bodies, police force and fire service, University and voluntary sector.

6.4.2 Though all agencies and members of the partnership have been consulted, due to time pressures and the timing of consultation over the summer holidays the consultation has not been as thorough and extensive as the team would have liked. We are still working with some partners to refine metrics.

6.4.3 ICPs are expected to iterate and refine their shared outcomes and more specific DHSC guidance on shared outcomes, as noted above, is expected in April 2023 and therefore we plan to continue and expand engagement to inform the next iteration of the framework.

6.5 **Consideration by Overview and Scrutiny**

6.5.1 The report has not yet been presented to Overview and Scrutiny.

6.6 **Climate Impact**

6.6.1 As the most pressing public health threat this century, climate change (specifically reduction of carbon emissions) is included as a key priority outcome.

6.7 **Community Impact**

6.7.1 This outcomes framework covers the Northamptonshire Integrated Care Partnership footprint of the whole county.

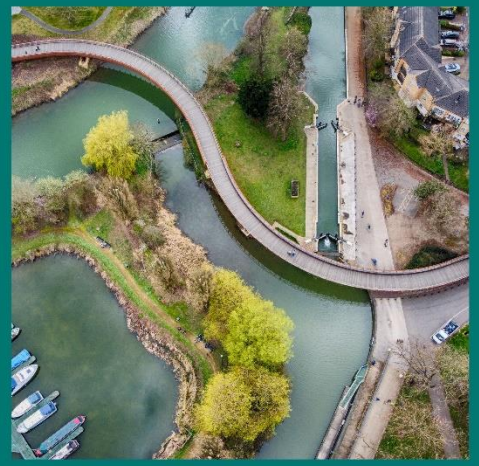
7. Background Papers

7.1 Guidance on the preparation of integrated care strategies https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies

7.2 Policy paper - Health and social care integration: joining up care for people, places and populations https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations/health-and-social-care-integration-joining-up-care-for-people-places-and-populations

Integrated Care Northamptonshire

An update on the development of the ICP Outcomes Framework



FIRST ITERATION (DRAFT V7.1)

Context

- In order to influence the first 5-year joint forward plan Northamptonshire ICS has to publish an initial strategy by December 2022.
- The integrated care strategy is an opportunity to work with a wide range of people, communities and organisations to develop evidence-based system-wide priorities that will improve the public's health and wellbeing and reduce disparities.
- Agreement by all actors within the integrated care system on p**riority outcomes, based on the needs identified in the joint strategic needs assessments**, is a powerful way for the integrated care strategy to bring focus to the system, galvanising joint working and driving progress on the most important outcomes for the local population.

  "We expect this to be an important aspect of all integrated care strategies, which can also play an important role in supporting the setting of joint goals for local areas"

Development Process

1. As a starting point we have taken the 2020/21 **NHCP Outcomes Framework (NHCPOF) metrics** (process below) and mapped them to the 10 new ICP **"Live Your Best Life" (LYBL) Ambitions**
2. Work within the PH team has then been to articulate specific outcomes (based on known needs in existing JSNA documents) to describe the 10 LYBL ambitions and find nationally bench-marked metrics to measure outcomes where there are gaps in the NHCPOF
3. Through July and August we will engage with service areas, topic experts and system leaders to refine outcomes and metrics selected (iterative process), mapping of selected metrics against existing corporate/organisational scorecards/frameworks to ensure all partners aligned in achieving population outcomes selected

live your best life

Integrated Care Northamptonshire

- Best Start in Life
- Access to the best available education and learning
- Opportunity to be fit, well and independent
- Employment that keeps them and their families out of poverty
- Housing that is affordable, safe, and sustainable in places which are clean and green
- To feel safe in their homes and when out and about
- Connected to their families and friends
- The chance for a fresh start when things go wrong
- Access to health and social care when they need it
- To be accepted and valued simply for who they are

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Principles

- Outcomes should reflect local priorities as identified in existing needs assessments (also using any new insights identified by stakeholders)
- Outcomes should reflect existing strategic outcomes for partners that require whole system partnership working to effect meaningful change
- Outcomes should be balanced between those focusing on health and care service delivery with those focused on wider and social determinants of health
- Metrics measuring each outcome should be high level to inform the strategic-level board, with more nuanced and granular detail contained in supporting "scorecards".
- Reducing inequalities should be a "golden thread" throughout (inc. reflecting CORE20PLUS5)

N.B. metrics selected are *currently available* data/measures though we recognise that new local measures should be developed as part of this work.

Stakeholder Engagement

- The team have engaged stakeholders across the local authorities, NHS, voluntary sector, and other key organisations e.g. University of Northampton.
- Stakeholders were asked for feedback on both outcomes and their wording as well as selected metrics and sources of data to measure selected outcomes.
- Given the tight timescales for engagement, there are partners from whom feedback has not yet been collected/collated.
- This version presented is therefore subject to minor amendments in response to this feedback.

- Feedback from HWBs is welcomed.

Timescales

- June 2022 – initial draft for stakeholder engagement finalised
- July 2022 – stakeholder engagement
- August 2022– stakeholder engagement
- September 2022 – final draft of first iteration to be presented to Heath and Wellbeing Boards for endorsement before presentation to Partnership Board
- **December 2022** – **final draft** of ICS Strategy including Outcome Framework presented
- April 2023 – government publication of Outcomes Framework Guidance
  Iterative process of refining the Outcomes Framework continues

Framework Structure

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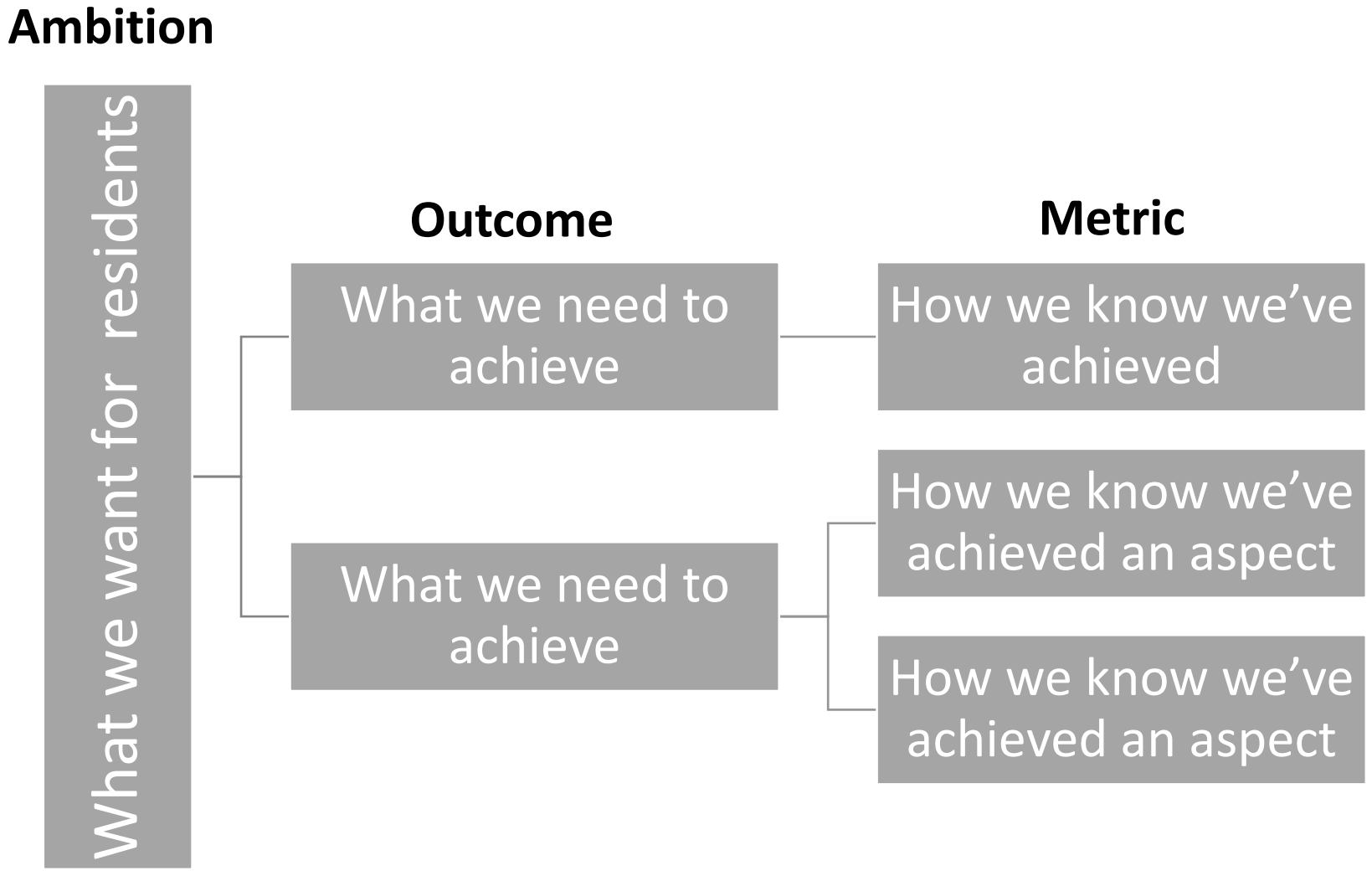

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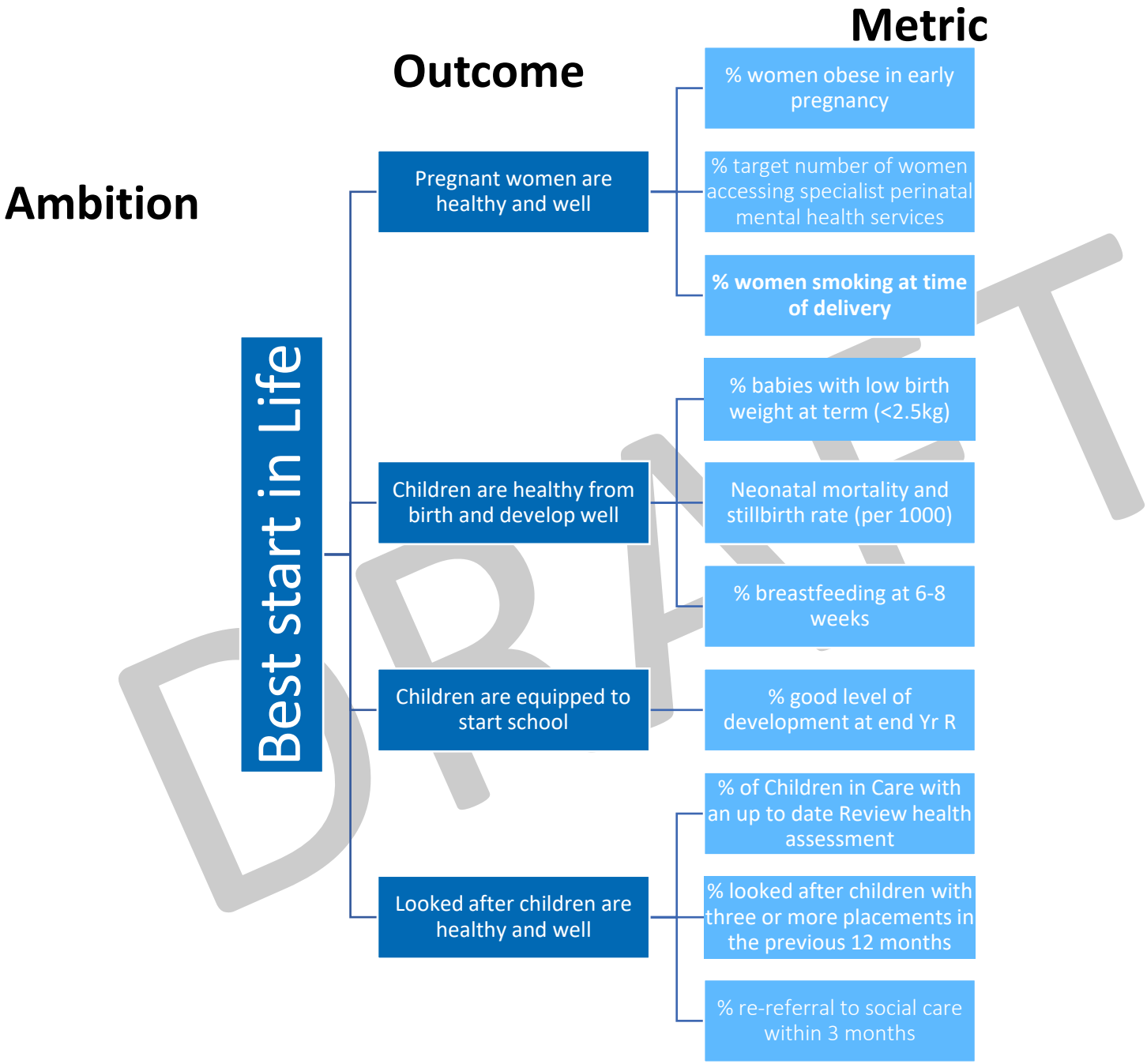

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Ambition	Outcome	Metric
Best available education	Children and young people perform well at all key stages	% all pupils achieving 9-4 pass in Eng & Maths
		% LAC pupils achieving 9-4 pass in Eng & Maths
	SEND education is accessible and meets the needs of children locally	% SEND children electively home educated
		% SEND children in out-of-county schools
	Schools serve all children and young people well and nobody misses out on learning	Number of fixed term/permanent exclusions and part time timetables
	Adults have access to learning opportunities which support employment and life skills	Number completing ESOL Entry 1 qualifications
		% care leavers in Education Employment or Training (ages 17-21)

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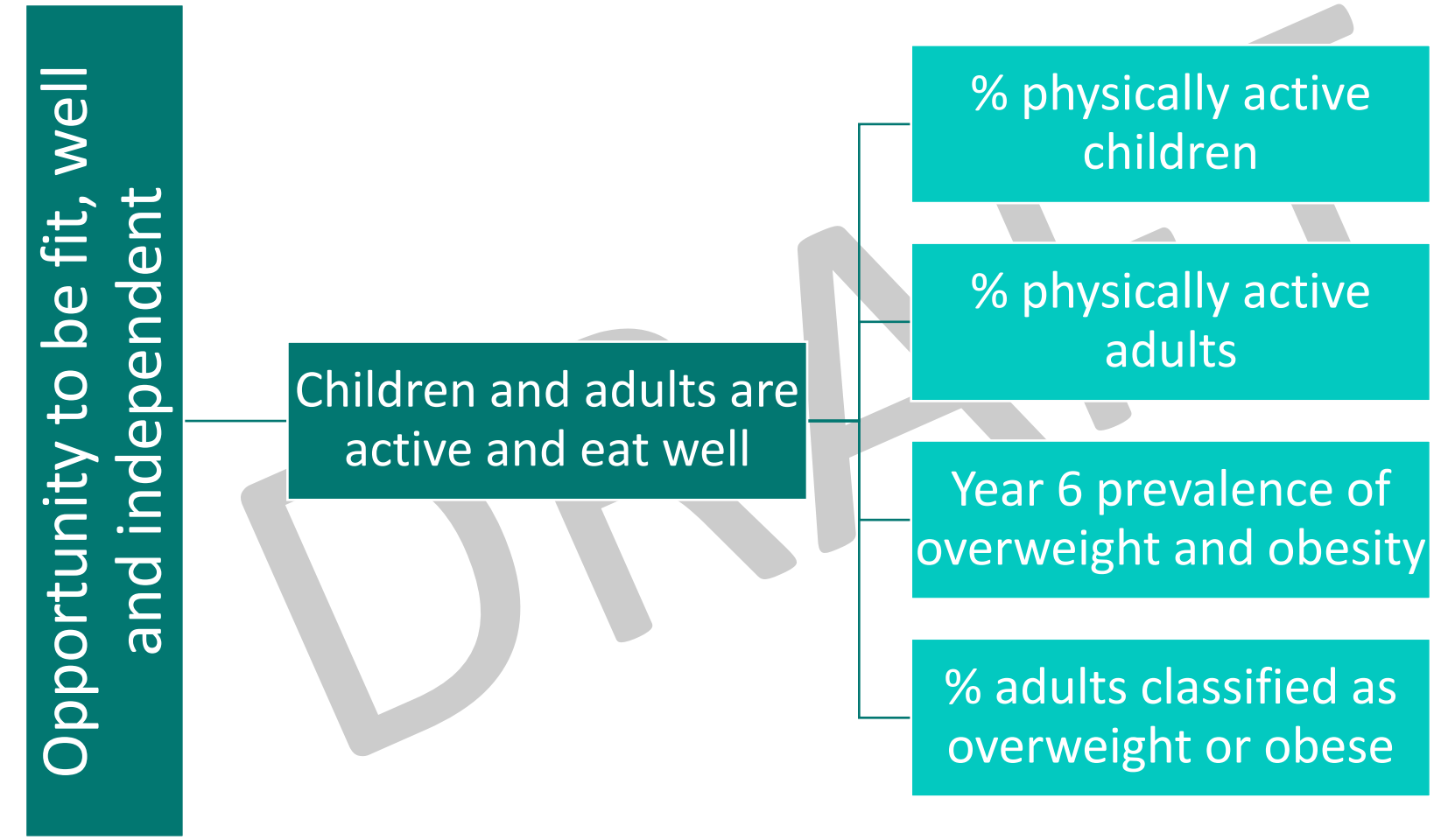

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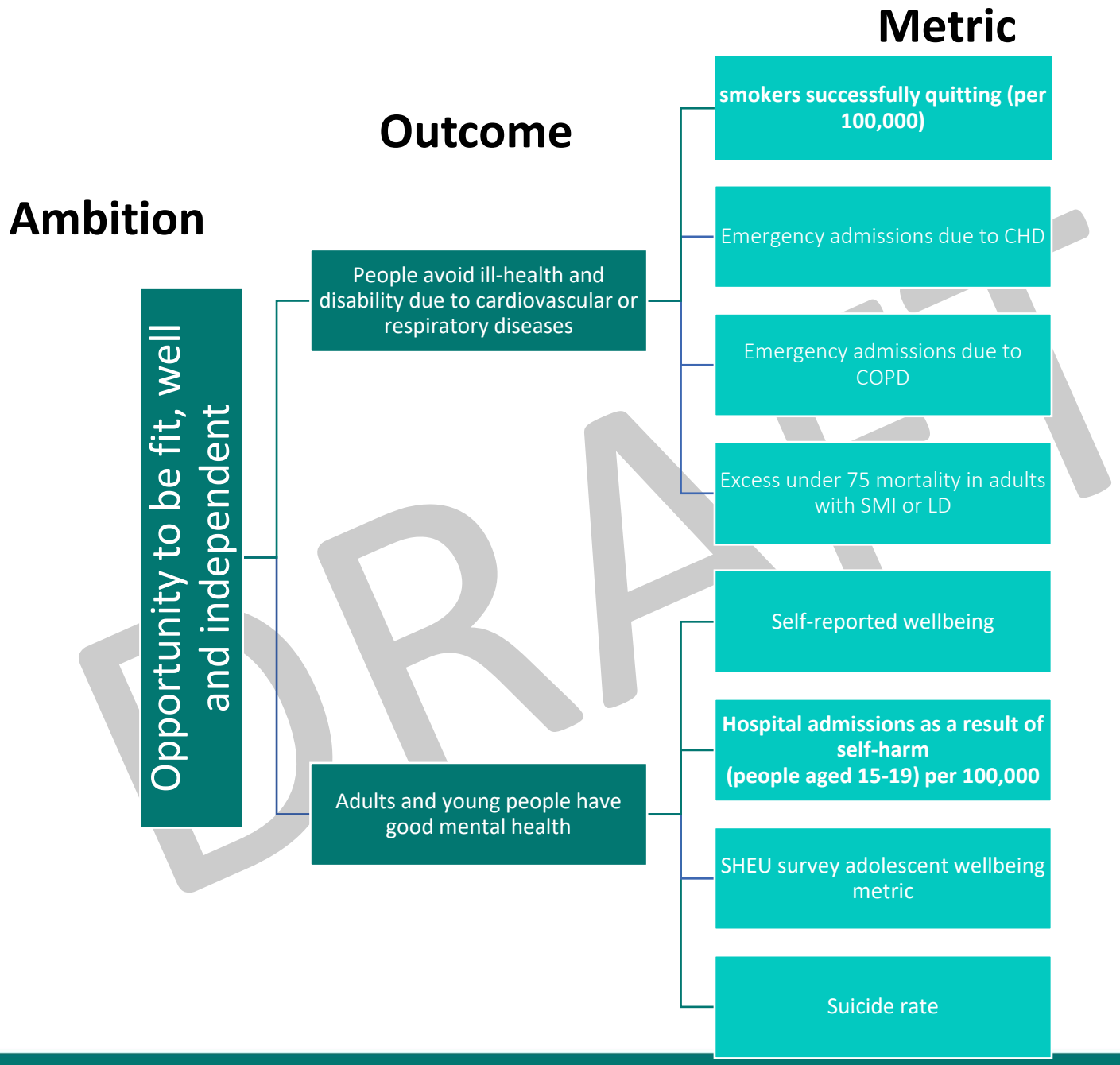

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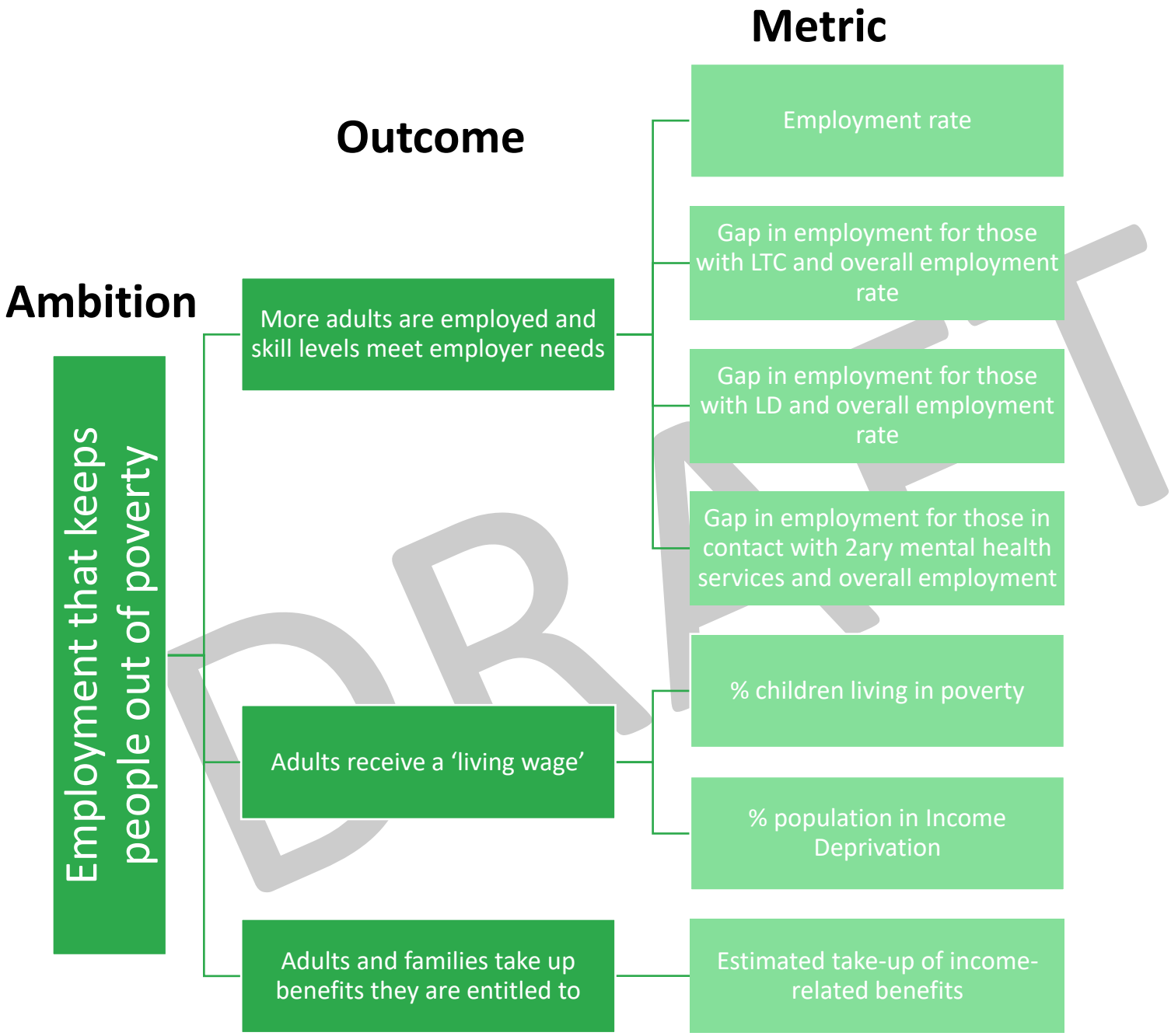

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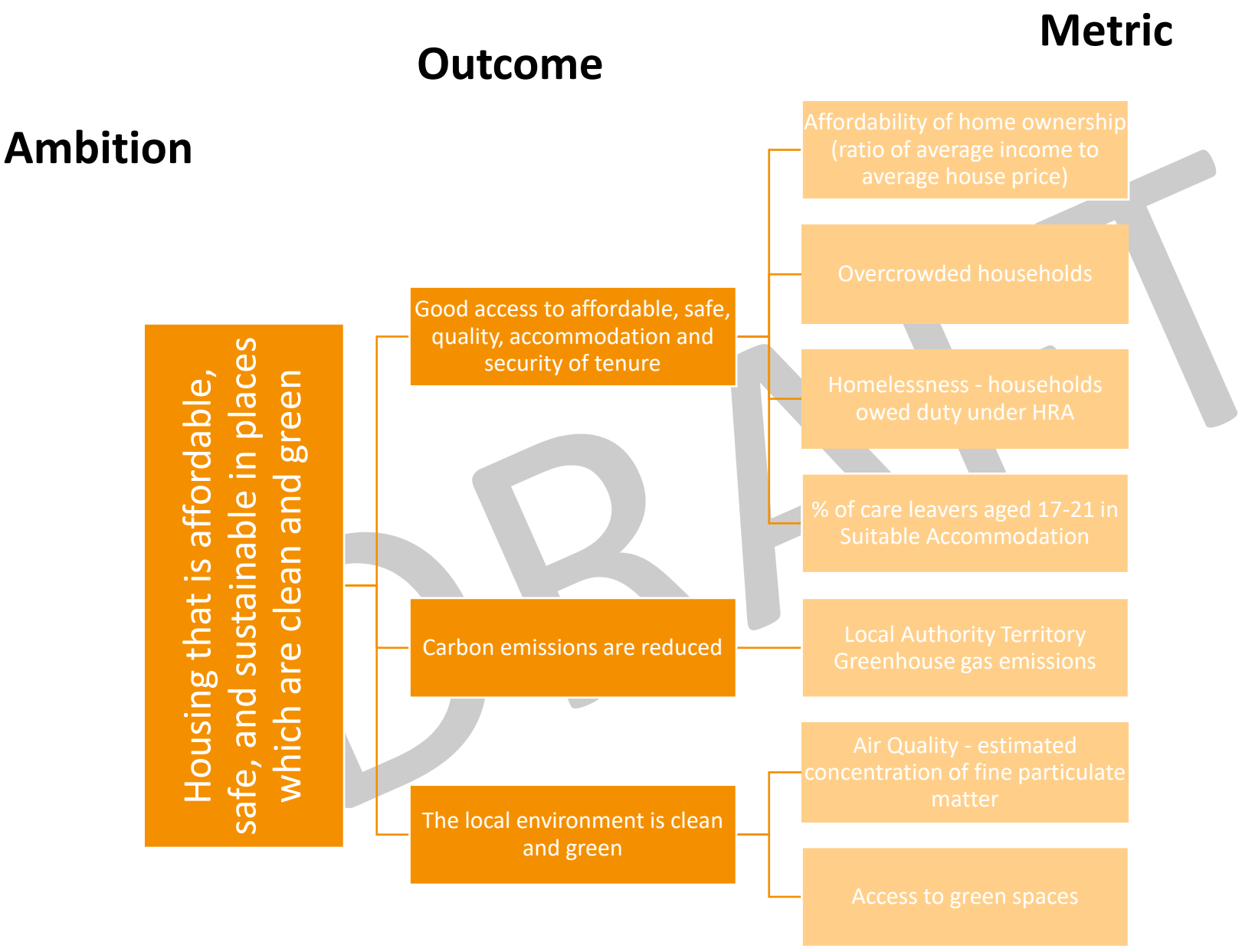

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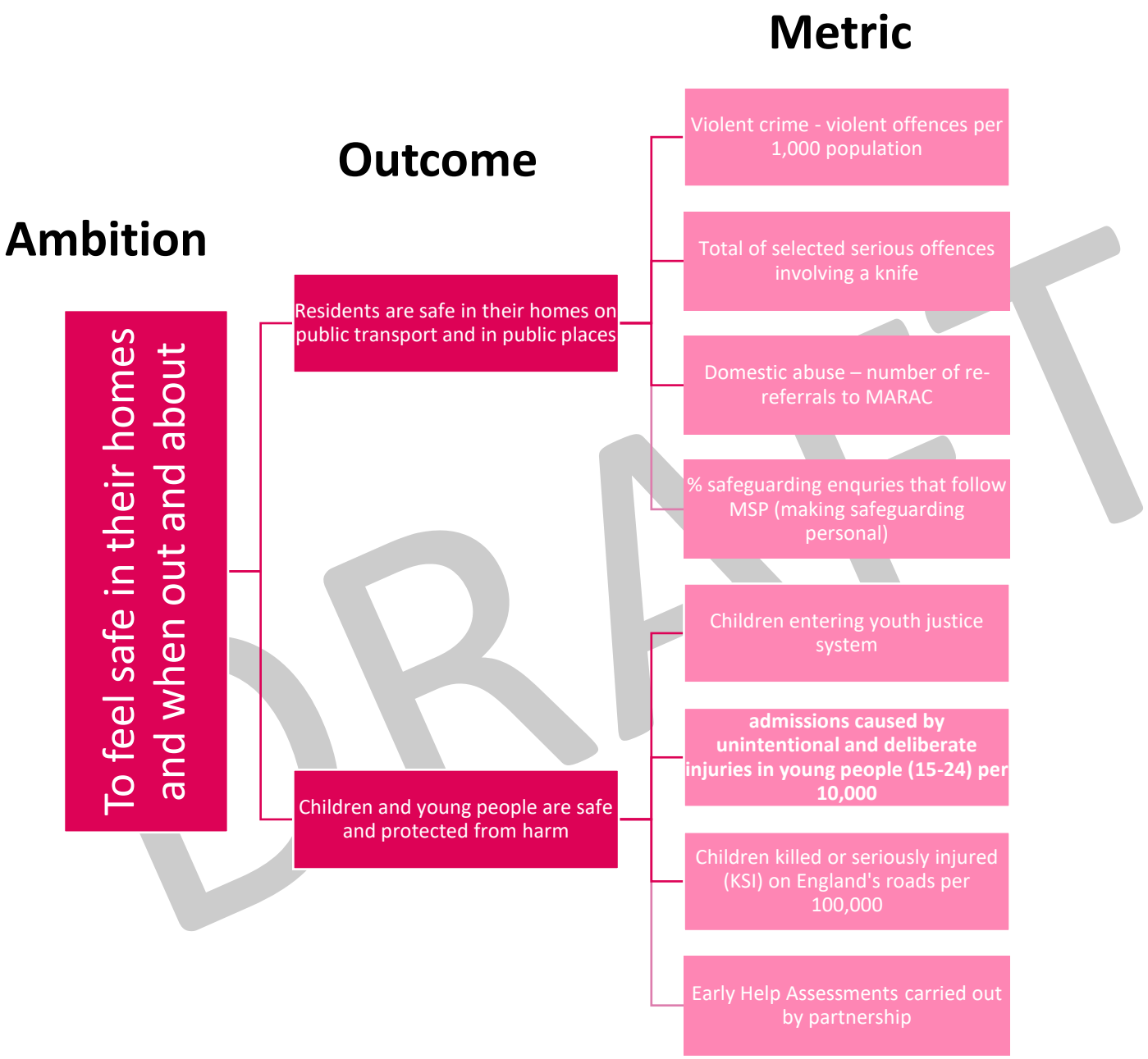

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Ambition	Outcome	Metric
Connected to their families and friends	People feel well connected to family, friends and their community	Social isolation: percentage of adult social care users who have as much social contact as they would like
	Public transport supports people to connect with family and friends	Number of concessionary travel claims made
	People have good access and skills to use new technology for social links to family and friends	Digital Exclusion Index

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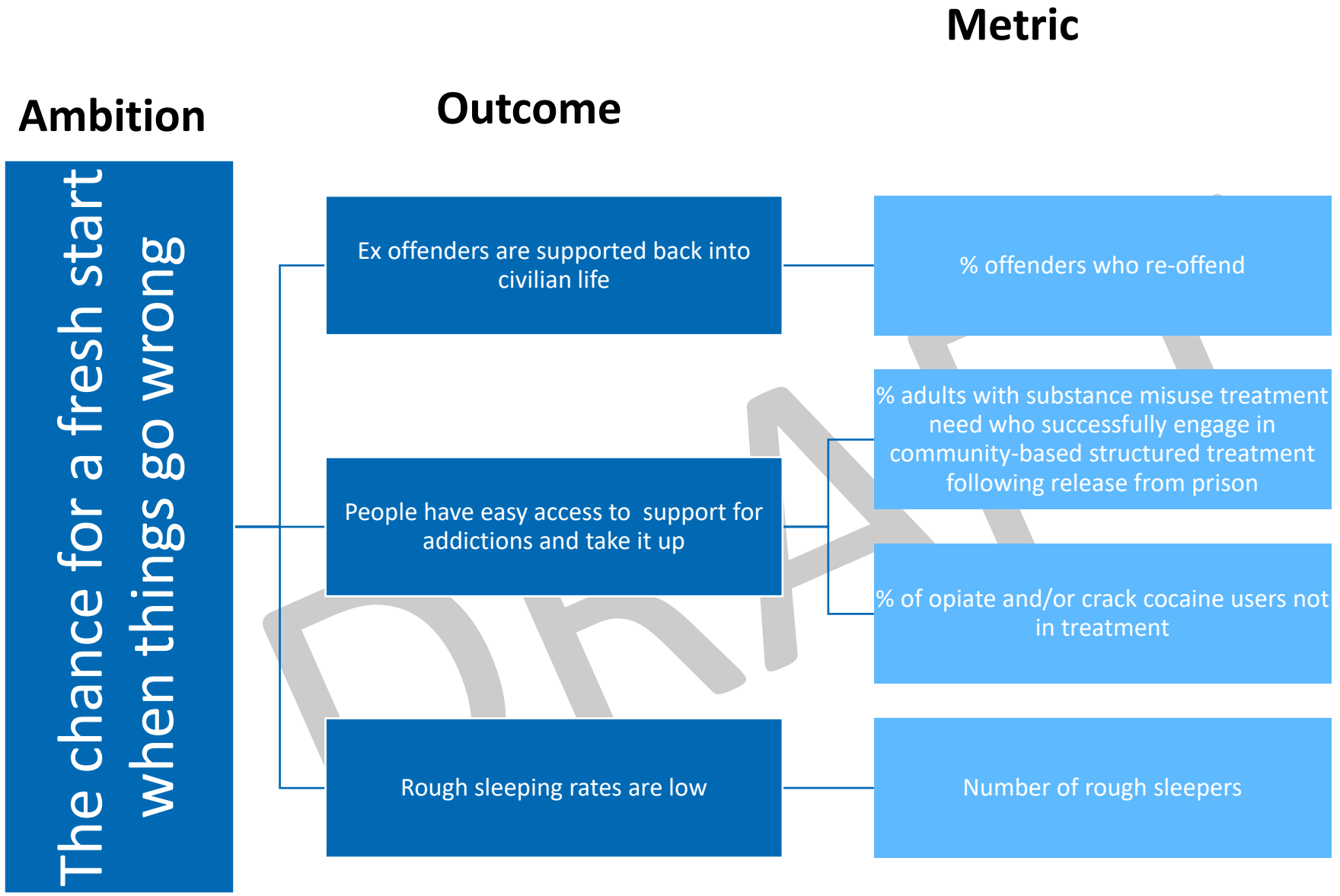

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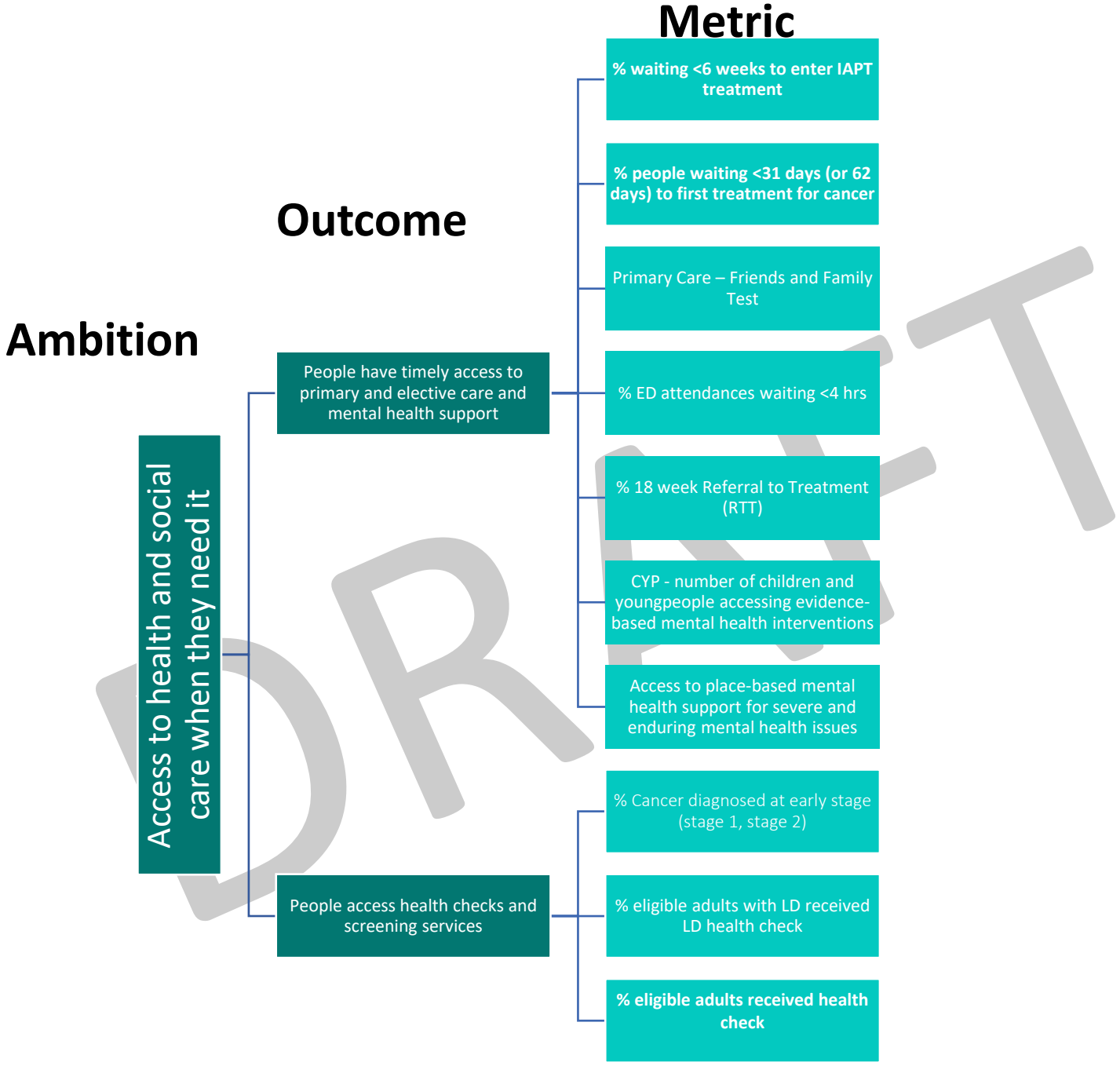

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Integrated Care Northamptonshire

Ambition

Access to health and social care when they need it

Outcome

Metric

Outcome	Metric
Fewer people are hospitalised with seasonal/flu/ pneumonia/covid	**Flu vaccine coverage in 65+ age group**
People get timely access to personal and social care	% people triaged duty within 24 hours
	% people that are in crisis that receive a commissioned service within 24 hours
	% outside of crisis situations pepole that require commissioned service receive it within 1 month
people only spend as much time in hospital as necessary	% people discharged within 7 days
Disabled and frail elderly people are supported to live at home	People that return to their normal place of residence after discharge from hospital
	% adult social care service users who feel they have control over their daily lives, age 65+
	Rate of hospital admissions due to falls (65+) per 100,000

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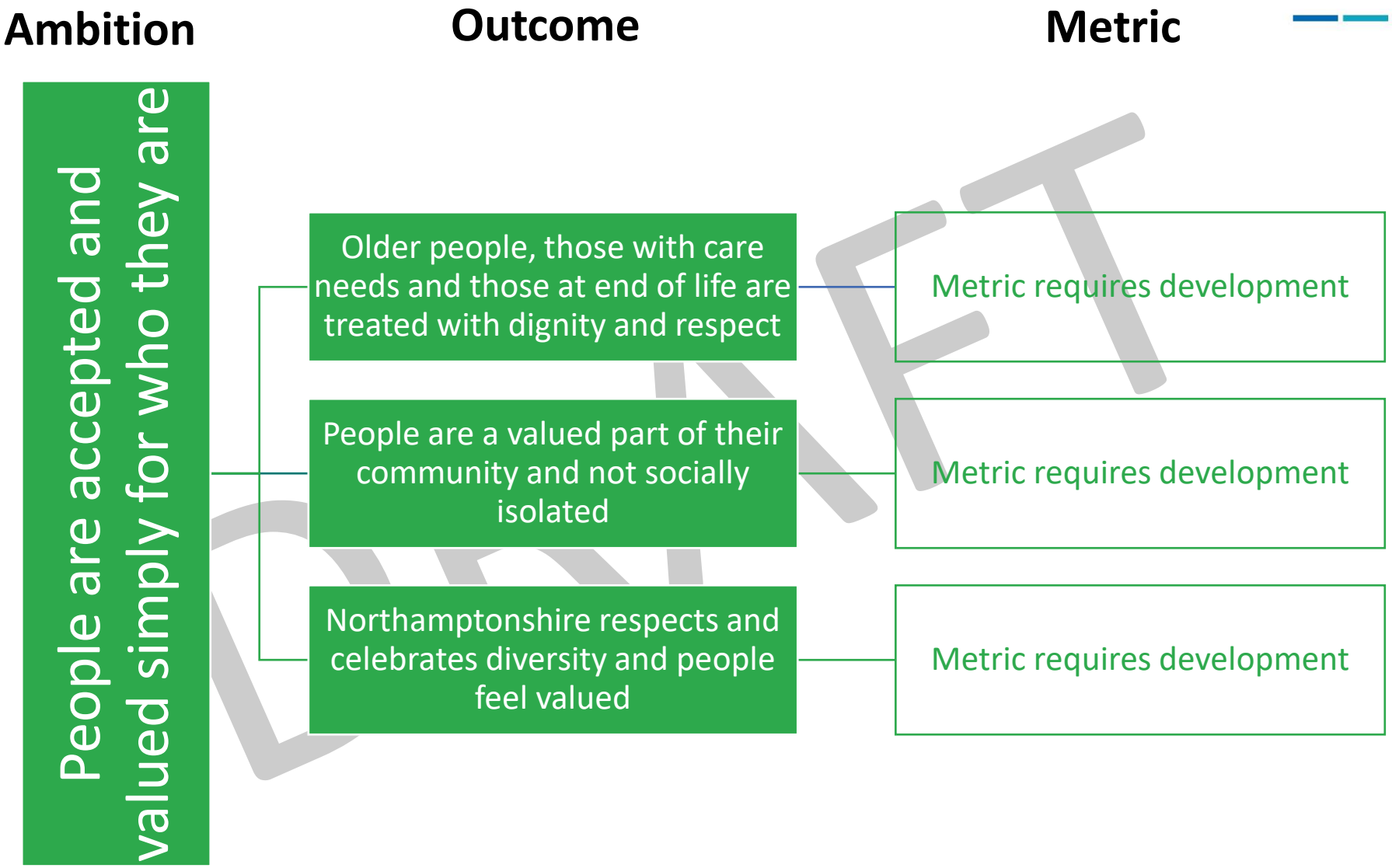
Integrated Care Northamptonshire



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WEST NORTHANTS Health and Wellbeing Board
live your best life

Item no: 10

WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

8th September 2022

Report Title	Summary Joint Strategic Needs Assessment (JSNA)
Report Author	Rhosyn Harris, Consultant in Public Health

Contributors/Checkers/Approvers		
Other Director/SME	Sally Burns (DPH) Director for Public Health, West Northants Council	30th August 2022

List of Appendices

Appendix A – Summary Joint Strategic Needs Assessment (JSNA)
Appendix B – Local Insights Report (North Northamptonshire)
Appendix C – Local Insights Report (West Northamptonshire)

1. Purpose of Report

1.1. The purpose of the Summary Joint Strategic Needs Assessment (JSNA) is to bring together and summarise existing published needs assessments and reports to provide a summary overview of health and wellbeing needs and determinants in the county.

1.2. This summary overview will be used by the Northamptonshire Integrated Care Partnership (ICP) Strategy Development Board to inform the first iteration of the Northamptonshire Integrated Care Strategy, of which a first draft is expected to be published in December 2022.

2. Executive Summary

2.1 This summary JSNA identifies, alongside some of the great strengths of Northamptonshire, some of the significant challenges we face as a system in improving and narrowing the gap in health and wellbeing.

2.2 There remain significant inequalities in life expectancy due to socioeconomic deprivation, as well as inequalities for certain communities of interest. While we have relatively good data on, for example, the gap in life expectancy for adults with learning disabilities, there is a dearth of data and evidence on experiences and outcomes for some of our other communities.

2.3 Northamptonshire's population is growing at a rate faster to England but follows the national trend of our population ageing.

2.4 Northamptonshire benefits from high employment levels and a beautiful rural setting but many in our communities face the same challenges affecting people nationally around poverty (including food poverty and fuel poverty), a lack of affordable housing, and crime and safety in our neighbourhoods as well as issues such as a lack of access to green space. These all have a significant impact on the health of our children, young people, and adults alike and affect our ability to be able to engage in healthy behaviours like eating well, moving more, sleeping well, drinking less alcohol and stopping smoking.

2.5 The conditions that cause the greatest burden of ill-health and early deaths to the people of Northamptonshire are cancers, heart disease, chronic lung disease, musculoskeletal disease, and poor mental health. While rate of death and disability due to these conditions may be similar in scale to the national average, the volume of hospital care required is significantly higher than the national average suggesting that the county is much better at treating these conditions when they cause problems, than preventing them.

3. Recommendations

3.1 For Health and Wellbeing Board to approve the ICP Summary JSNA for publication.

4. Report Background

4.1 The Health and Social Care Act 2012 introduced Health and Wellbeing Boards (HWBs), which became operational on 1 April 2013 in all 152 local authorities with social care and public health responsibilities.

4.2 Since then, the Health and Care Act 2022, which received Royal Assent in April 2022, looks to enable greater integration between partners across the health (which includes physical and mental health) and social care sector. This includes collaboration between partners who can address the wider determinants of health.

4.3 HWBs continue to be responsible for assessing the health and wellbeing needs of the area and publishing a JSNA.

4.4 JSNAs and Joint Health and Wellbeing Strategies are the vehicles for ensuring that the needs, and the local determinants of health of the local population are identified and agreed. The JSNA provides the evidence base for the health and wellbeing needs of the local population and should be kept up to date.

5. Issues and Choices

5.1 The Summary JSNA identifies key issues in addressing health and wellbeing in Northamptonshire.

6. Implications (including financial implications)

6.1 Resources and Financial

6.1.1 The Summary JSNA itself does not directly have financial/budget implications but instead should set our priorities to shape future budget setting across the system.

6.2 Legal

6.2.1 The delivery of a JSNA is the statutory duty of the Health and Wellbeing Board. When the integrated care partnership receives a new JSNA from a HWB, it must consider refreshing the integrated care strategy.

6.3 Risk

6.3.1 There are no significant risks arising from the proposed recommendations to publish the Summary JSNA.

6.4 Consultation

6.4.1 This document is a summary that draws on existing published needs assessments and public health profiles and therefore draws on consultation conducted as part of their development.

6.4.2 However, there is in development an insights pack that summarises recent local public engagement findings that is intended to be presented alongside this data pack.

6.5 Consideration by Overview and Scrutiny

6.5.1 The report has not yet been presented to Overview and Scrutiny.

6.6 Climate Impact

6.6.1 As the most pressing public health threat this century, this Summary JSNA notes climate change as a key health and wellbeing priority for the people of Northamptonshire.

6.7 Community Impact

6.7.1 This report considers the health and wellbeing of both North and West Northamptonshire.

7. Background Papers

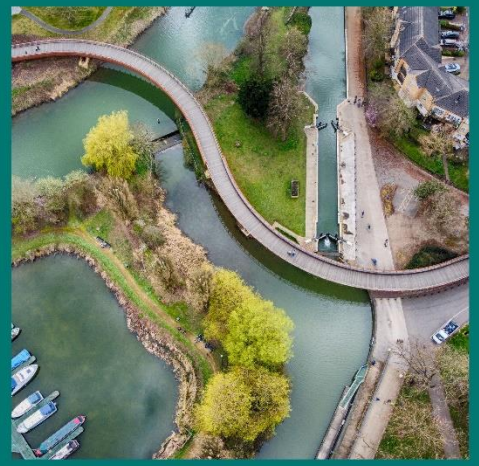
7.1 Public Health Profiles
https://fingertips.phe.org.uk/

7.2 Northamptonshire Joint Strategic Needs Assessments
https://www.westnorthants.gov.uk/health-leisure-and-parks/northamptonshire-jsna

Integrated Care Northamptonshire

ICS Summary JSNA

DRAFT WORKING DOCUMENT



Introduction

- This summary joint strategic needs assessment (JSNA) was assembled drawing from existing published Northamptonshire strategic needs assessments, where possible we have enhanced this information with more up-to-date nationally published data.
- This summary document is intended to support the Integrated Care Partnership in identifying strategic priorities as part of development of the Integrated Care Strategy
- This summary document should be considered alongside the more in-depth health needs assessments, as well as other key supporting documents and reports including, importantly, Healthwatch reports and wider community engagement insights that have been gathered together into an insights pack to accompany this document.

Executive Summary

- This summary JSNA identifies, alongside some of the great strengths of Northamptonshire, some of the significant challenges we face as a system in improving and narrowing the gap in health and wellbeing.
- There remain significant inequalities in life expectancy due to socioeconomic deprivation, as well as inequalities for certain communities of interest. While we have relatively good data on, for example, the gap in life expectancy for adults with learning disabilities, there is a dearth of data and evidence on experiences and outcomes for some of our other communities.
- Northamptonshire's population is growing at a rate faster to England but follows the national trend of our population ageing.
- Northamptonshire benefits from high employment levels and a beautiful rural setting but many in our communities face the same challenges affecting people nationally around poverty (including food poverty and fuel poverty), a lack of affordable housing, and crime and safety in our neighbourhoods as well as issues such as a lack of access to green space. These all have a significant impact on the health of our children, young people and adults alike and affect our ability to be able to engage in healthy behaviours like eating well, moving more, sleeping well, drinking less alcohol and stopping smoking.
- The conditions that cause the greatest burden of ill-health and early deaths to the people of Northamptonshire are cancers, heart disease, chronic lung disease, musculoskeletal disease and poor mental health. While rate of death and disability due to these conditions may be similar in scale to the national average, the volume of hospital care required is significantly higher than the national average suggsting that the county is much better at treating these conditions when they cause problems, than preventing them.

Sections

Integrated Care Northamptonshire

1. Summary Infographics

2. Local Context and overarching indicators

3. Social Determinants

4. Health and wellbeing through the lifecourse

Integrated Care Northamptonshire

Summary Infographics

Health and Wellbeing in North Northamptonshire, August 2022

Start Well

3,789 babies were born in 2021.

12.2% of mothers smoked at the time of birth in 2020/21. This is worse than the England average.

The population of North Northamptonshire was 359,500 in 2021.

70% of children achieved a good level of development at the end of reception class in 2019.

14% of children aged under 16 lived in low income families in 2020/21. This is better than the England average.

24% of children in reception class were overweight or obese in 2019/20. This is similar to the England average.*

34% of children in Year 6 were overweight or obese in 2019/20. This is similar to the England average.*

69% of young people gained a standard pass (4) in English and Maths GCSEs in 2021.

The Chlamydia detection rate was 1,330 per 100,000 in 15 to 24 year olds in 2020. This is below the national target range.

There were 14 pregnancies in females aged under 18 per 1,000 girls aged 15 to 17 in 2020. This is similar to the England average.

** Please note that figures on childhood excess weight should be interpreted with caution due to low 2019/20 NCMP participation.*

Live Well

A 2018 based projection estimated there were 150,136 households in North Northamptonshire in 2021.

The average salary (persons) in 2020 was £30,189. This was an increase of 9% compared to 2019.

79.6% of adults were employed in 2020/21. This is better than the England average.

10% of households experienced fuel poverty in 2018.

There were 323 new sexually transmitted infections per 100,000 population in 2020. This is lower than the England average.

62.6% of adults were physically active in 2020/21. This is worse than the England average.

53% of the population aged 16+ ate their "5-a-day" in 2019/20. This is worse than the England average.

70% of adults were overweight or obese in 2020/21. This is worse than the England average.

There were 431 alcohol related hospital admissions per 100,000 population in 2020/21. This is better than the England average.

18% of adults smoked in 2019. This is worse than the England average.

There were 11 suicides per 100,000 population in 2018-2020. This is similar to the England average.

There were 196 hospital admissions for self-harm per 100,000 population in 2020/21. This is worse than the England average.

There were 4 deaths from drug misuse per 100,000 population in 2018-2020. This is similar to the England average.

38 people were killed or seriously injured on roads per 100,000 population in the 2016-2018. This is better than the England average.

There were 28 deaths in under 75s from preventable cardiovascular diseases per 100,000 population in 2017-2019. This is similar to the England average.

There were 24 deaths in under 75s from preventable respiratory diseases per 100,000 population in 2017-2019. This is worse than the England average.

There were 60 deaths from preventable cancers per 100,000 population in 2017-2019. This is worse than the England average.

Age Well

There were 1,893 hospital admissions due to falls in people aged 65+ per 100,000 65+ population in 2020/21. This is better than the England average.

The average male life expectancy was 79.2 in 2018-2020. This is similar to the England average.

The average female life expectancy was 82.4 in 2018-2020. This is worse than the England average.

Produced by Public Health Intelligence, North Northamptonshire Council. All figures have been calculated using the latest district level data available in August 2022 and rounded to whole numbers. Icons by Freepik from flaticon.com.

Health and Wellbeing in West Northamptonshire, August 2022

Start Well

4,647 babies were born in 2021.

12.3% of mothers smoked at the time of birth in 2020/21. This is worse than the England average.

The population of West Northamptonshire was 425,700 in 2021.

72% of children achieved a good level of development at the end of reception class in 2019.

14% of children aged under 16 lived in low income families in 2020/21. This is better than the England average.

21% of children in reception class were overweight or obese in 2019/20. This is better than the England average.*

30% of children in Year 6 were overweight or obese in 2019/20. This is better than the England average.*

73% of young people gained a standard pass (4) in English and Maths GCSEs in 2021.

The Chlamydia detection rate was 1,417 per 100,000 in 15 to 24 year olds in 2020 This is below the national target range.

There were 10 pregnancies in females aged under 18 per 1,000 girls aged 15 to 17, in 2020. This is lower than the England average.

** Please note that figures on childhood excess weight should be interpreted with caution due to low 2019/20 NCMP participation.*

Live Well

A 2018 based projection estimated there were 170,103 households in West Northamptonshire in 2021.

The average salary (persons) in 2020 was £32,467. This was an increase of 2% compared to 2019.

78% of adults were employed in 2020/21. This is similar to the England average.

9% of households experienced fuel poverty in 2018.

There were 374 new sexually transmitted infections per 100,000 population in 2020. This is lower than the England average.

63% of adults were physically active in 2020/21. This is worse than the England average.

52% of the population aged 16+ ate their "5-a-day" in 2019/20. This is worse than the England average.

69% of adults were overweight or obese in 2020/21. This is worse than the England average.

There were 467 alcohol related hospital admissions per 100,000 population in 2020/21. This is similar to the England average.

15% of adults smoked in 2019. This is similar to the England average.

There were 8 suicides per 100,000 population in 2018-2020. This is lower than the England average.

There were 297 hospital admissions for self-harm per 100,000 population in 2020/21. This is worse than the England average.

There were 3 deaths from drug misuse per 100,000 population in 2018-2020. This is lower than the England average.

42 people were killed or seriously injured on roads per 100,000 population in the 2016-2018. This is similar to the England average.

There were 26 deaths from preventable cardiovascular diseases per 100,000 population in 2017-2019. This is similar to the England average.

There were 20 deaths in under 75s from preventable respiratory diseases per 100,000 population in 2017-2019. This is similar to the England average.

There were 54 deaths from preventable cancers per 100,000 population in 2017-2019. This is similar to the England average.

Age Well

There were 2,727 hospital admissions due to falls in people aged 65+ per 100,000 65+ population in 2020/21. This is worse than the England average.

The average male life expectancy was 79.8 in 2018-2020. This is better than the England average.

The average female life expectancy was 82.8 in 2018-2020. This is worse than the England average.

Produced by Public Health Intelligence, North Northamptonshire Council. All figures have been calculated using the latest district level data available in August 2022 and rounded to whole numbers. Icons by Freepik from flaticon.com.

Integrated Care Northamptonshire

Local Context and Overarching Indicators

Integrated Care
Northamptonshire

Context

Geography

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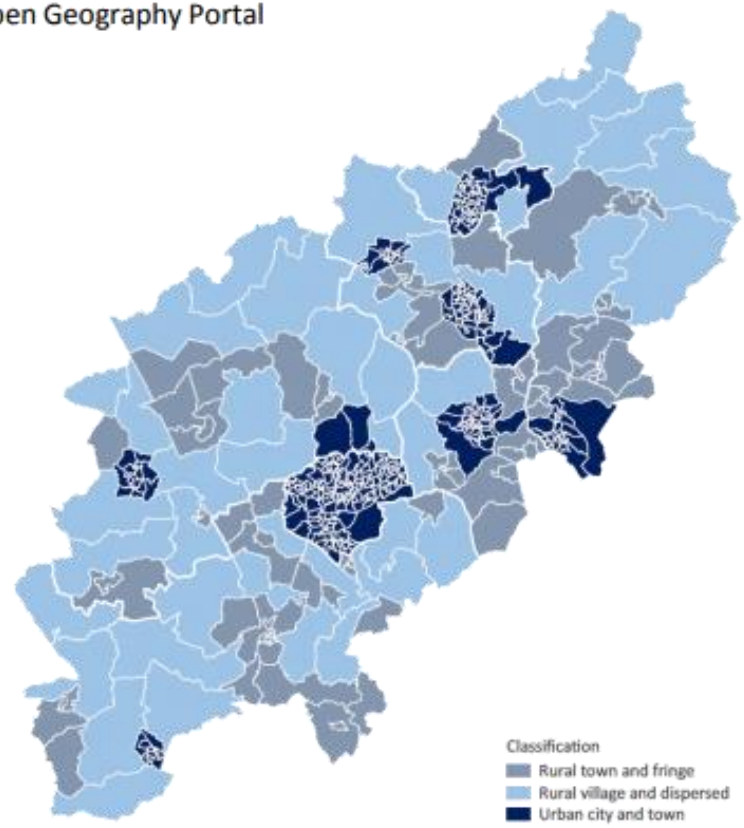
- Northamptonshire is located in the centre of England, well placed strategically on key transport routes between London and Birmingham and sat between other key cities of Oxford, Cambridge and Leicester. Administratively part of the East Midlands Region, it borders three other local government regions.
- A largely rural county (with much of the land area agricultural) nearly 70% of Northamptonshire residents live in Urban/Town areas. These areas are highlighted in dark blue on the map (right).
- The county town of Northampton sits in West Northamptonshire with other major population centres of Daventry, Towcester and Brackley; with Corby, Wellingborough, Kettering and Rushden sitting in North Northamptonshire.
- Northamptonshire has an extensive network of rivers and canals, with the Nene Valley and its lakes and wetland areas traversing the county.

Northamptonshire Lower Super Output Areas by urban/rural classification (Source: Urban/rural classifications sourced from ONS Open Geography Portal



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Population Size

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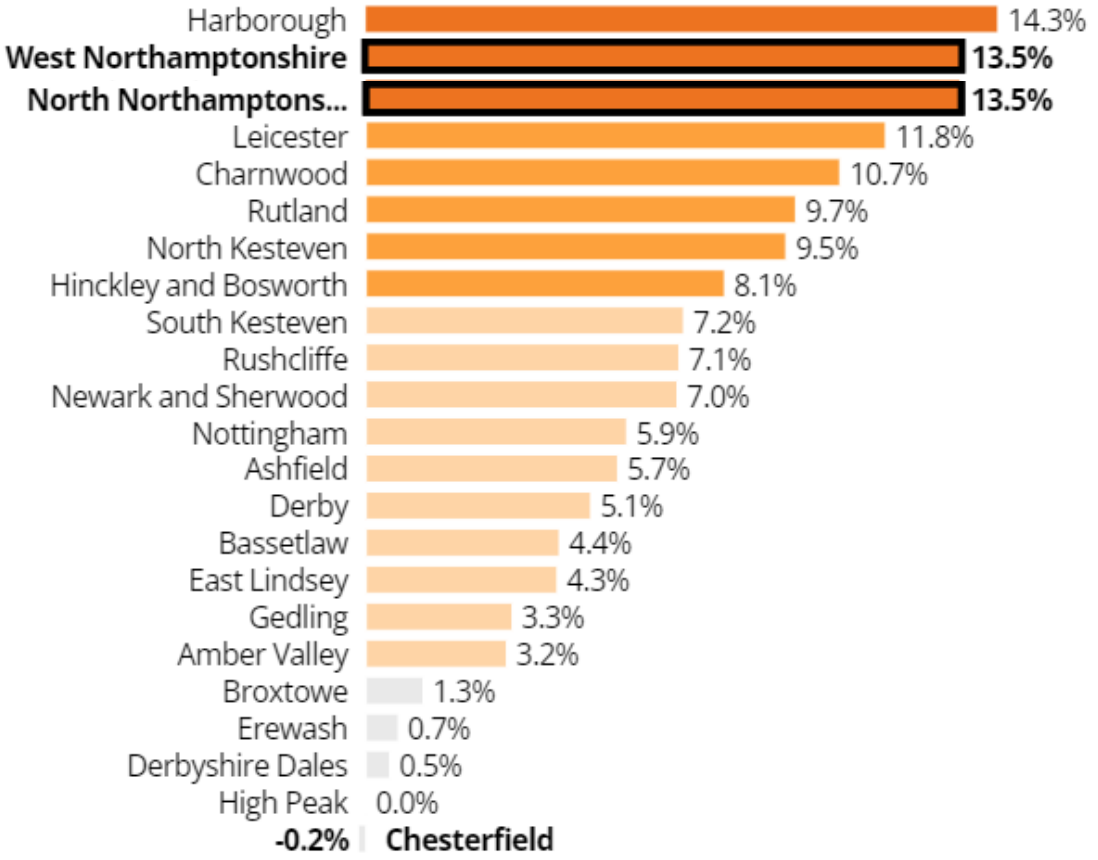
In 2021 the population of West Northamptonshire was **425,700** and North Northamptonshire **359,500**

In the last 10 years the population has increased by over 42,000 in North Northamptonshire and over 50,000 in West Northamptonshire (**an increase of 13.5%**).

This is higher than the overall increase for England (6.6%), where the population grew by nearly 3.5 million and among the highest population growth in the region.

West Northamptonshire is now the 13th and North Northamptonshire the 21st largest local authority in England.

Population change of local authorities in the East Midlands between 2011 and 2021 (Percentage change)



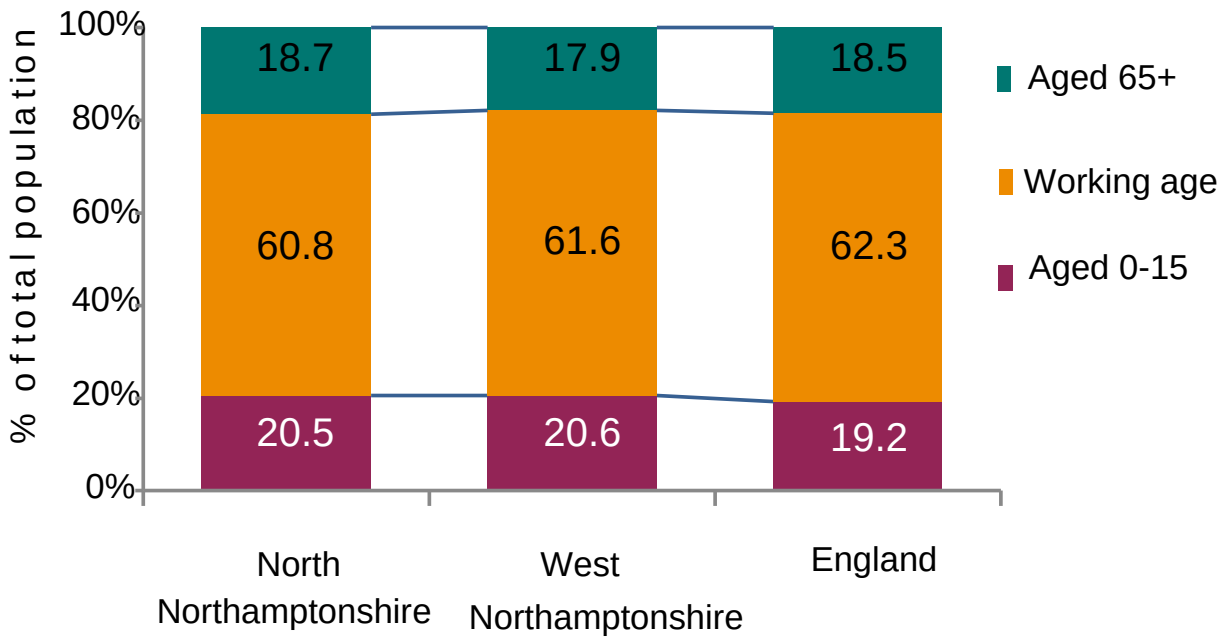
Source: How the population changed, Census 2021 - ONS

Demography

Integrated Care Northamptonshire

Changes in age structure of populations of West and North Northamptonshire are very similar with an **increase of around 30% in people aged 65 years and over**, and an **increase of around 10% in people aged 64 and under**

Source: How the population changed, Census 2021 - ONS



In the 2011 Census 16% of people in West Northants and 12.3% of people in North Northants described their ethnicity as something other than “white UK”; 10% of people were described as being from Black and Minority Ethnic (BME) groups in West Northants and 6.6% in North.

Diversity of our communities varies significantly from very diverse wards in Northampton and Wellingborough to more rural areas of Yelvertoft and Woodford where more than 97% of the population identify as White British.

Of those residents born outside England, the largest group in West Northants are from EU Accession countries (3%) and in North Northants are from Scotland (4%).

Source: Census 2011

Health inequalities

Integrated Care Northamptonshire

- Health inequalities are the **preventable, unfair and unjust differences** in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions. Groups that experience this can be categorised according to:

Socioeconomic Status

- Those living in deprived areas

Other under-served or vulnerable groups

- Children who are looked after and care leavers
- Carers
- Veterans

Protected Characteristics

including but not limited to:

- Race and religion (including those from black and minority ethnic backgrounds)
- Disability – including physical and sensory, as well as learning disabilities
- Sexual orientation and gender reassignment

Social Exclusion

Some groups are particularly excluded or extremely marginalised including:

- Rough sleepers
- Gypsy, Roma and Traveller communities
- Refugees and asylum seekers or vulnerable migrants
- Sex workers

Communities of Interest

Integrated Care Northamptonshire

Community/group		Inequity of access or inequalities in outcomes
Deprived communities	It's estimated that over 127,000 people in Northamptonshire live in the 20% most deprived communities in England (source: IMD 2019, Census 2021)	There is almost a decade difference in life expectancy between men living in the most and least deprived communities in Northamptonshire (source: PHE Fingertips)
BAME groups	8.5% (around 66,000 people) of the county identify as being from black and minority ethnic communities (source: Census 2011)	In the UK black women are four times more likely to die in pregnancy or childbirth than white women (source: MBRRACE-UK)
Physical disability and sensory impairment	Around 30,000 people claim Personal Independence Payments to help with extra costs caused by long-term disability, ill-health or terminal ill-health (source: Local Insights Report)	Common barriers to health care are exacerbated for many disabled people...this is particularly the case for those with visual, hearing and mobility impairments (source: Improving access for all: reducing inequalities in access to general practice services. NHS England)
Learning Disability and Autism	Around 2.3% of the adult population, predicted to rise from 13,076 in 2015 to 14,106 in 2025 (source: Learning from Deaths Review (LeDeR) For People with Learning Disabilities Annual Report 2020/21)	Whilst the average age of death for adults in Northamptonshire is 79.6 for males and 82.7 for females, for our local population of people with learning disabilities it is between 50-59 years of age. 32% difference in life expectancy. (LeDeR Annual Report)
LGBTQ+	Subnational sexual identity estimates (ons.gov.uk) suggest that 3,140 people in Northamptonshire identify as Gay or Lesbian.	The 2017 National LGBT Survey identified that at least 16% and 38% of respondents had a negative experience accessing health services because of their sexual orientation and gender identity respectively.

Communities of Interest

Integrated Care Northamptonshire

Community/group		Inequity of access or inequalities in outcomes
Rough sleepers	Rough sleepers – 91 counted (2018) and a further approx 6,000 statutorily homeless	The mean age at death of homeless people was 44 years for men, 42 years for women and 44 years for all persons between 2013 and 2017 (source: ONS)
Gypsy, Roma and Traveller communities	Gypsy/Travellers – 527 (2011) with around 250 permanent pitches	Gypsy and Traveller women live 12 years less than women in the general population and men 10 years less (source: Traveller Movement, Gypsy and Traveller Health Briefing, March 2012)
Refugees and vulnerable migrants	93 unaccompanied asylum seeking children in the Northamptonshire Looked After Children population, March 2019.	Most migrants to the UK come to work or study and are young and healthy. There are however some groups of migrants who may have increased health needs associated with their experiences before, during and after migration.
Sex workers	No good estimates available	research into the impact of sex work on general health (not sexual health) is lacking
Children who are looked after and care leavers	Care leavers – almost 700 young people left care in 2017/18	Looked-after children are four times more likely to have a mental health condition than their peers (source: JSNA Insights pack)
Carers	Estimated 75,000+ unpaid carers in Northamptonshire (2019)	The PHE Report “Caring as a social determinant of health” concludes that carers experience poor physical and mental health but also have unmet care needs themselves
Veterans	Est.3,000 - 4,000 serving or former armed forces personnel (2018)	While due to the nature of their work usually fit and active, veterans may have health and wellbeing needs caused by their service

Deprivation

Integrated Care Northamptonshire

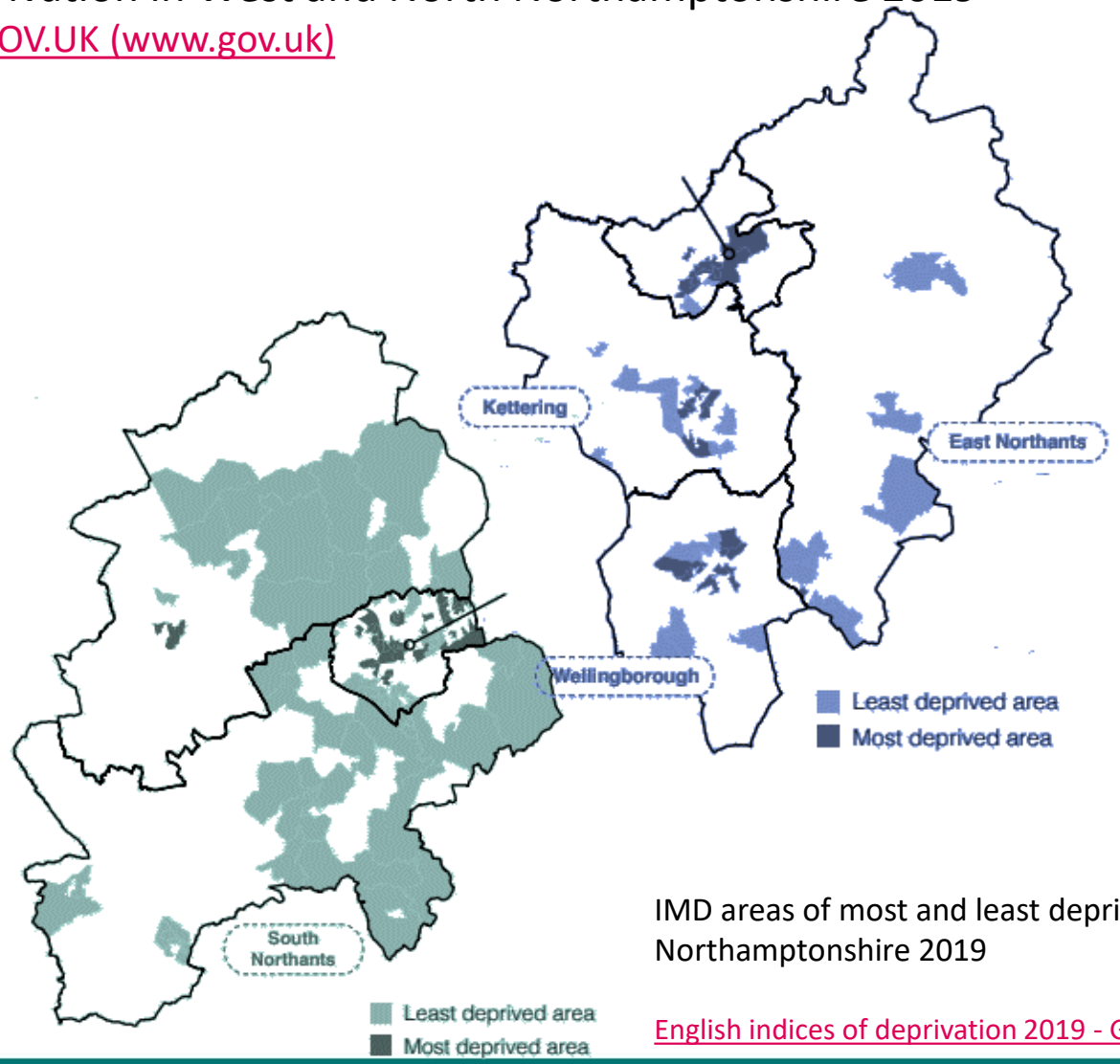
IMD areas of most and least deprivation in West and North Northamptonshire 2019

English indices of deprivation 2019 - GOV.UK (www.gov.uk)

16.95% of the population of West Northamptonshire live in the 20% most deprived areas (LSOA).

The area with the highest proportion of residents living in the top 20% deprived areas is Northampton (28.2%). No part of South Northamptonshire is in the 20% most deprived areas of England.

28.8% of West Northamptonshire residents live in the 20% least deprived areas. Over 58% of residents in South Northamptonshire live in the top 20% least deprived.



IMD areas of most and least deprivation in West and North Northamptonshire 2019

English indices of deprivation 2019 - GOV.UK (www.gov.uk)

15.5% of the population of North Northamptonshire live in the 20% most deprived areas (LSOA).

The areas with the highest proportions of residents living in the top 20% deprived areas are Corby (26.4%) and Wellingborough (23.5%)

19.9% of North Northamptonshire residents live in the top 20 least deprived areas. In East Northants this figure is highest at 31.8%, it's lowest in Corby with 4.9%.

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Overarching Indicators

Healthy Life Expectancy

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West

Average life expectancy at birth for men is
79.8

Men living in the more affluent 20% of the West can expect to live
9 years longer
than those in the 20% most deprived areas

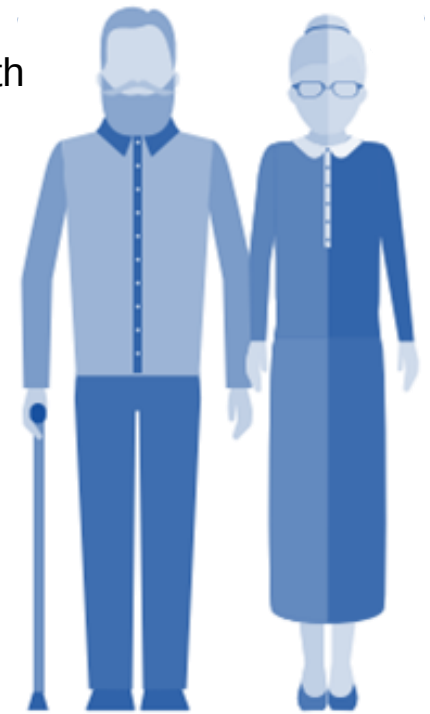
Average life expectancy at birth for women is
82.8

Women living in the more affluent 20% of the West can expect to live
8 years longer
than those in the 20% most deprived areas

North

Average life expectancy at birth for men is
79.2

Men living in the more affluent 20% of the North can expect to live
9 years longer
than those in the 20% most deprived areas



Average life expectancy at birth for women is
82.4

Women living in the more affluent 20% of the North can expect to live
7 years longer
than those in the 20% most deprived areas

Healthy life expectancy (the average number of years a person would expect to live in good health) for men and women in Northamptonshire ranges between 63 and 65 years of age meaning that most people will start their retirement with some degree of poor health

Source Data : Fingertips 2018-2020

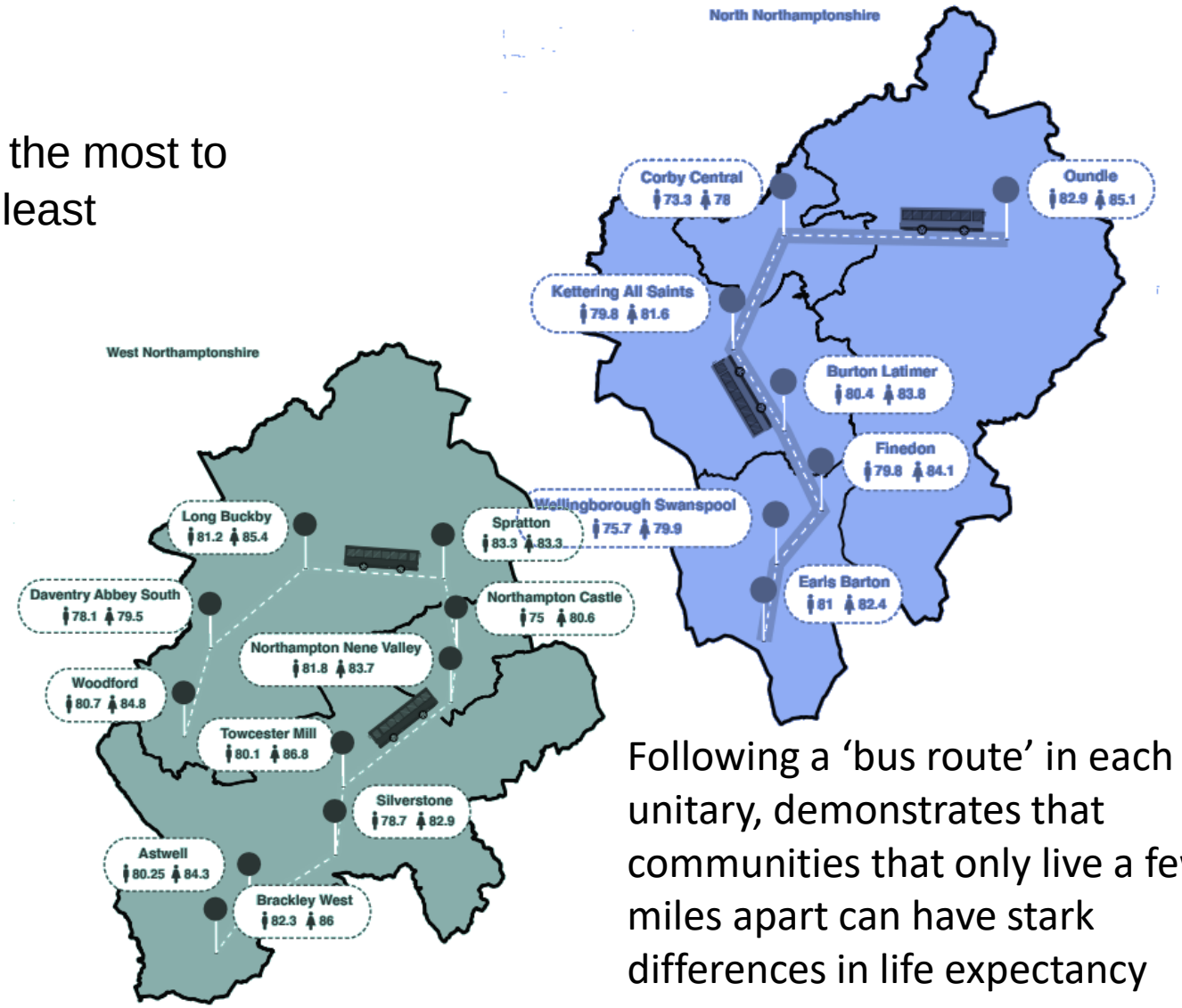
Inequality in life expectancy

Integrated Care Northamptonshire

As illustrated on the previous slide

The top 3 broad causes of death that contributed the most to the gap in life expectancy between the most and least deprived areas in Northamptonshire are:

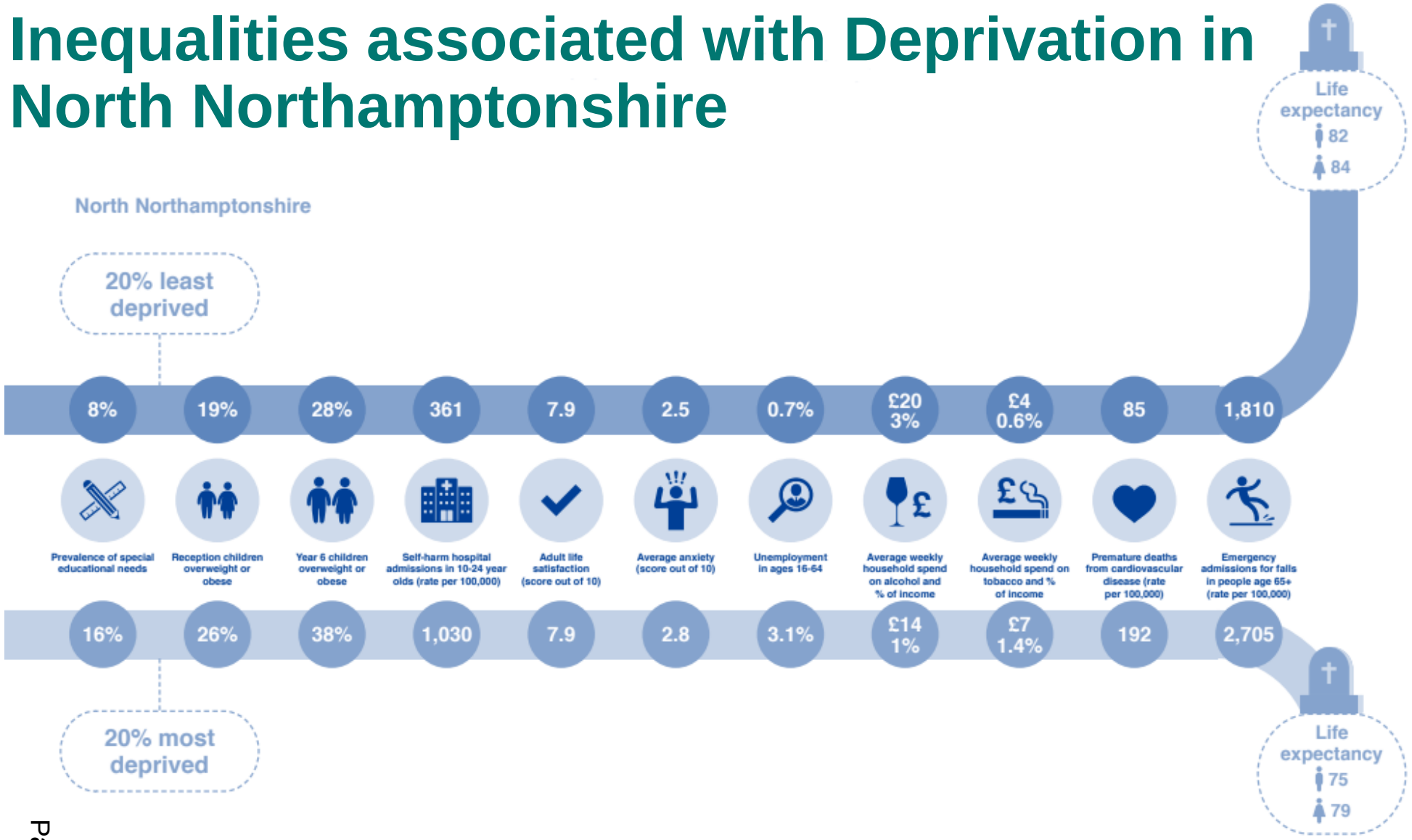
- Cardiovascular disease
- Cancer
- Respiratory disease



Following a ‘bus route’ in each unitary, demonstrates that communities that only live a few miles apart can have stark differences in life expectancy

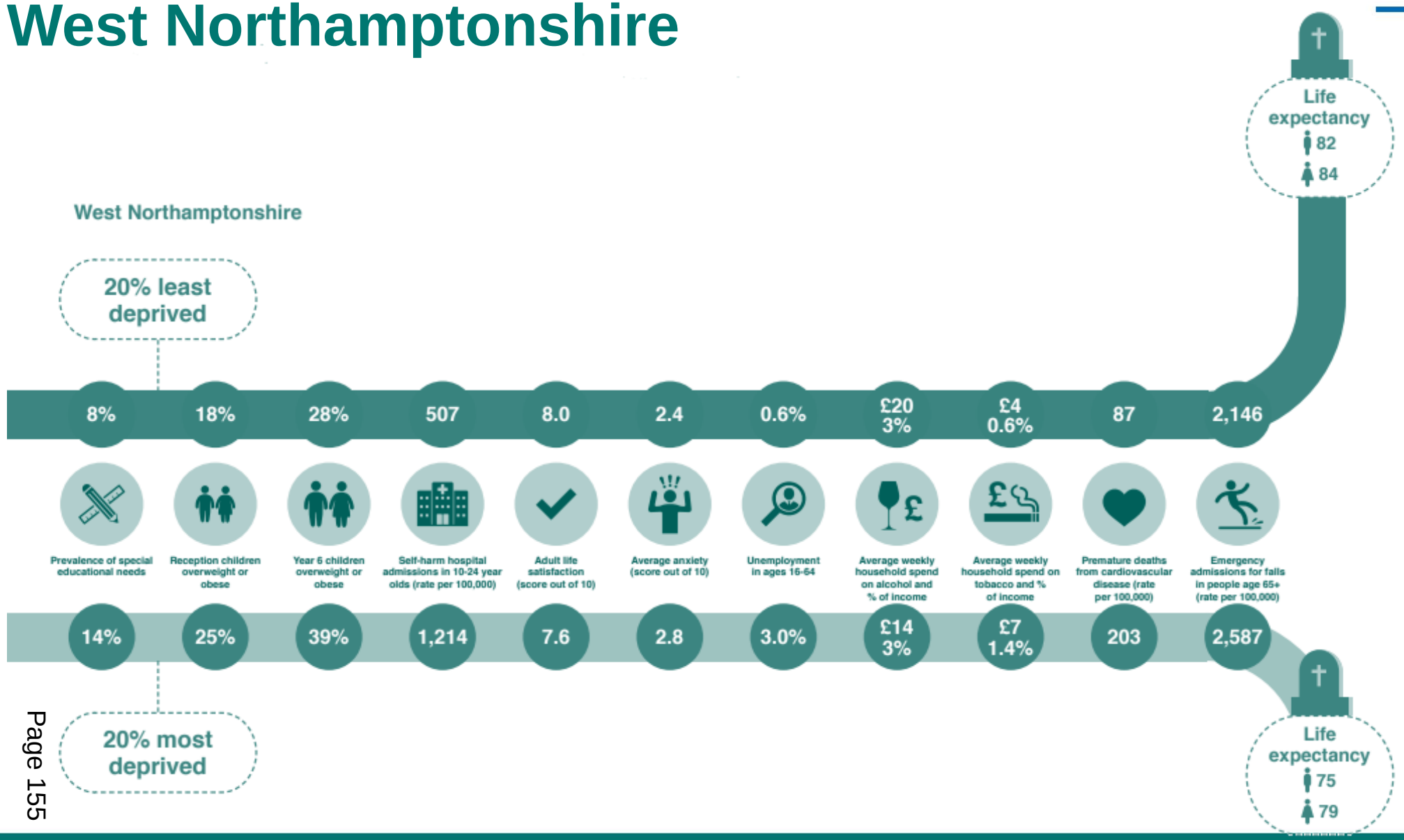
Inequalities associated with Deprivation in North Northamptonshire

Integrated Care Northamptonshire



Inequalities associated with Deprivation in West Northamptonshire

Integrated Care Northamptonshire



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Social Determinants

Environment

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Our health and wellbeing is impacted by our environment in countless ways.

More direct impacts include exposure to hazardous chemicals through air and water pollution, as well as hazardous natural occurrences (floods, heatwaves etc.).

Our environment, particularly exposure we have to the natural environment and how we navigate built-up areas also have a significant impact on how we feel and behave and therefore significantly affect our health and wellbeing.

At the centre of all these considerations, **climate change** has been identified as the **most important health threat of the century.**

There are greater proportions of younger people in urban areas and greater proportions of older people in rural areas. In urban areas 16% of the population is aged over 65 compared with rural villages where the proportion is 23% (Census 2011)

Access to Healthy Assets & Hazards index (AHAH) combines measures on health harming environments (e.g. access fast food outlets/gambling outlets and **air quality**) with access to assets (e.g. GP surgeries, **green spaces**) and rates all small areas (LSOAs) in England.

Over a third (36.3%) of the population of West Northamptonshire live in areas which score among the poorest performing in England compared with 13.4% of the population in North Northamptonshire (poorest performing quintile) in terms of AHAH score.

There is significant variation within local authority areas.

Travel and Transport

Integrated Care Northamptonshire

The connections between transport and health are multiple – from enabling access to essential services to supporting social connections. Moreover, active travel is an important way for people to meet physical activity recommendations.

In 2019/20 the percentage of Northamptonshire residents walking for travel at least 3 times per week was 10.8%; significantly lower than the national figure of 15.1%.

Ranging from as low as 7.9% in mainly rural East Northamptonshire to up to 14.4% (though still low) in urban Northampton.

Only 1% of adults in the county reported cycling for travel at least three days per week.

Over 2018-20 913 people were killed or seriously injured on Northamptonshire's roads this equates to around 39 per 100,000 population similar to the England rate; though this ranges significantly from 80 per 100,000 in Daventry to 25 per 100,000 in Northampton. (source: Department for Transport)

In 2018/19 over 5 million concessionary bus journeys were made in Northamptonshire. On average those with free bus passes made around one journey per week.
(Bus statistics: https://www.gov.uk/government/organisations/department-for-transport/series/bus-statistics)

Economy and Employment

Integrated Care Northamptonshire

80% of North Northamptonshire and 78% of West Northamptonshire residents aged 16-64 are in employment (2020/21). These are the highest rates of employment in the East Midlands. However this high employment rate is not enjoyed by all in our communities and is:

- 9.9% (percentage points) lower in those with a long-term health condition
- 71.2% (percentage points) lower in those who are in contact with secondary mental health services
- 78.2% (percentage points) lower in those with a learning disability

In 2018, the West Northants economy produced goods and services valued at £11.5 (bn) (GVA) and supported around 242,800 jobs* and in 2019 North Northants had an economic output of £7.2 (bn) (GVA) with 158,000 jobs**.

Northamptonshire authorities are part of South-East Midlands Local Enterprise Partnership (SEMLEP). The sectors most important to this region are Creative and Cultural; High Performance Technology; Logistics and Manufacturing and Advanced Technology

The SEMLEP Business Survey 2021 found that in this region

- Three-quarters of businesses rated their local area as “a good place to do business”
- Availability of affordable housing, the local town centre and skill-match were identified as challenging areas

Sources

*: West Northamptonshire Housing and Economic Needs Assessment West Northamptonshire Council July 2021

** North Northmptonshire Economic Prospectus

Income and Resources

Integrated Care Northamptonshire

Around **1 in 10 people** in the county live in **low-income households** (9.6% West Northamptonshire and 11.3% of people in North Northamptonshire experiencing income deprivation in 2019) (source: PHE Fingertips).

When focusing on children who are living in relatively low income households the figure is slightly higher in 2020 at 13.7% in West and 13.9% in North. .(source: Local Insights/DWP)

The number of people that have claimed Local Council Tax Support in recent years are, in North Northants 17,728 and in West Northants – 20,305 (source: Department for Levelling up, Housing & Communities- 2015-16 Q1 to 2021-22 Q4)

As noted in the Marmot Report 2010 *"Having insufficient money to lead a healthy life is a highly significant cause of health inequalities".*

The concepts of a Minimum Income for Healthy Living (MIHL) or Minimum Income Standard (MIS) were developed to convey the level of income needed for adequate nutrition, physical activity, housing, social interactions, transport, medical care and hygiene.

The National Living Wage introduced in 2016 (those aged over 23 are eligible) is higher than the national minimum wage and has brought people closer to reaching the minimum income standard though as reported in "Marmot 10 Year on" in 2020, is still lower than the minimum income standard,

Housing

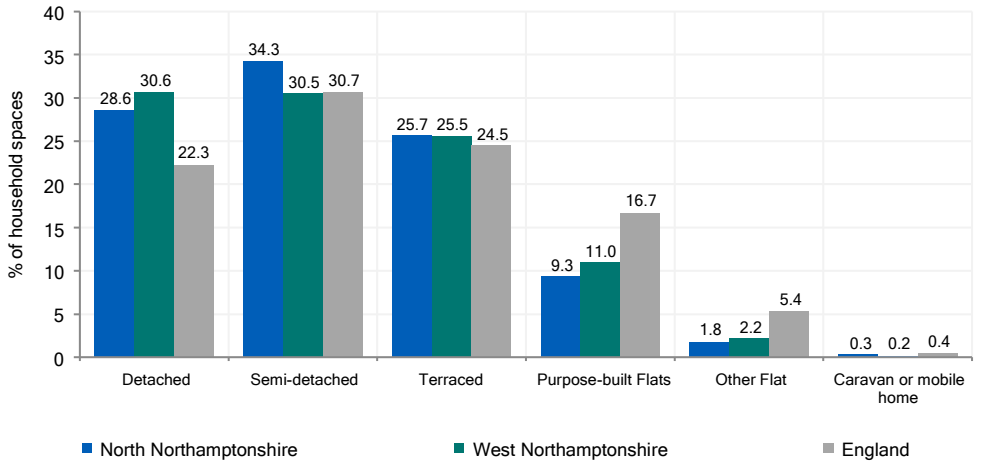
Integrated Care Northamptonshire

Having a safe and secure place of residence is an absolute foundation for good health and wellbeing.

Availability of affordable housing, either to buy or rent, is a challenge nationally. The median monthly private rental price in Northampton town (source: ONS 1 April 2021 to 31 March 2022) was £750 which is similar to the England average). In 2021 in West Northamptonshire average house prices were 9 times average gross annual household income (source: ONS) .

Housing statistics data returns for 2020 to 2021 indicate that over 9,000 people were on a waiting list for social housing in the county over this time.

As well as affordability, quality and safety of housing is an important consideration. Around 10,000 households in West Northants and 6,000 households in North Northants are overcrowded (according to census data 2011) and just under 30,000 households were estimated to be experiencing fuel poverty in 2018.



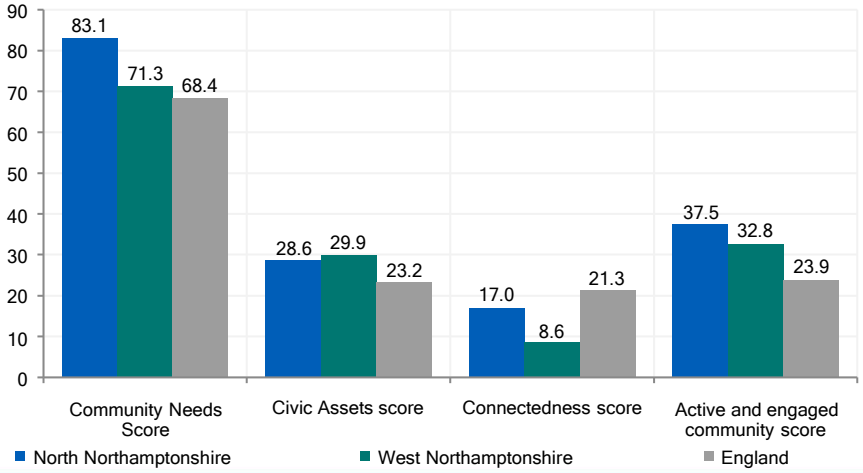
The majority of dwellings across the county are detached or semi-detached. The age of a property is the most significant factor associated with energy efficiency, and while housing stock inn Northamptonshire is largely post-war, over 40,000 dwellings were built pre-1900 and therefore more likely to be energy inefficient. (source: West and North Northants Insights Reports)

Community Connections and Safety

Integrated Care Northamptonshire

OCI have developed a Community Needs Index, combining three domain measures: access to civic assets (e.g. libraries, community centres); connectedness (e.g. digital access, travel and transport); and community activity and engagement (i.e levels of participation in voluntary and community sector).

The graph below illustrates overall Community Needs scores for North and West Northants (higher score = higher needs) and the three domain scores.



(source: Insights Report)

Neighbourhood safety is strongly associated with residents' health and wellbeing.

In the year to May 2022 the rate of violent crimes in the county was around 40 per 1000 population compared with the England rate of around 32 per 1000.

In 2020/21 Northamptonshire had among the highest rates in the East Midlands of domestic abuse related incidents and crimes reported to the police at 31 per 1000 population (England rate 30).

In 2020/21 2.5 per 1000 children aged 10-17 in Northamptonshire entered the youth justice system; similar to the regional and England rate

(source: PHE Fingertips)

Education and Learning

Integrated Care Northamptonshire

Educational attainment is a predictor of health outcomes.

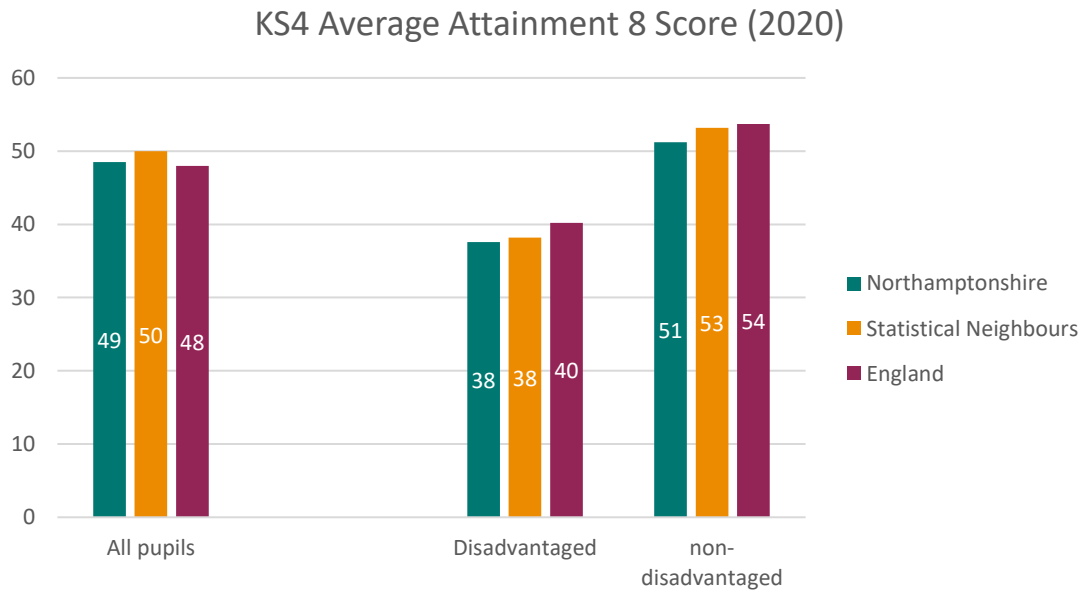
In 2019 in Northamptonshire attainment at KS1 was (not statistically significantly) lower than national level and that of our statistical neighbours. Attainment at KS2 and KS4 was also not statistically significantly lower than that of our statistical neighbours.

There is a **large gap in attainment between those who are least and most disadvantaged**, and while the gap in attainment at KS4 is slightly lower than for our statistical neighbours the gap has been increasing from 2016 to 2020.

In 2018, over 14,400 children and young people (12.5% of pupils) in Northamptonshire were assessed to have had Special Educational needs (SEN). As noted by the national SEND report 2022, current data collection on outcomes for this group of young people is inadequate; new metrics and dashboards are in development to address this gap.

University of Northampton provides higher education opportunities within the county.

In the East Midlands there are 3,381 students in higher education per 100,000 of the adult population. This is similar to the England average.



Integrated Care Northamptonshire

Lifecourse

Pregnancy and Birth

Integrated Care Northamptonshire

Maternal health and wellbeing before, during and after pregnancy are all critical indicators of child health outcomes

Around **8,000** babies were born in Northamptonshire in 2020

Of those, **6.6%** had **low birth weight** (higher than our statistical neighbours). Low birth weight is associated with an increased risk of infant mortality and poorer health in later life, and may result from smoking, substance or alcohol misuse during pregnancy, poor nutrition or pregnancy-related complications.

Just over **900** babies were born to mothers who were **smoking at the time of delivery** (12% of pregnancies; significantly higher than the national rate)

6.6 in every 1000 babies born in 2019 were stillborn or died within the first 28 days of life (similar to national rate).In 2010 the government set a target to halve the rate of stillbirths and neonatal deaths by 2025 (to 4 per 1000). While progress has been made, significant inequalities persist.

Data shows that black women are more than **four times** more likely to die in childbirth than white women. (source: MBRRACE)

In 2017/18 it was estimated that the number of women experiencing mild-moderate depressive illness and anxiety in perinatal period in Northamptonshire ranged between 679 and1,018. Of those 204 are expected to have experienced severe depressive illness.

Early Years

Integrated Care Northamptonshire

Observational studies have shown that breastfeeding is associated with lower levels of child obesity. Just over half (52.5%) of mothers in Northamptonshire are still breastfeeding babies at 6-8 weeks higher than the England rate of 47.6% in 2020/21

By the time they reach age 5, one in four children in the county have evidence of tooth decay (2018/19 - similar to England). This has reduced from just under one in three children (30.3%) in 2011/12. At this age 22.4% are classified as overweight or obese.

Tooth decay

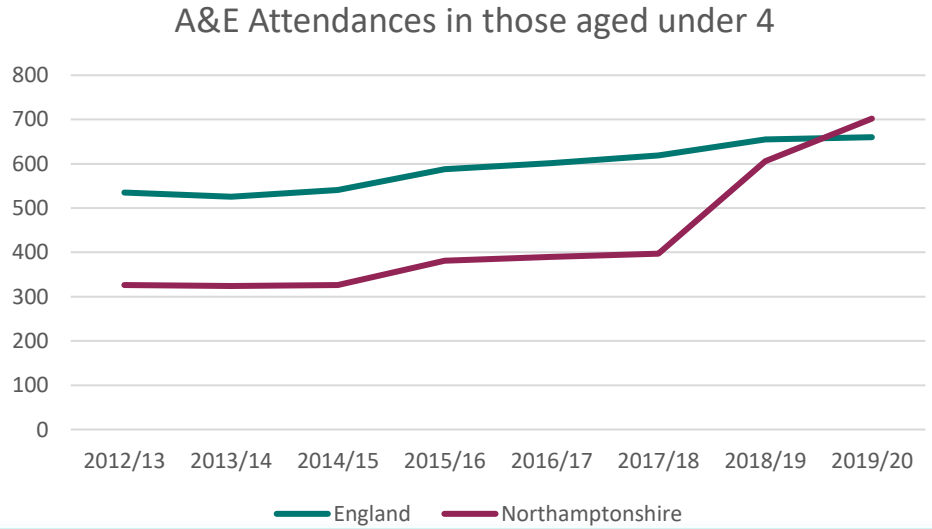
Overweight/obesity

2018/19 71% of children had a good level of development at Reception Year (similar to England).

In 2020/21 only 92.4% of 2 year olds had at least one dose of MMR vaccine. Lower than previous years and under target of 95%

A&E attendances in under 4 year olds are rising and are higher in North Northants (2019/20) The number of those children who then require admissions to hospital for children is higher in West Northants (2020/21).

Source: PHE Fingertips



Children in Need

Integrated Care Northamptonshire

Children who require input from social care to maintain good health and wellbeing are sometimes referred to as "children in need", this includes children with disabilities as well as looked after children.

The most common reason for becoming **looked after** is abuse or neglect. These are considered to be major **adverse childhood events (ACEs)** and can cause trauma and can lead to long-term damaging effects on children and young people's physical and mental health.

In 2021 there were **1,143 children looked after** in Northamptonshire (a rate of 66 per 10,000 which is similar to the England rate). This group of children experience significantly worse health and wellbeing outcomes than their peers.

Although ensuring placements are the right fit for looked after children is key, we know that psychological, social and academic outcomes are worse for people who have many changes of placement than for those who do not. In 2021 9% of children in Northamptonshire had 3 or more different placements in the year – this is a similar rate to England.

In 2021 the percentage of looked after children who had up to date health checks was only 54% in Northamptonshire compared with 91% in England an 81% in the county in the previous year.

Source: PHE Fingertips

Developing Well

Integrated Care Northamptonshire

Future in Mind, the Children and Young People's Mental Health and Wellbeing Taskforce's report, estimates that **half of mental health conditions in adult life start by the age of 14**. An NHS Digital survey found that one in six children in England had a probable mental disorder in 2021 - an increase from one in nine in 2017.

There were **50,000 contacts** with **community and outpatient mental health services among under-18**s in Northamptonshire in 2019/20. This equates to a rate that is higher than the England rate. The rate of inpatient mental health stays for under 18s was also higher in the county than for England.

Poor school attendance impacts not only childrens educational achievement but also their social and emotional development.

Children and young people may not attend school for a number of reasons including fixed and permanent exclusions (where they may then need to be educated differently). Outcomes for excluded children are often poor and there is an association between school exclusion and entrance to criminal justice system.

In 2020/21 just over 4% of the Northamptonshire school population were given fixed exclusions and 0.06% of pupils permanently excluded. These rates are lower than pre-pandemic levels likely due to the difference in teaching delivery over these years.

Source: PHE Fingertips

Living Well

Integrated Care Northamptonshire

What we eat and drink as well as how active we are has a significant impact on our health and wellbeing both in the short term and in the long term in terms of our risks of developing chronic diseases and cancers.

Over one in four adults in the county are classified as **physically inactive** [sig worse than national rate] and almost two thirds (65.4%) are classified as overweight or obese (2020/21) [similar to national]

Over 1,700 admissions to hospital in Northamptonshire's working-aged population were due to alcohol-related conditions. This equates to a rate of 742 per 100,000 in West Northants [similar to England] and 632 per 100,000 in North Northants (lower than England) (2020/21).

Smoking is the **single greatest risk factor for death and disability in the county***. An estimated 95,000 people were current smokers in the county (16.4% of the population) (2019).

Poor mental health is only second to **musculoskeletal conditions** in Northamptonshire in terms of causes of years spent living with ill health.*

National surveys have identified a fluctuation in levels of psychological distress in the period since March 2020 and the onset of COVID-related restrictions.

In 2017 it was estimated that over 90,000 adults in the county were experiencing a common mental health disorder (depression and/or anxiety) which is around 16% of the adult population.

The rate of suicide in the county in the three years to 2020 was 9.4 per 100,000 population, similar to the England rate.

* source: Global Buren of Disease Study 2019

Living Well

Integrated Care Northamptonshire

Alongside **cancer, cardiovascular and respiratory diseases** are two of the biggest drivers of inequality in life expectancy in Northamptonshire.

Indicators of coronary heart disease (CHD) and chronic obstructive pulmonary disease (COPD) show similar patterns in the county, of diagnosed prevalence similar to the national average but hospital attendances for these conditions significantly higher than the national average. This picture may reflect either under-detection of these conditions or poor control of conditions in the community or a combination.

Indicator	Period	Northamptonshire			NHS regions (pre ICB)	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
CHD: QOF prevalence (all ages) (Persons, All ages)	2020/21	↓	23,033	2.9%	3.2%	3.0%	1.8%		4.3%
CHD admissions (all ages) (Persons, All ages)	2020/21	↓	2,970	419.2	-	367.6	482.3		260.9
Coronary heart disease mortality rates, under 75 years (Persons, <75 yrs)	2017 - 19	–	701	35.8	-	37.5	57.9		22.6
COPD: QOF prevalence (all ages) (Persons, All ages)	2020/21	→	15,328	1.9%	1.9%	0.9%			3.8%
Emergency hospital admissions for COPD, all ages (Persons, All ages)	2020/21	→	1,335	192.5	133.5	287.2			69.5
Mortality rate from COPD as a contributory cause (Persons, All ages)	2017 - 19	–	1,084	55.69	53.90	112.27			25.08

Living Well

Integrated Care Northamptonshire

Cancer detection and treatment continues to improve so that the number of people living with cancer continues to increase. Good cancer outcomes rely on early diagnosis (often through screening)

Coverage of:

- breast cancer screening 69.2% (national target 70%)
- Bowel cancer screening 65.1% (national target 60%)
- Cervical cancer screening (under 50s) 69.6% (national target 80%)

In 2017 around half of cancers in the county were diagnosed at an early stage (similar to England).

In 2020/21 there were significantly higher cancer emergency admissions in Northamptonshire than the England rate. Deaths from all cancer, under 75 years (standardised mortality ratio) in the five years to 2020 are similar to that for England.

According to the Global Burden of Disease study 2019, the third biggest contributor to deaths and disability (DALYs) in Northamptonshire is musculoskeletal disease (MSK) (after cancers and heart disease) It is top of the list when it comes to years lived with disability.

In 2021 just under **one in five people** in Northamptonshire reported living wit a **musculoskeletal condition** (17.4% in West Northamptonshire and 19.1% in North Northamptonshire, similar to and higher than the England average respectively).

In terms of years lived with ill health or disability, diabetes is an important condition. In Northamptonshire we have the highest rate of **hospital spells for diabetic foot disease** in England at 271per 10,000 but a rate of major diabetic lower-limb amputation procedures that's significantly lower than the national average.

Ageing Well

Integrated Care Northamptonshire

Being **fit and well in older age** depends very much on **good physiological reserves in middle age,** though action to address frailty once developed are also important.

Falls are an important cause of poor health in older people and injuries, particularly hip fractures, as a result of falls increase risk of mortality.

Hospital admissions for falls in those aged 65+ are higher in West Northamptonshire at 2,727 per 100,000 compared with 1,893 per 100,000 in North Northamptonshire (2020/21). This difference, however, may to a degree represent differences in data coding or processes rather than differences in numbers of falls occurring in each area as rate of ambulance transfers due to falls in both areas show less significant difference.

Rates of hip fractures in the over 65s are similar in both local authority areas and similar to the national hip fracture rate.

Infections such as pneumococcal pneumonia, influenza and COVID are all important causes of ill-health (hospital admissions) and deaths in older adults particularly over winter. By August 23rd 2022 over 81% of over 75s had received their spring COVID booster vaccination.

Ultimately, some older adults will need support from social care to meet their needs. According to ASCOF 2019/20 Overall satisfaction with social care services:

England score – 64.2

East Midlands score – 63.6

Northamptonshire score – 64.1

With this indicator, the higher the satisfaction, the higher the score. The current range listed on the ASCOF interactive tool is from 61.0-72.0.

Local Insight profile for ‘North Northamptonshire’ area

LI - West Northamptonshire Council

Report created 28 July 2022

Local Insight

Finding your way around this Local Insight profile

Introduction Page 3 for an introduction to this report

Population	There are 350,448 people living in North Northamptonshire See pages 4-9 for more information on population by age and gender, ethnicity, country of birth, language, migration, household composition and religion	**Education & skills**	24% of people have no qualifications in North Northamptonshire compared with 22% across England See pages 46-48 for more information on qualifications, pupil attainment and early years educational progress
Vulnerable groups	14% of children aged 0-19 are in relative low-income families in North Northamptonshire compared with 19% across England See pages 10-23 for more information on children in poverty, people out of work, people in deprived areas, disability, pensioners and other vulnerable groups	**Economy**	44% people aged 16-74 are in full-time employment in North Northamptonshire compared with 39% across England See pages 49-55 for more information on people's jobs, job opportunities, income and local businesses
Housing	2% of households lack central heating in North Northamptonshire compared with 3% across England See pages 24-33 for more information on dwelling types, housing tenure, affordability, overcrowding, age of dwelling and communal establishments	**Access & transport**	19% of households have no car in North Northamptonshire compared with 26% across England See pages 56-58 for more information on transport, distances services and digital services
Crime & safety	The overall crime rate is higher than the average across England See pages 34-35 for more information on recorded crime and crime rates	**Communities & environment**	The % of people 'satisfied with their neighbourhood' (74.7%) is lower than the average across England (79.3%) See pages 59-66 for more information on neighbourhood satisfaction, the types of neighbourhoods locally, local participation and the environment, air pollution
Health & wellbeing	17% of people have a limiting long-term illness in North Northamptonshire compared with 18% across England See pages 36-45 for more information on limited long-term illness, life expectancy and mortality, general health and healthy lifestyles	**Appendix A**	Page 67 for information on the geographies used in this report, publication dates for new indicators and acknowledgements.

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Local Insight

Local Insight for LI - West Northamptonshire Council

Local Insight gives you access to interactive maps and reports at small area level. These reports show key social and economic indicators and allow you to compare the area selected to comparator areas.

OCSI

Local Insight is a tool developed by Oxford Consultants for Social Inclusion (OCSI) based on a project developed jointly between OCSI and HACT.

OCSI develop and interpret the evidence base to help the public and community organisations deliver better services. A 'spin-out' from the University of Oxford Social Policy Institute, OCSI have worked with more than 100 public and community sector clients at local, national and international level. See www.ocsi.co.uk for more.

About the indicators

Information published by government as open data – appropriately visualised, analysed and interpreted – is a critical tool for Local Authorities.

OCSI collect all local data published by more than 50 government agencies, and have identified key indicators relevant to local authorities to use in this report and the interactive webtool (local.communityinsight.org).

How we have identified the "North Northamptonshire" area

This report is based on the definition of the "North Northamptonshire" area created by LI - West Northamptonshire Council, (you can view this area on the Local Insight map, through finding the area on the 'show services' dropdown in the top left hand corner of the map). We have aggregated data for all the neighbourhoods in "North Northamptonshire" to create the charts and tables used in this report.

Alongside data for the "North Northamptonshire", we also show data for selected comparator areas: West Northamptonshire and England.

Local Insight

Population: Age and gender

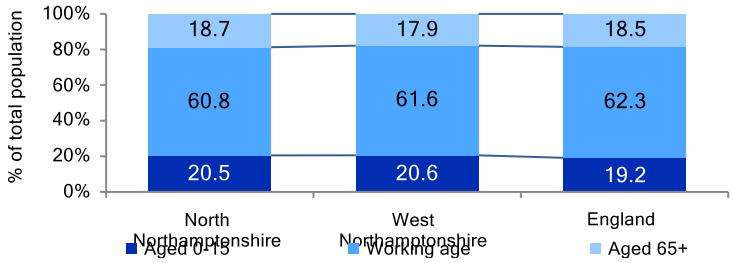
What information is shown here?

The information on this page shows the number of people living in North Northamptonshire. These population figures provide detail of the structure of the population by broad age bands and sex.

The first information box shows the total number of people usually resident in the area, with the male female breakdown. Also shown are numbers by age, and the 'dependency ratio'. This is the ratio of non-working age (those aged 0-15 and over 65) to working age population and is useful in understanding the pressure on a productive population in providing for the costs of services and benefits used by the youngest and oldest in a population. For example, a ratio of 25% would imply one person of non-working age for every four people of working age.

The population pyramid compares the proportion of males and females by five-year age bands. The line chart shows how the population is changing over time in North Northamptonshire and comparator areas. The stacked bar chart, below, shows the age breakdown of the population in North Northamptonshire and comparator areas by broad age band.

Figure: Population by age
Source: Mid-Year Estimates (ONS) 2020



Total Population	Aged 0-15	Working age population	Aged 65+	Dependency ratio
350,448	71,933	212,907	65,607	0.65
49.3% male; 50.7% female	20.5% (England average = 19.2%)	60.8% (England average = 62.3%)	18.7% (England average = 18.5%)	England average = 0.60

Source: Mid-Year Estimates (ONS) 2020

Figure: Population estimates by 5-year age band
Source: Mid-Year Estimates (ONS) 2020

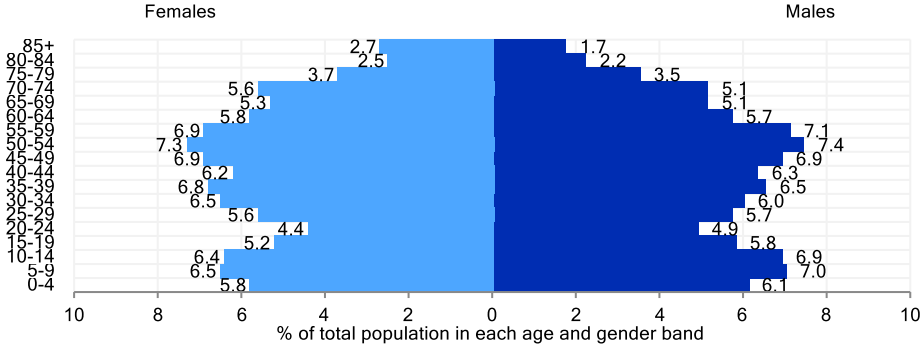
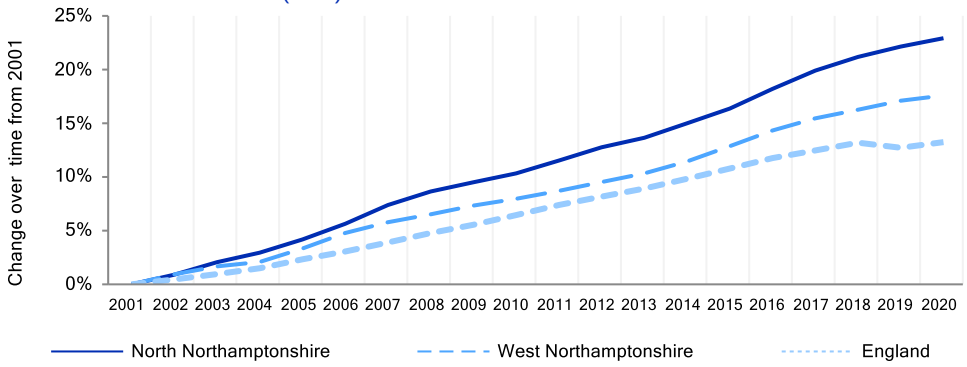


Figure: % change in total population from 2001-2020
Source: Mid-Year Estimates (ONS)



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Population: Ethnicity

What information is shown here?

The information on the right shows the number of people in North Northamptonshire by ethnicity, based on each person's perceived ethnic group and cultural background.

The information boxes display the number of people who have identified themselves as White British and the number from non-White ethnic minority groups, as well as the five broad ethnic minority groups (White non-British, Mixed, Asian, Black and other ethnic groups.

The final information box shows the proportion of households where not all household members are of the same ethnicity (households with multiple ethnic groups).

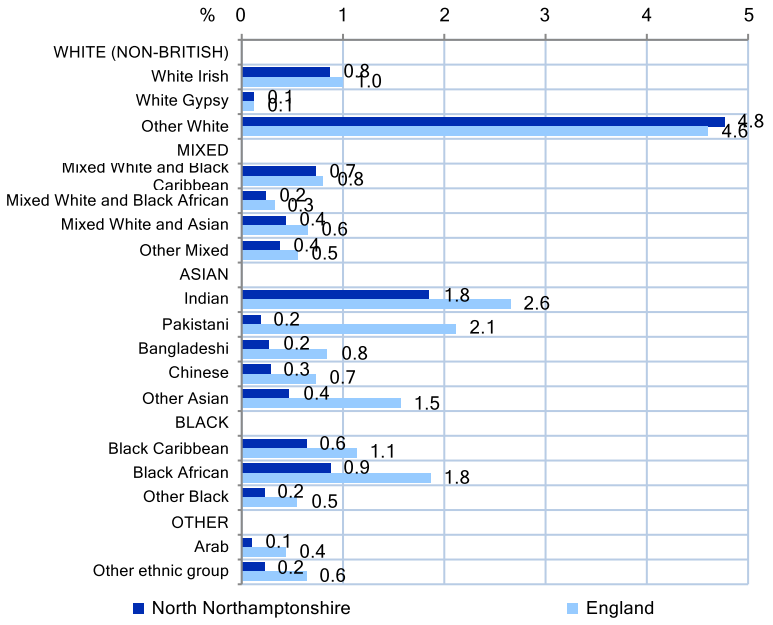
The bar chart on the right shows a detailed breakdown of the percentage of people in ethnic minority groups by ethnic category.

White British	Non-White	White-non-British	Mixed
277,831	20,962	18,058	5,359
87.7% (England average = 79.8%)	6.6% (England average = 14.6%)	5.7% (England average = 5.7%)	1.7% (England average = 2.3%)

Asian	Black	Other ethnic group	Households with multiple ethnicities
9,364	5,325	914	8,367
3.0% (England average = 7.8%)	1.7% (England average = 3.5%)	0.3% (England average = 1.0%)	6.3% (England average = 8.9%)

Source: Census 2011

Figure: Population by ethnic group (excluding White British)
Source: Census 2011



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Population: Country of birth and household language

What information is shown here?

The information on the right shows the number of people in North Northamptonshire by country of birth.

The top row information boxes display the number of people in North Northamptonshire who were born in England and outside the UK as well as the number of people with a UK passport and non-UK passport.

The second row information boxes show the language breakdown of households, identifying the number of households in North Northamptonshire with one or more members who cannot speak English.

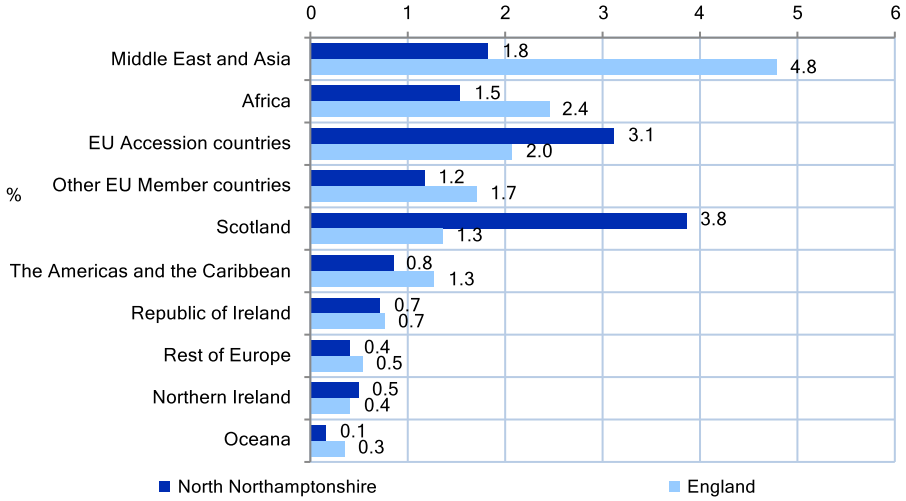
The bar chart on the right shows a detailed breakdown of the percentage of people in North Northamptonshire born outside of England by the geographic region of birth.

Born in England	Born Outside the UK	With a UK passport	With a non-UK passport
270,004	30,578	232,118	21,085
85.2% (England average = 83.5%)	9.7% (England average = 13.8%)	73.3% (England average = 75.8%)	6.7% (England average = 8.8%)

All people in households have English as main language	At least one adult (not all) has English as main language	No adults but some children have English as main language	No household members have English as main language
124,782	2,638	538	4,677
94.1% (England average = 90.9%)	2.0% (England average = 3.9%)	0.4% (England average = 0.8%)	3.5% (England average = 4.4%)

Source: Census 2011

Figure: Population born outside England
Source: Census 2011



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What information is shown here?

The information box shows the number and percentage of migrants in North Northamptonshire and across England as a whole. A migrant is defined as a person with a different address one year before Census day. The migrant status for children aged under one in households is determined by the migrant status of their 'next of kin' (defined as in order of preference, mother, father, sibling (with nearest age), other related person, Household Reference Person).

The chart on the right shows the population turnover rate by age band. This is calculated as the rate of in or out migratory moves within England and Wales per 1,000 resident population.[1] Figures are based on GP patient register records. The left-hand bars (lighter colour) show people moving *out of* the area – higher values for a particular group indicate that this age-group is more likely to move away from the area. The right-hand bars (darker colour) show people moving *into* the area – higher values for a particular group indicate that this age-group is more likely to move into the area.

The data table on the top right and the chart on the bottom right show the total number of people registering with a National Insurance number who have come from overseas. This is a measure of the number of people who have migrated to the UK from overseas to work, who have registered for a National Insurance number in the local area.

Note: For the year 20/21 The NINO allocation process was disrupted as a result of the coronavirus (COVID-19) pandemic. This has resulted in a significant reduction in the number of NINOs allocated.

People who have moved address within the last 12 months (Census 2011)	Overseas migrants (National Insurance no. registrations of overseas nationals) (DWP 2020/21)
33,378	1,057
10.5% (average = 12.3%)	0.5% (average = 0.6%)

Figure: Level of inward and outward migration (by age)
Source: Population Turnover Rates – Office for National Statistics (2010)

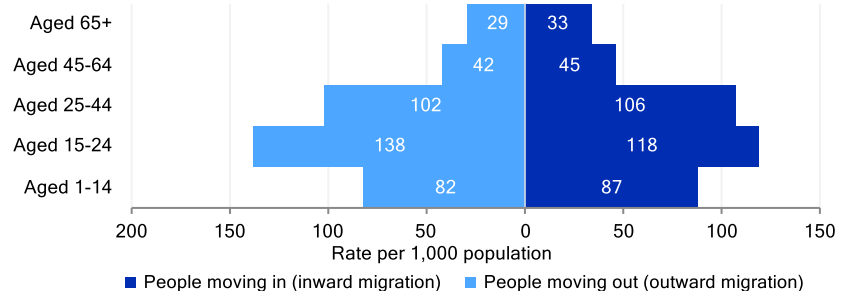
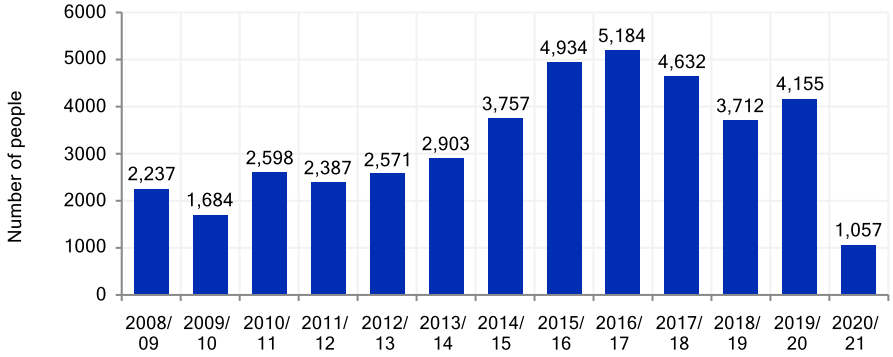


Figure: Number of overseas nationals registering with a National Insurance Number
Source: National Insurance No. registrations – Department for Work and Pensions (2020/21)



[1] Please note that there are currently no planned updates for this dataset, however we still consider it to be relevant.

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Population: All households

What information is shown here?

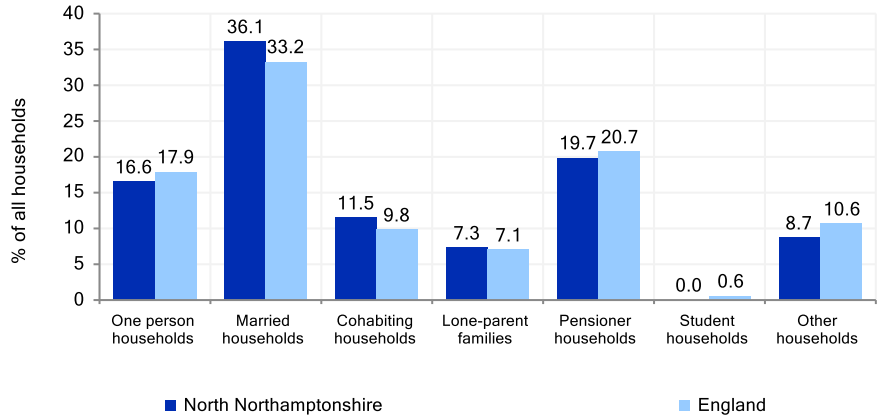
The information on this page shows the composition of household types in North Northamptonshire. The information boxes contain the number of households in North Northamptonshire classified under the main household composition breakdowns. The chart shows the same information as a percentage of all households.

Pensioner households	One person households (aged under 65)	Lone parent families with dependent children
26,170	21,992	9,743
19.7% (England average = 20.7%)	16.6% (England average = 17.9%)	23.9% of all families with dependent children (England average = 24.5%)

Married households	Cohabiting households	Student households
47,880	15,281	14
36.1% (England average = 33.2%)	11.5% (England average = 9.8%)	0.0% (England average = 0.6%)

Source: Census 2011

Figure: Population by household composition
Source: Census 2011



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What information is shown here?

The information on the right shows the number of people living in North Northamptonshire by religious belief, categorised by the six major religions, other religion and no religion.

The bar chart shows the percentage of people in North Northamptonshire and comparator areas who are of non-Christian religious belief, displayed by religion.

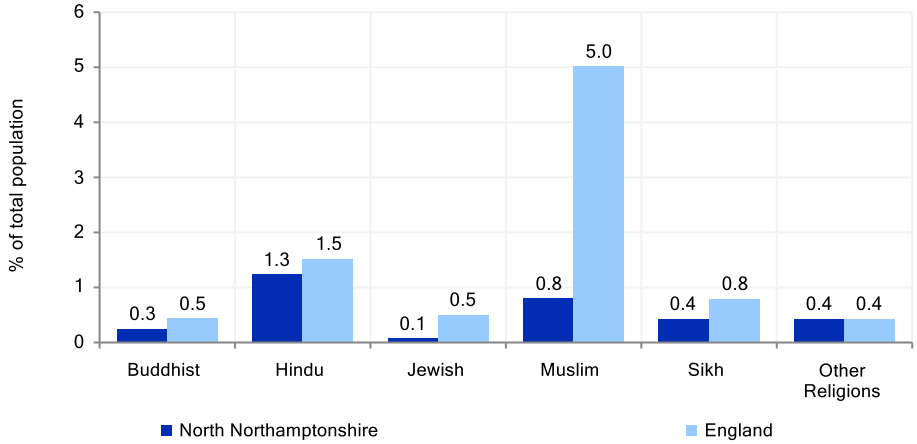
Note, figures in the table and charts may not add up to 100% because they do not include figures for those for who did not reply to the religion question – who were recorded as 'religion not stated' in the census data publication.

Christian	Buddhist	Hindu	Jewish
187,965	796	3,971	235
59.3% (England average = 59.4%)	0.3% (England average = 0.5%)	1.3% (England average = 1.5%)	0.1% (England average = 0.5%)

Muslim	Sikh	Other religion	No religion
2,569	1,374	1,329	97,516
0.8% (England average = 5.0%)	0.4% (England average = 0.8%)	0.4% (England average = 0.4%)	30.8% (England average = 24.7%)

Source: Census 2011

Figure: Population with non-Christian religion
Source: Census 2011



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What information is shown here?

The information in this section shows counts of people who are out of work and receiving workless benefits: Jobseekers Allowance (JSA)/Universal Credit (UC) and Incapacity Benefit (IB)/Employment and Support Allowance (ESA).

JSA is payable to people under pensionable age who are available for, and actively seeking, work of at least 40 hours a week. A subset of UC claimants (claimants in the 'searching for work' conditionality group) are additionally included in the 'Unemployment Benefit' count, as UC is slowly replacing JSA for new claims. *Note, 'the searching for work' conditionality group includes a small number of claimants who would not be considered unemployed under the previous JSA benefits regime e.g. those with work limiting illness awaiting health checks. Therefore, there is likely to be a slight overcount of the proportion of Unemployed Benefit claimants in areas where the UC rollout is more advanced.*

IB and ESA are workless benefits are payable to people who are out of work and have been assessed as being incapable of work due to illness or disability and who meet the appropriate contribution conditions. *Note, since March 2016, ESA is being replaced by UC for new claimants. It is not possible to capture the total number of claimants of sickness benefits as the UC does not provide a breakdown for health condition; therefore, the total count of ESA/IB claimants presented here is likely to be an underestimate of the full count of those workless and receiving benefits due to sickness or disability.*

The information boxes on the top right show: the total number of adults (aged 16-64) receiving JSA and UC; the total claiming for more than 12 months; claimants aged 18-24 and 50+, the number of people receiving 'Incapacity benefits' (IB or ESA); and the number and proportion of 16-64 year olds receiving workless benefits (UC, JSA, IB or ESA).

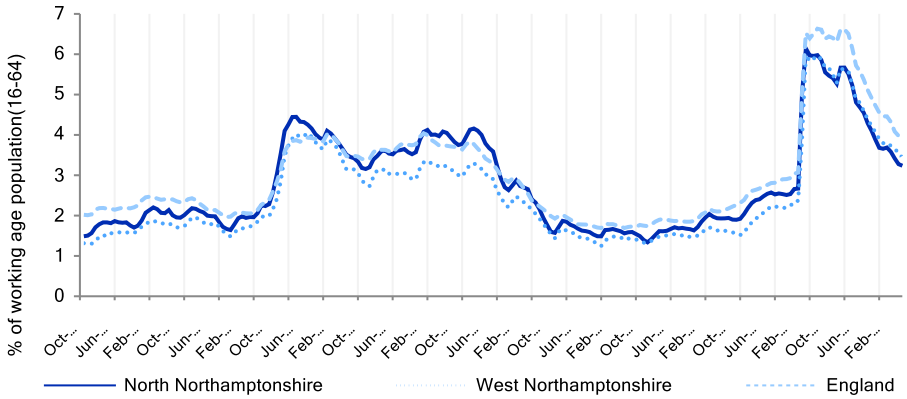
Unemployment Benefit (JSA and UC) claimants (Jun-22)	Youth unemployment (JSA/UC) claimants aged 18-24) (Jun-22)	Older unemployed (JSA/UC claimants aged 50+) (Jun-22)
6,890	1,120	1,730
3.2% (England average = 3.9%)	4.9% (England average = 4.5%)	1.3% (England average = 1.6%)

Male unemployment claimants (JSA and UC) (Jun-22)	Female unemployment claimants (JSA and UC) (Jun-22)	Working age workless benefit claimants * (Nov-21)	Incapacity benefits claimants (Nov-21)
3,960	2,970	16,377	8,107
3.7% (England average = 4.5%)	2.8% (England average = 3.2%)	7.7% (England average = 8.9%)	3.8% (England average = 4.2%)

Source: Department for Work and Pensions

* 'Working age workless benefit claimants' is a combination of 'Unemployment benefit claimants (JSA and Universal Credit)' + and 'Incapacity benefits claimants (IB/ESA)'

Figure: Unemployment benefit (Jobseekers Allowance/Universal Credit) claimants
Source: Department for Work and Pensions



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Vulnerable groups: People out of work (2)

The line charts below show month on month changes in the proportion of people claiming IB or ESA and the proportion claiming JSA or UC in the searching for work conditionality group across North Northamptonshire and comparator areas.

Figure: % of Jobseekers Allowance claimants claiming for more than 12 months
Source: Department for Work and Pensions (Jun-22)

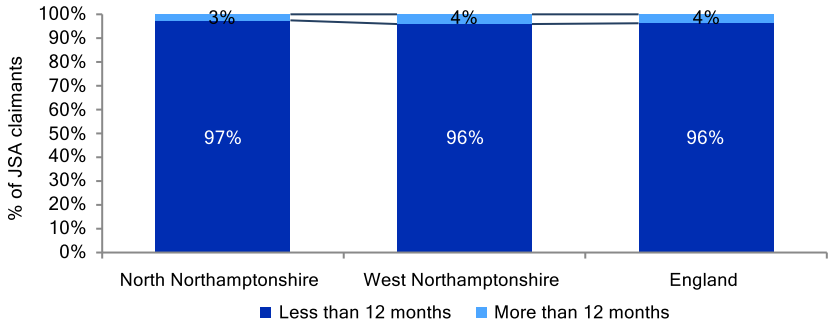


Figure: Workless benefit claimants aged 16-24 (May-16) and 16-64 (Nov-21)
Source: Jobseekers Allowance/Universal Credit/Incapacity benefits/Employment and Support Allowance – Department for Work and Pensions (May-16/ Nov-21)

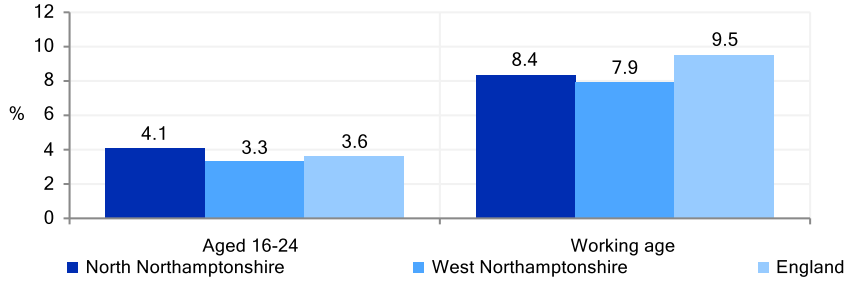


Figure: Working age population (16-64) claiming incapacity benefits (Employment Support Allowance and Incapacity Benefit)
Source: Department for Work and Pensions

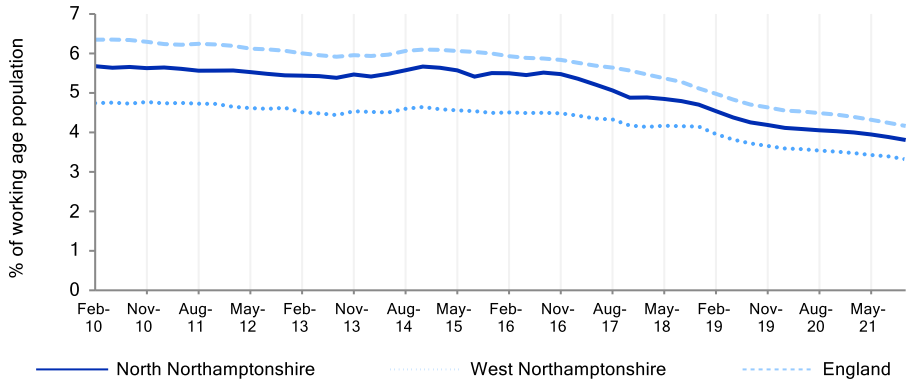
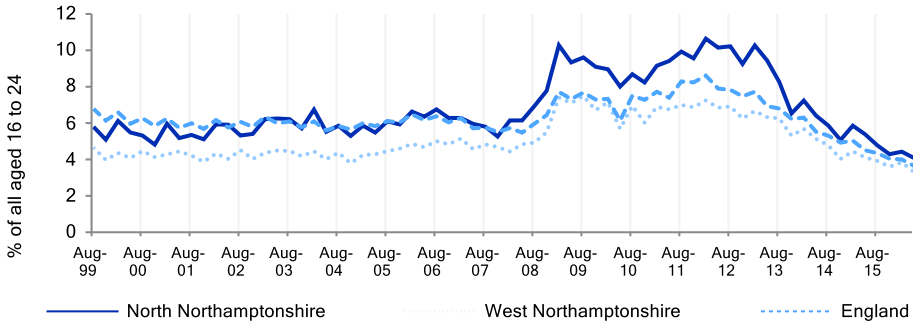


Figure: 16-24-year olds receiving 'Workless' benefits (Incapacity Benefit, Employment Support Allowance, Jobseekers Allowance and Universal Credit)
Source: Department for Work and Pensions



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What information is shown here?

The information in this section looks at the prevalence of disability among people living in North Northamptonshire. There are three measures of disability presented: those claiming Attendance Allowance, Personal Independence Payments and Disability Living Allowance.

Attendance Allowance is payable to people over the age of 65 who are so severely disabled, physically or mentally, that they need a great deal of help with personal care or supervision.

Until April 2013, Disability Living Allowance was payable to children and adults in or out of work who are below the age of 65 and who were disabled, and required help with personal care or had walking difficulties. It is a non-means tested benefit, which means it is not affected by income. From April 2013 Personal Independence Payments (PIP) have been introduced to replace Disability Living Allowance for all new claimants. PIP helps with some of the extra costs caused by long-term disability, ill-health or terminal ill-health.

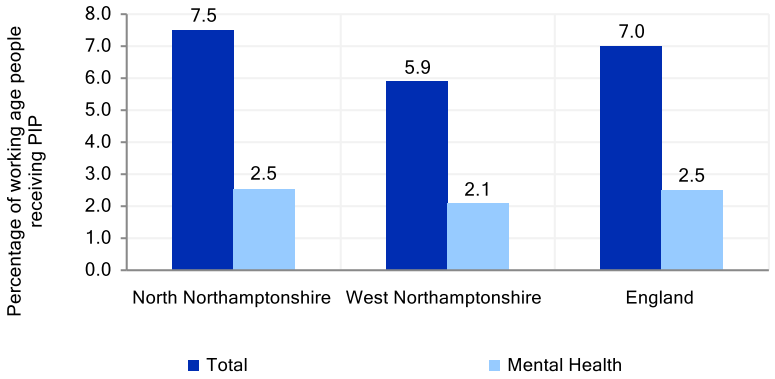
The information boxes on the right show the total number of people receiving Attendance Allowance, Disability Living Allowance and PIP (by key breakdown) and for household receiving Universal Credit due to poor physical or mental health (Limited Capability for Work Entitlement) across North Northamptonshire.

Attendance Allowance claimants (Nov-21)	Personal Independence Payment (PIP) (Apr-22)	PIP Males (Apr-22)	PIP Females (Apr-22)
7,089	15,957	7,073	8,883
10.8% of people (England= 11.4%)	7.5% of people (England= 7.0%)	6.7% of males (England= 6.4%)	8.3% of females (England= 7.6%)

PIP with mental health conditions (Apr-22)	PIP with respiratory disease (Apr-22)	Households on Universal Credit - Limited Capability for Work Entitlement (Feb-22)	Disability Living Allowance claimants (Nov-21)
5,401	582	3,552	5,754
2.5% of people (England= 2.5%)	0.3% of people (England= 0.3%)	2.6% of households (England= 3.0%)	1.6% of people (England= 2.0%)

Source: Department for Work and Pensions

Figure: Personal Independence Payment (PIP) recipients
Source: Department for Work and Pensions (Apr-22)



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Universal Credit: Conditionality Regime

What information is shown here?

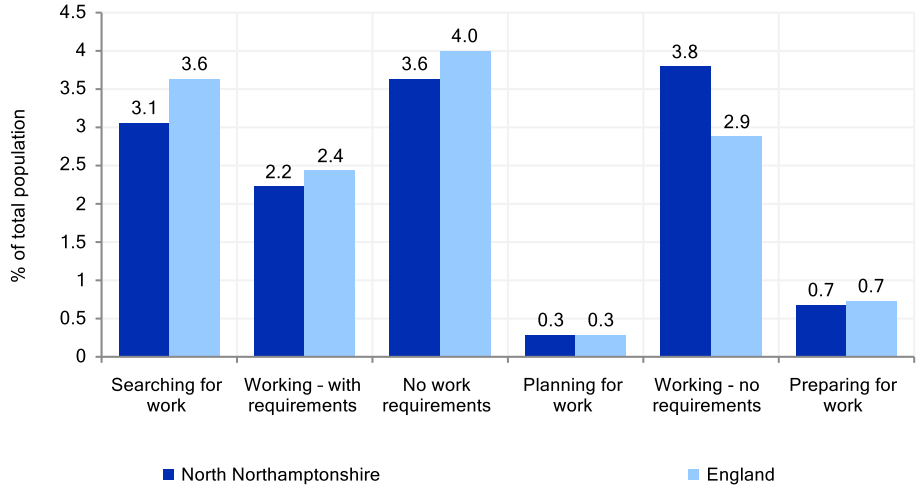
The information in this page shows the proportion of people in receipt of Universal Credit against six levels of conditionality. Conditionality refers to work-related activities an eligible adult will have to do in order to get full entitlement to Universal Credit.

- **Searching for work:** Claimants who are not working, or with very low earnings. The claimant is required to take action to secure work - or more / better paid work. The Work Coach supports them to plan their work search and preparation activity.
- **Working with requirements:** Claimants who are in work but could earn more, or not working but has a partner with low earnings.
- **No work requirements:** Claimants who are not expected to work at present. Health or caring responsibility prevents claimant from working or preparing for work.
- **Planning for work:** Claimants who are expected to work in the future. Lone parent / lead carer of child aged 1 (Aged 1 - 2, prior to April 2017). The claimant is required to attend periodic interviews to plan for their return to work.
- **Working no requirements:** Claimants whose individual or household earnings is over the level at which conditionality applies. Required to inform DWP of changes of circumstances, particularly if at risk of decreasing earnings or losing job.
- **Preparing for work:** Claimants who are expected to start preparing for future even with limited capability for work at the present time or a child aged 2 (Aged 3 - 4, prior to April 2017), the claimant is expected to take reasonable steps to prepare for work including Work Focused Interview.

Universal Credit claimants: Searching for work (Jun-22)	Universal Credit claimants: Working with requirements (Jun-22)	Universal Credit claimants: No work requirements (Jun-22)
6,496	4,735	7,731
3.1% (England average = 3.6%)	2.2% (England average = 2.4%)	3.6% (England average = 4.0%)
Universal Credit claimants: Planning for work (Jun-22)	**Universal Credit claimants: Working no requirements (Jun-22)**	**Universal Credit claimants: Preparing for work (Jun-22)**
599	8,079	1,436
0.3% (England average = 0.3%)	3.8% (England average = 2.9%)	0.7% (England average = 0.7%)

Source: Department for Work and Pensions (DWP)

Figure: Working age population claiming Universal Credit by conditionality breakdown
Source: Department for Work and Pensions



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What information is shown here?

The information in this page shows a breakdown of Universal Credit (UC) households by type and criteria.

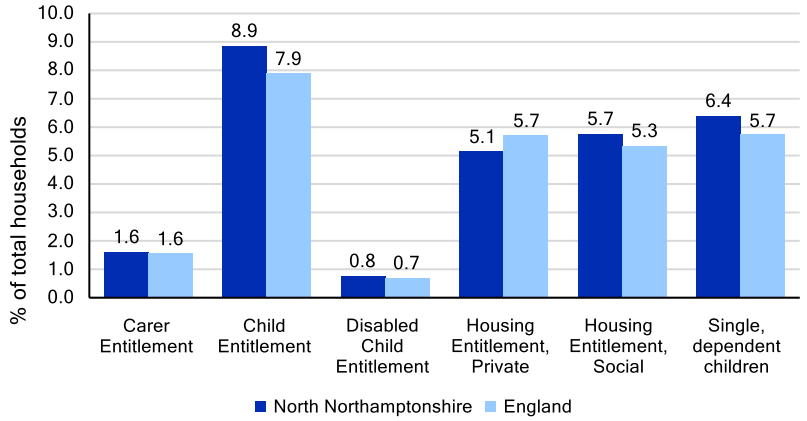
- **Carer Entitlement:** Households on UC containing household members who have regular and substantial caring responsibilities for at least 35 hours per week. Only one carer element is allowed per individual; in joint claims, two carer elements can be included providing both partners are not caring for the same disabled person.
- **Child Entitlement:** Households on UC where a child element is included in a Universal Credit award where there is responsibility for a child or qualifying young person who normally lives in the household.
- **Disabled Child Entitlement:** Households on UC where a child element is included in a Universal Credit award and the child element is increased by a disabled child addition if a child meets the criteria.
- **Housing Entitlement, Private rented:** Households on UC that are renting privately and eligible for housing entitlement. This element is to help with housing costs.
- **Housing Entitlement, Social rented:** Households on UC that are renting social housing and eligible for housing entitlement. This element is to help with housing costs.
- **Single with dependent children:** Households on Universal Credit that comprise a single person with child dependant(s).

UC households: Carer Entitlement (Feb-22)	UC households: Child Entitlement (Feb-22)	UC households: Disabled Child Entitlement (Feb-22)
2,218	12,225	1,052
1.6% (England average = 1.6%)	8.9% (England average = 7.9%)	0.8% (England average = 0.7%)

UC households: Housing Entitlement, Private (Feb-22)	UC households: Housing Entitlement, Social (Feb-22)	UC households: Single, dependent children (Feb-22)
7,107	7,932	8,812
5.1% (England average = 5.7%)	5.7% (England average = 5.3%)	6.4% (England average = 5.7%)

Source: Department for Work and Pensions (DWP)

Figure: Total households claiming Universal Credit by type and criteria breakdown
Source: Department for Work and Pensions



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Vulnerable groups: Working age benefit claimants (1)

What information is shown here?

The information in this page shows the number of people in receipt of key welfare benefits payable by the Department for Work and Pensions (DWP).

Working age DWP Benefits are benefits payable to all people of working age (16-64) who need additional financial support due to low income, worklessness, poor health, caring responsibilities, bereavement or disability.

Universal Credit (UC) has replaced legacy benefits for new claimants. The UC rollout began in April 2013, with single jobseeker's moving on to the new benefit and by March 2016 the rollout intensified to include other groups who are out of work or on low incomes. The chart on the right shows a breakdown of the proportion of UC claimants that are either in employment or unemployed across North Northamptonshire and comparator areas.

Housing Benefit (HB) can be claimed by a person if they are liable to pay rent and if they are on a low income and provides a measure of the number of households in poverty.

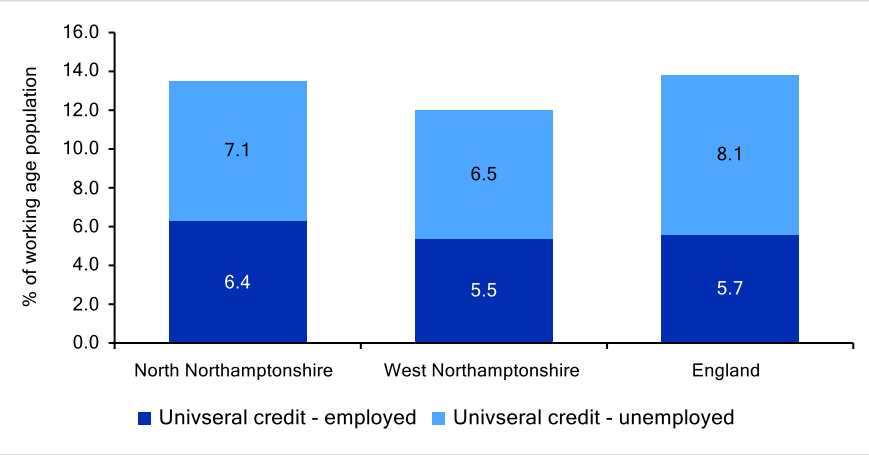
Income Support is a measure of people of working age with low incomes and is a means tested benefit payable to people aged over 16 working less than 16 hours a week and having less money coming in than the law says they need to live on.

The charts on the following page show the change in the proportion of Income Support and Housing Benefits claimants across North Northamptonshire and comparator areas. *Note, recent changes observed in these charts can be partially attributed to the migration of claimants from legacy working age DWP benefits, Housing Benefit and Income Support towards Universal Credit.*

Universal Credit claimants – in Employment (May-22)	Universal Credit claimants – Unemployed (May-22)	
13,603	15,065	
6.4% (England average = 5.7%)	7.1% (England average = 8.1%)	
Income Support (IS) claimants (Nov-21)	**Housing Benefit claimants (Feb-22)**	**Universal Credit claimants (Jun-22)**
921	10,441	29,073
0.4% (England average = 0.5%)	7.6% (England average = 9.7%)	13.7% (England average = 13.9%)

Source: Department for Work and Pensions (DWP)

Figure: Universal Credit claimants employment indicator
Source: Department for Work and Pensions (May-22)



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Vulnerable groups: Working age benefit claimants (2)

Figure: Income Support claimants
Source: Department for Work and Pensions (Nov-21)

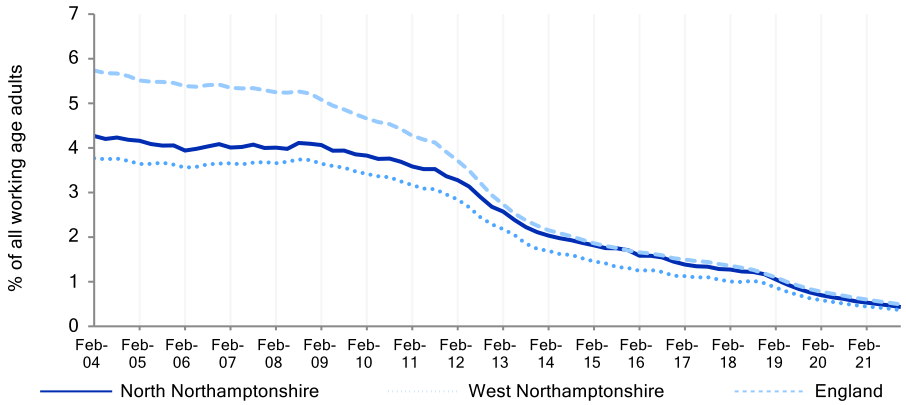
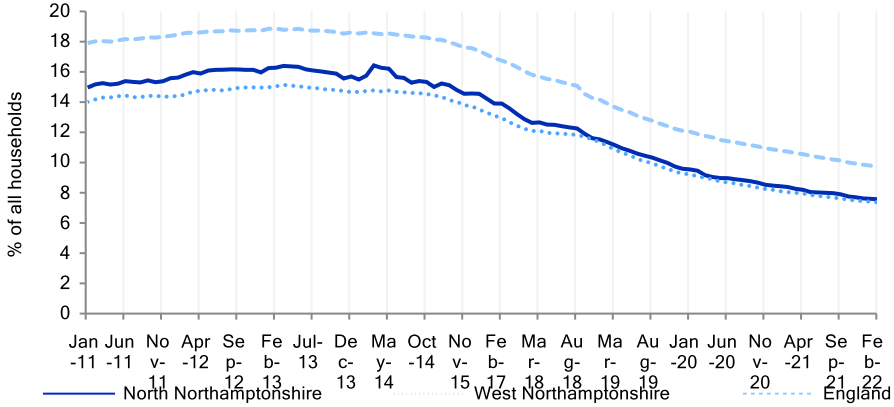


Figure: Housing Benefit claimants



Source: Department for Work and Pensions

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Vulnerable groups: Deprived neighbourhoods (1)

What information is shown here?

The information on this page looks at overall levels of deprivation across North Northamptonshire based on the Index of Multiple Deprivation (IMD) 2019. IMD 2019 is the most comprehensive measure of multiple deprivation available. The concept of multiple deprivation upon which the IMD 2019 is based is that separate types of deprivation exist, which are separately recognised and measurable. The IMD 2019 therefore consists of seven types, or domains, of deprivation, each of which contains a number of individual measures, or indicators.[2]

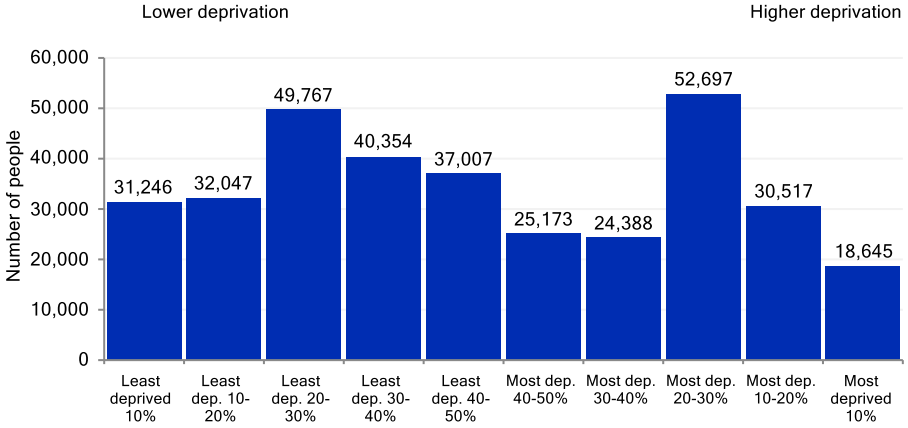
The information boxes on the right show the number of people in North Northamptonshire living in neighbourhoods ranked among the most deprived 20% of neighbourhoods in England on IMD 2019 and the seven IMD domains. The chart on the right shows the number of people living in neighbourhoods grouped according to level of deprivation. The charts on the following pages show the same information for each of the domains. All neighbourhoods in England are grouped into ten equal sized groups "deciles"; the 10% of neighbourhoods with the highest level of deprivation (as measured in the IMD) are grouped in decile 10, and so on with the 10% of neighbourhoods with the lowest levels of deprivation grouped in decile 1.

Number of people in North Northamptonshire living in the most deprived 20% of areas of England by Indices of Deprivation (ID) 2019 domain

Index of Multiple Deprivation	Income domain	Employment domain	Education domain
49,162	37,859	45,901	95,397
14.1% (England average = 20.0%)	10.9% (England average = 20.0%)	13.2% (England average = 19.5%)	27.4% (England average = 19.8%)
Health domain	**Barriers to Housing and Services domain**	**Living Environment domain**	**Crime domain**
64,217	56,508	19,022	59,806
18.4% (England average = 19.6%)	16.2% (England average = 21.4%)	5.5% (England average = 21.0%)	17.2% (England average = 20.4%)

Source: Ministry of Housing, Communities and Local Government (Indices of Deprivation 2019)

Figure: Number of people in each deprivation decile, Index of Multiple Deprivation 2019
Source: Ministry of Housing, Communities and Local Government (Indices of Deprivation 2019)



[2] The seven domains of deprivation included are: Employment deprivation, Income deprivation, Health deprivation and disability, Education, skills and training deprivation, Crime, Living environment deprivation, Barriers to housing and services.

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Figure: Number of people in each deprivation decile, ID 2019 Income domain
Source: Ministry of Housing, Communities and Local Government (Indices of Deprivation 2019)

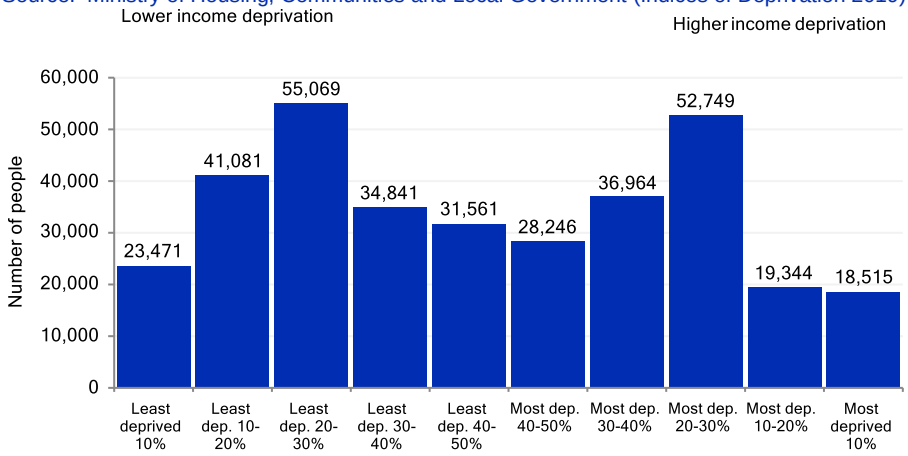


Figure: Number of people in each deprivation decile, ID 2019 Education domain
Source: Ministry of Housing, Communities and Local Government (Indices of Deprivation 2019)

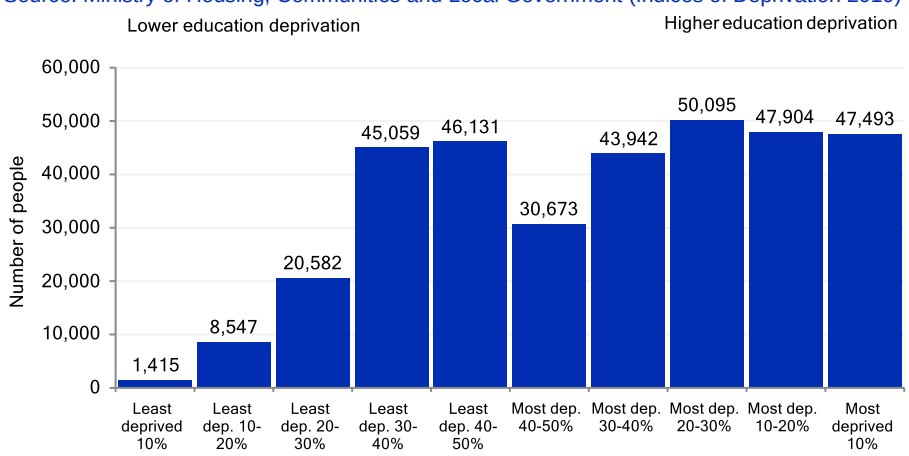


Figure: Number of people in each deprivation decile, ID 2019 Employment domain
Source: Ministry of Housing, Communities and Local Government (Indices of Deprivation 2019)

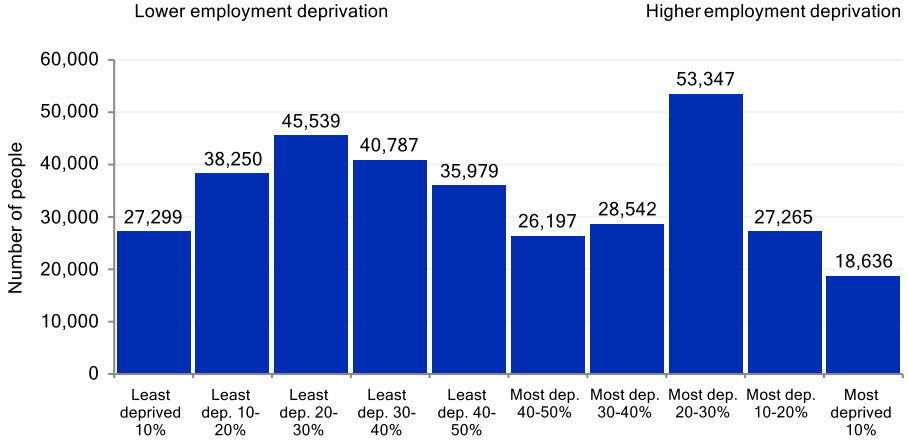
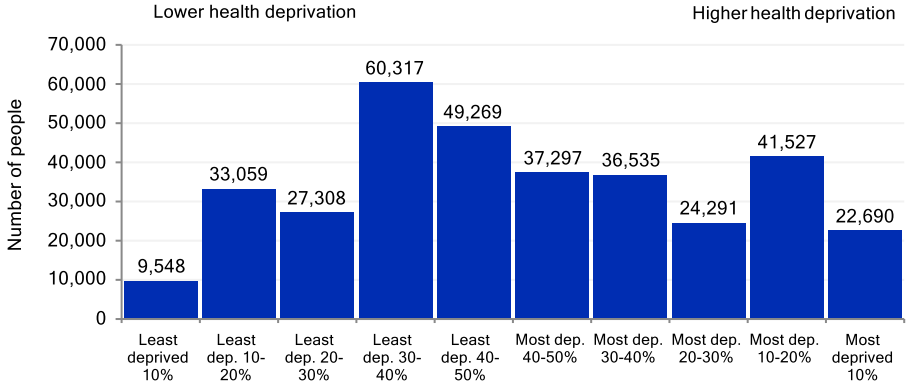


Figure: Number of people in each deprivation decile, ID 2019 Health domain
Source: Ministry of Housing, Communities and Local Government (Indices of Deprivation 2019)



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Vulnerable groups: Deprived neighbourhoods (3)

Figure: Number of people in each deprivation decile, ID 2019 Barriers to Housing and Services domain
Source: Ministry of Housing, Communities and Local Government (Indices of Deprivation 2019)

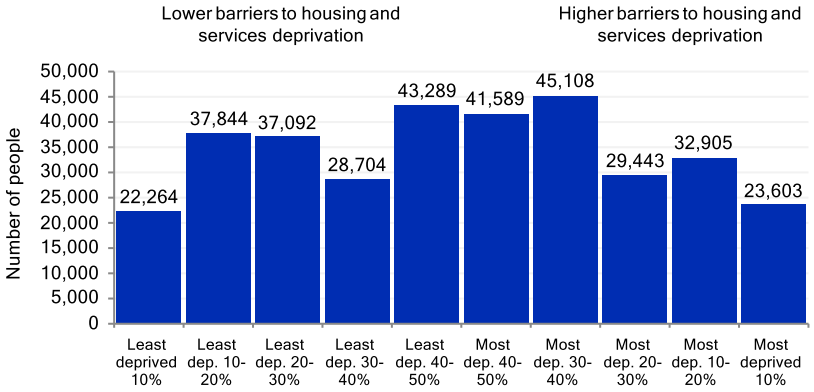


Figure: Number of people in each deprivation decile, ID 2019 Crime domain
Source: Ministry of Housing, Communities and Local Government (Indices of Deprivation 2019)

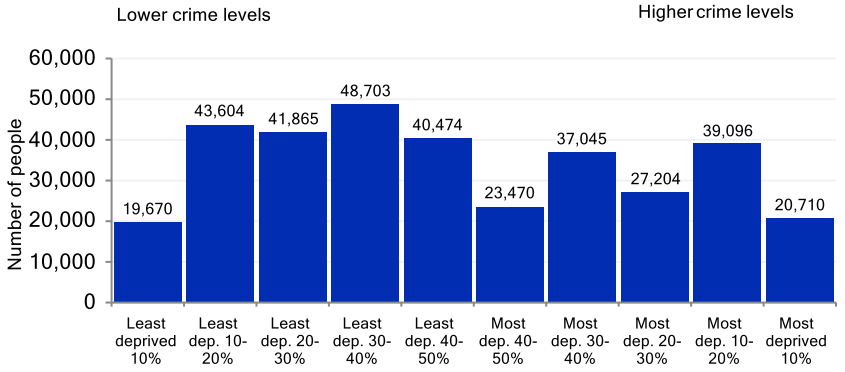
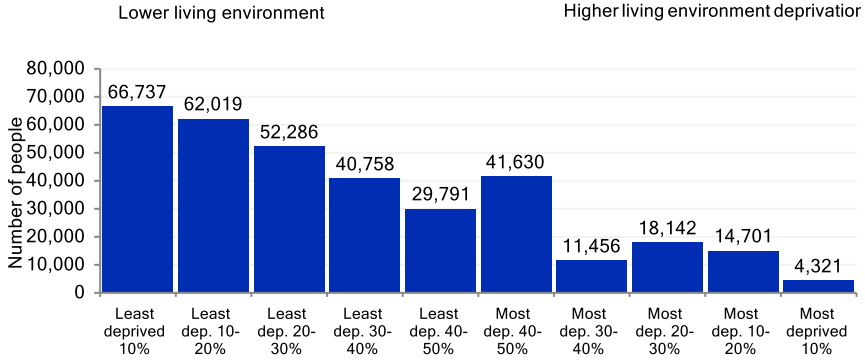


Figure: Number of people in each deprivation decile, ID 2019 Living Environment domain
Source: Ministry of Housing, Communities and Local Government (Indices of Deprivation 2019)



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Vulnerable groups: Children (1)

What information is shown here?

This page looks at children in low-income families, out of work households and lone parent households. Relative low income is defined as a family in low income Before Housing Costs (BHC) in the reference year. Absolute low income is a family in low income Before Housing Costs (BHC) in the reference year in comparison with incomes in 2010/11. A family must have claimed one or more of Universal Credit, Tax Credits or Housing Benefit at any point in the year to be classed as low income in these statistics. Children are dependent individuals aged under 16; or aged 16 to 19 in full-time non-advanced education.

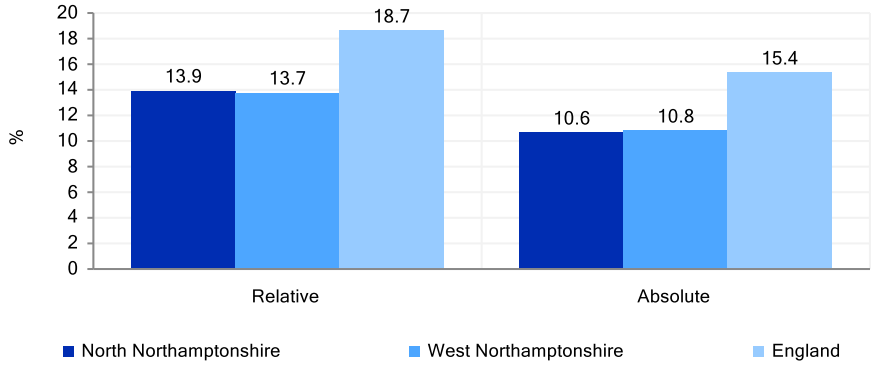
This is the first release of these statistics, which have replaced DWP's Children in out-of-work benefit households and HMRC's Personal Tax Credits: Children in low-income families local measure. See here for more information: https://www.gov.uk/government/collections/children-in-low-income-families-local-area-statistics#release

The information boxes on the right show the count of people in each of these categories in North Northamptonshire. The bar chart shows the percentage of children in relative and absolute low-income families.

Children in relative low income families	Children in absolute low income families	Children in relative low income lone parent families	Children in relative low income out of work families
12,088	9,256	5,405	3,755
13.9% (England average = 18.7%)	10.6% (England average = 15.4%)	44.7% of relative low-income families (England average = 40.2%)	31.1% of relative low-income families (England average = 30.6%)

Source: Children in low-income families, Department for Work and Pensions (2020)

Figure: Children living in low-income families
Source: Department for Work and Pensions (2020)



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What information is shown here?

The information on this page looks at pensioner groups including those that may face greater risks or who may have different types of need. There are three measures included: pensioners without access to transport, pensioner loneliness and pensioners in poverty.

Pensioners without access to transport are those with no access to a car or van. The dataset only includes pensioners living in private households.

There are two indicators of pensioner loneliness. The census provides a measure of the proportion of pensioners living alone (defined as households of one pensioner and no other household members). In addition, Age Concern have developed a Loneliness Index (which predicts the prevalence of loneliness amongst people aged 65+) based on census data. Areas with a value closer to 0 predict a greater prevalence of loneliness amongst those aged 65 and over and living in households compared to areas with a value further away from 0.

Pensioners in poverty are those in receipt of Pension Credit. Pension Credit provides financial help for people aged 60 or over whose income is below a certain level set by the law.

The information boxes present information on the counts of pensioner households or pensioners in each category. The chart on the top right shows the change in the proportion of people receiving Pension Credit across North Northamptonshire and comparator areas.

The chart on the bottom right compares Loneliness Index scores across North Northamptonshire and comparator areas - a value closer to 0 predicts a greater prevalence of loneliness amongst those aged 65.

Private pensioner households with no car or van (Census 2011)	Households of one pensioner (Census 2011)	State pension claimant (DWP Nov-20)	Pension credit claimant (DWP Nov-21)
10,050	14,843	60,346	6,455
38.4% of pensioner households (England average = 40.8%)	56.7% of pensioner households (England average = 59.6%)	92.0% (England average = 92.5%)	9.8% (England average = 11.5%)

Figure: Pension Credit claimants, Source: Department for Work and Pensions (Nov-21)

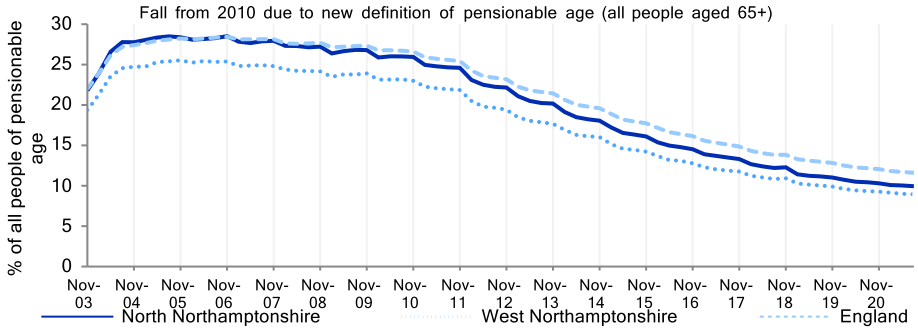
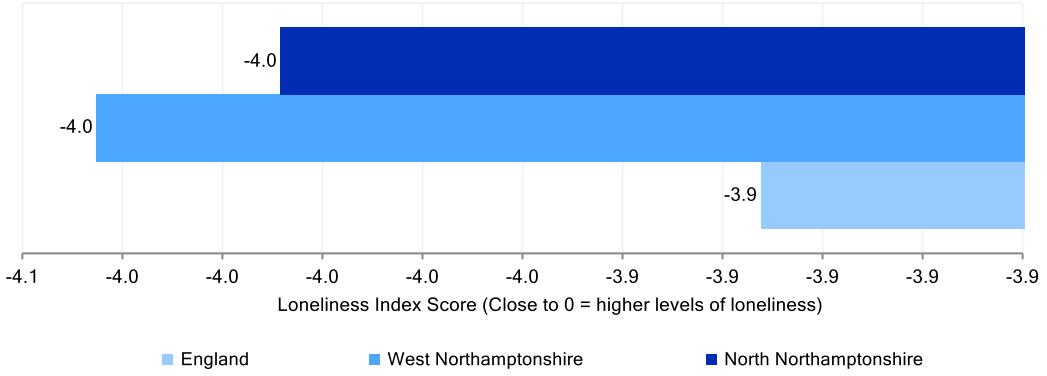


Figure: Loneliness index (probability of loneliness for those aged 65 and over). Source: Age UK (2011)



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Vulnerable groups: Households with multiple needs

What information is shown here?

The information on this page looks at household deprivation and households with multiple deprivation.

The information boxes show the number of households which are deprived in one of the four Census 2011 deprivation dimensions. The Census 2011 has four deprivation dimension characteristics: a) Employment: Any member of the household aged 16-74 who is not a full-time student is either unemployed or permanently sick; b) Education: No member of the household aged 16 to pensionable age has at least 5 GCSEs (grade A-C) or equivalent AND no member of the household aged 16-18 is in full-time education c) Health and disability: Any member of the household has general health 'not good' in the year before Census or has a limiting long term illness d) Housing: The household's accommodation is either overcrowded; OR is in a shared dwelling OR does not have sole use of bath/shower and toilet OR has no central heating. These figures are taken from responses to various questions in census 2011.

Households with multiple deprivation are households experiencing four key measures of deprivation:

- All adult household members have no qualifications
- At least one household member is out of work (due to unemployment or poor health)
- At least one household member has a limiting long-term illness
- The household is living in overcrowded conditions

Household is not deprived in any dimension (Census 2011)	Household is deprived in 1 dimension (Census 2011)	Household is deprived in 2 dimensions (Census 2011)	Household is deprived in 3 dimensions (Census 2011)
57,827	43,724	24,806	5,842
43.6% (England average = 42.5%)	33.0% (England average = 32.7%)	18.7% (England average = 19.1%)	4.4% (England average = 5.1%)

Households suffering multiple deprivation (Census 2011)
436
0.3% (England average = 0.5%)

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What information is shown here?

The information on this page looks at the number and proportion of people in two groups with specific needs: mental health issues and people providing unpaid care.

The figures for people with mental health issues are based on Employment Support Allowance/Incapacity Benefit claimants who are claiming due to mental health related conditions. Incapacity Benefit is payable to persons unable to work due to illness or disability.

Informal care figures show people who provide any unpaid care by the number of hours a week they provide that care. A person is a provider of unpaid care if they give any help or support to another person because of long-term physical or mental health or disability, or problems related to old age.

The line chart on the right shows the change in the number of people claiming Incapacity benefit for mental health reasons as a proportion of the working age population and the chart below it includes figures for children and all people providing unpaid care across North Northamptonshire.

Mental health related benefits (DWP Nov-21)	People providing unpaid care (Census 2011)	Unpaid care (50+ hours per week) (Census 2011)
3,784	32,609	7,381
1.8% of working age adults (England average = 2.1%)	10.3% (England average = 10.2%)	2.3% (England average = 2.4%)

Figure: Receiving Employment Support Allowance (ESA) and Incapacity Benefit (IB) due to mental health
Source: Department for Work and Pensions

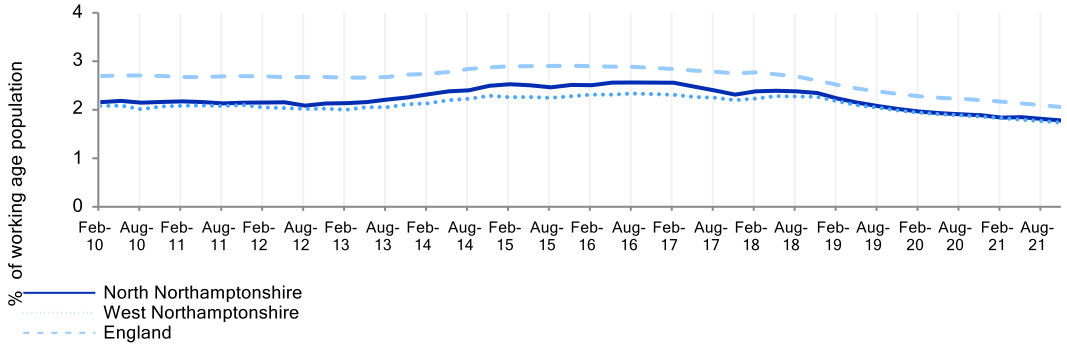
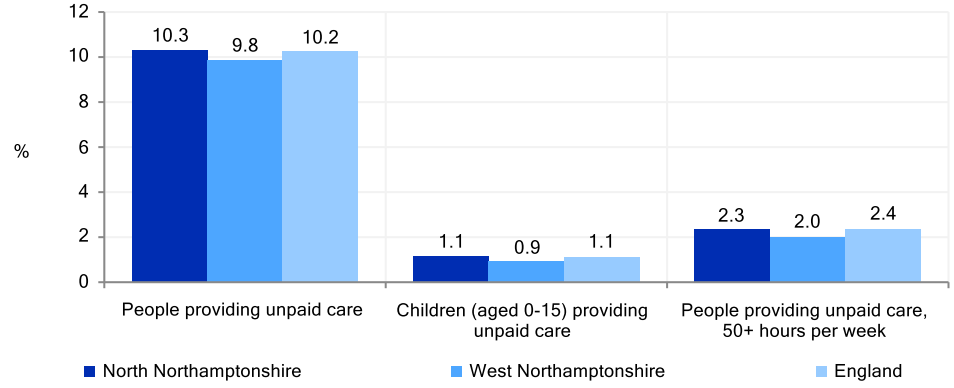


Figure: People providing unpaid care
Source: Census 2011



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Housing: Type

What information is shown here?

The information on this page looks at the type of dwelling space people live in. A dwelling space is the accommodation occupied by an individual household or, if unoccupied, available for an individual household, for example the whole of a terraced house, or a flat in a purpose-built block of flats.

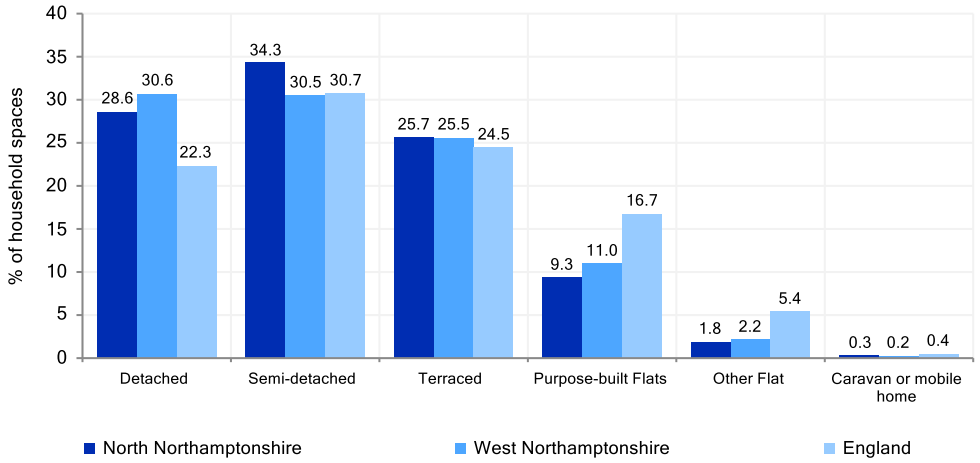
The information boxes to the right show the number of people in North Northamptonshire living in each accommodation type. The chart on the right shows a breakdown of households by accommodation type across North Northamptonshire and comparator areas.

Detached	Semi-detached	Terraced	Purpose built flat
39,471	47,357	35,428	12,905
28.6% (England average = 22.3%)	34.3% (England average = 30.7%)	25.7% (England average = 24.5%)	9.3% (England average = 16.7%)

Flat (in converted house)	Flat (in commercial property)	Caravan or other temporary dwelling	Second homes (2001)
1,531	932	465	325
1.1% (England average = 4.3%)	0.7% (England average = 1.1%)	0.3% (England average = 0.4%)	0.3% (England average = 0.6%)

Source: Census 2011

Figure: Dwellings type breakdown
Source: Census 2011



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Housing: Tenure

What information is shown here?

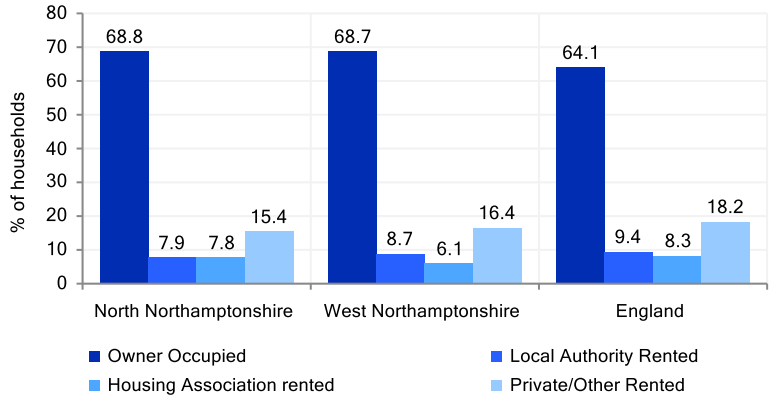
The information on this page looks at the tenure of housing in North Northamptonshire. The information boxes show the number of households broken down by tenure type and the chart shows the tenure breakdown across North Northamptonshire and comparator areas.

- 'Owner occupied' housing includes accommodation that is either owned outright, owned with a mortgage or loan, or shared ownership (paying part rent and part mortgage).
- 'Social rented' housing includes accommodation that is rented from a council (Local Authority) or a Housing Association, Housing Co-operative, Charitable Trust, Non-profit housing company or Registered Social Landlord.
- 'Rented from the Council includes accommodation rented from the Local Authority
- 'Housing Association or Social Landlord' includes rented from Registered Social Landlord, Housing Association, Housing Co-operative, Charitable Trust and non-profit housing Company.
- 'Private rented or letting agency' includes accommodation that is rented from a private landlord or letting agency.
- 'Other Rented' includes employer of a household member and relative or friend of a household member and living rent free.

Owner occupied	Owner-occupied: owned outright	Owner-occupied owned: with mortgage or loan
91,280	38,990	51,364
68.8% (England average = 64.1%)	29.4% (England average = 30.6%)	38.7% (England average = 32.8%)
Owner-occupied: shared ownership	**Social rented households**	**Rented from Council**
926	20,878	10,494
0.7% (England average = 0.8%)	15.7% (England average = 17.7%)	7.9% (England average = 9.4%)
Rented from Housing Association or Social Landlord	**Rented from private landlord or letting agency**	**Other rented dwellings**
10,384	17,112	3,365
7.8% (England average = 8.3%)	12.9% (England average = 15.4%)	2.5% (England average = 2.8%)

Source: Census 2011

Figure: Housing tenure breakdowns
Source: Census 2011



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Housing: How affordable is local housing? (1)

What information is shown here?

The information in this section shows measures of housing costs in North Northamptonshire. Data on house prices is from the Land Registry open data price-paid dataset (www.landregistry.gov.uk/market-trend-data/public-data/price-paid-data), which is updated monthly.

House prices by dwelling type

The information boxes on the right and the top-left chart on the following page show the mean house prices by accommodation type across North Northamptonshire and comparator areas for four key dwelling types (detached houses, semi-detached houses, flats and terraced houses). The bottom-left chart on page 25 shows the 10-year inflation adjusted average change in house prices across North Northamptonshire and comparator areas.

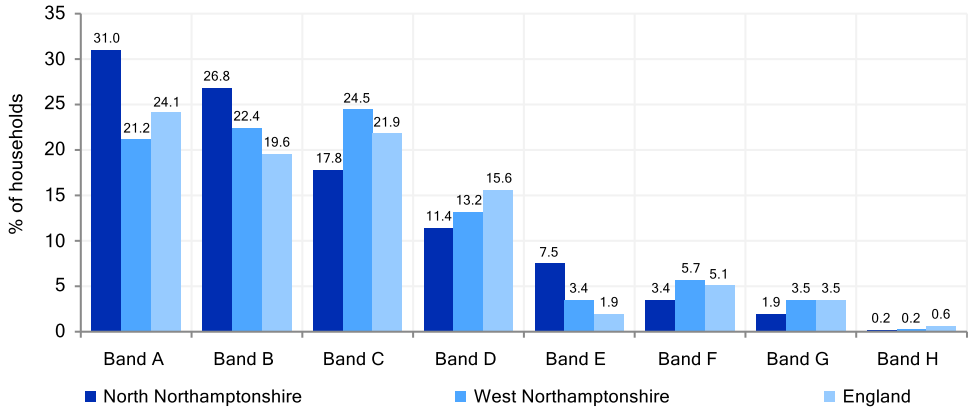
The top-right chart on page 25 displays the monthly change in the number of transactions and average price across North Northamptonshire and the bottom-right chart displays the ratio of the number of residential property transactions (Land Registry Jun-21 to May-22) to the number of owner occupied and privately rented dwellings (Census 2011) – an approximate measure of the proportion of housing stock that has change hands of the year, or the housing 'churn'.

Council tax bands

The data on Council Tax bands shows the number and proportion (as a percentage of all rateable households) of houses in bands A, B or C (the lowest price bands) and F, G and H (the highest price bands) locally. These price bands are set nationally, so can be used to show how the cost of all local property (not just those properties that have recently been sold) compares with other areas; the chart on the right compares North Northamptonshire and comparator areas for these Council Tax bands.

Average house price (all types of housing) (Land registry Jun-21 to May-22)	Average house price (detached) (Land registry Jun-21 to May-22)	Average house price (flats) (Land registry Jun-21 to May-22)
£262,830	£395,002	£172,266
England average = £345,372	England average = £514,628	England average = £392,299
Average house price (semi-detached) (Land registry Jun-21 to May-22)	**Average house price (terraced) (Land registry Jun-21 to May-22)**	**Households in Council Tax Band A (Valuation Office Agency (VOA) 2021)**
£316,655	£260,218	47,690
England average = £392,114	England average = £368,041	31.0% (England average = 24.1%)
Households in Council Tax Band B (VOA 2021)	**Households in Council Tax Band C (VOA 2021)**	**Households in Council Tax Band F-H (VOA 2021)**
41,310	27,380	8,470
26.8% (England average = 19.6%)	17.8% (England average = 21.9%)	5.5% (England average = 9.2%)

Figure: Dwelling stock by council tax band
Source: Valuation Office Agency (2021)



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Housing: How affordable is local housing? (2)

Figure: Average property price by dwelling type
Source: Land registry

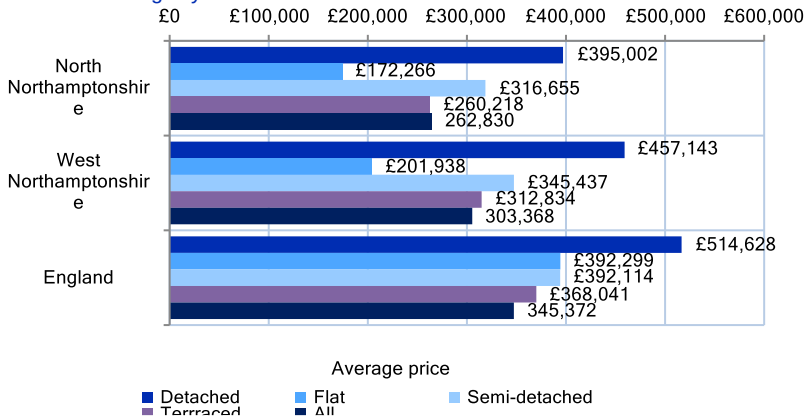


Figure: Average house prices and no. of transactions (note: there were no recorded transactions during the COVID-19 lockdown period so figures are shown as zero for this period), Source: Land Registry

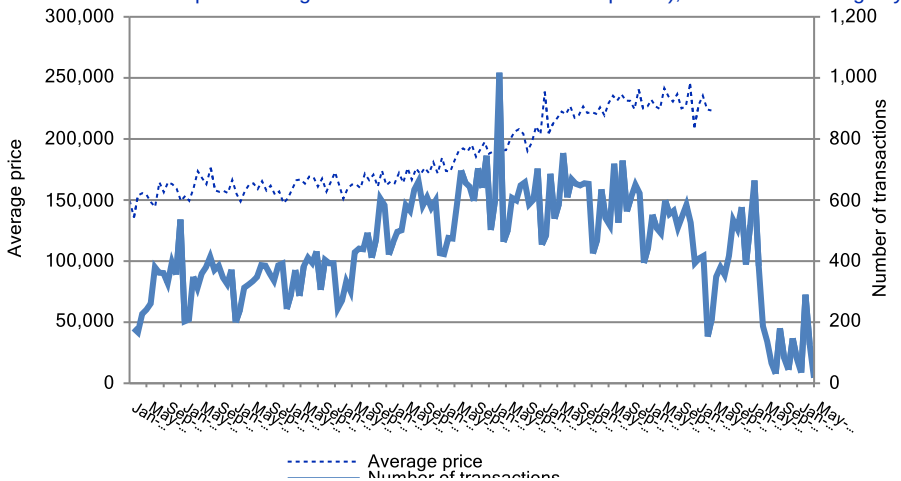
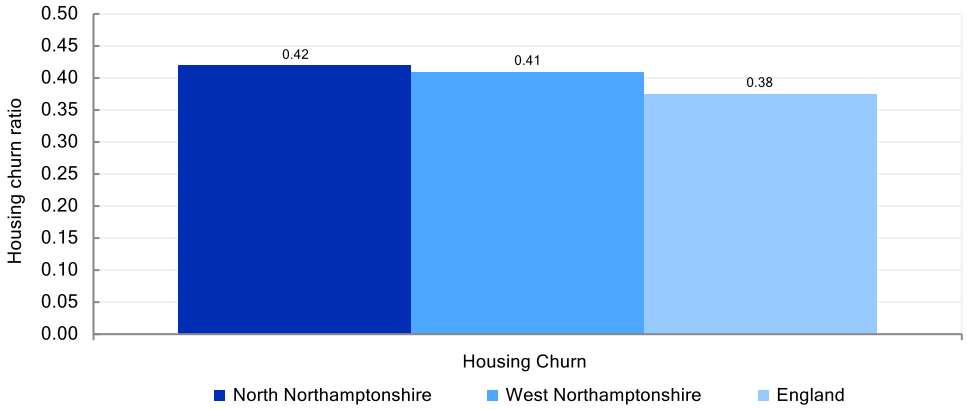


Figure: 10-year average house price change (inflation adjusted)
Source: Land registry Oct06-Oct07 to Oct16-Sep17

Figure: Ratio of residential property transactions to the total number of private dwellings
Source: Land Registry Jun-21 to May-22, Census 2011



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Housing: How affordable is local housing? (3)

What information is shown here?

The information in this section combines measures of local house prices and local earnings to provide a more balanced picture of housing affordability.

There are three indicators displayed here: **housing affordability gap**, **savings ratio** and **total affordability ratio**. Each of these indicators is given for two measures of house price: the average (median) house price and the lower quartile house price. The lower quartile house price is set such that the cheapest 25% of houses fall within this price and is a measure of the cost of cheaper, more affordable housing in the area.

Housing affordability gap: An estimate of the gap between the cost of local houses and the amount residents can borrow. This is defined as the difference between the local house price (either median or lower quartile) and 4.5 times local annual earnings (mortgage lenders are typically willing to lend 4-5 times annual salaries). Higher figures represent more unaffordable houses.

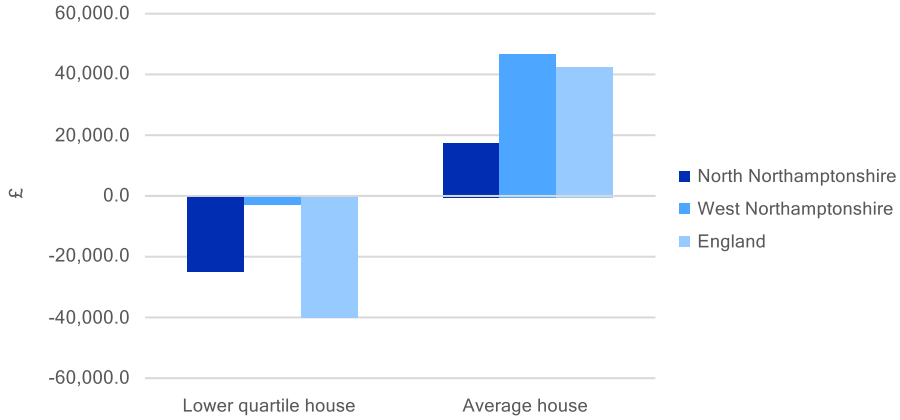
Savings ratio: The ratio between 15% of the house price (an estimate of the savings required for a deposit) and monthly earnings. It can be interpreted as the number of months' worth of earnings required for a deposit (not accounting for inflation or changes in earnings or house prices).

Total affordability ratio: This is the ratio between the total house price and annual earnings. It can be interpreted as the number of years' worth of earnings required for a deposit (not accounting for inflation or changes in earnings or house prices).

The data for these measures come from the ONS House Price Statistics for Small Areas (HPSSA) and ONS Income Estimates. Earnings data is published at MSOA level and house price data is published at LSOA level and above) Where necessary, we have modelled data to LSOA and OA geographies. The methodology used to produce these statistics is based ONS's housing affordability analysis.

Lower quartile house price ('affordable housing')	Average house price
Affordability gap	Affordability gap
-£24,298	£17,152
England average = -£39,328	England average = £42,272
Savings ratio (months of earnings for a deposit)	Savings ratio (months of earnings for a deposit)
7.08	9.25
England average = 6.54	England average = 10.41
Total ratio (years of earnings for a house)	Total ratio (years of earnings for a house)
3.87	4.95
England average = 3.57	England average = 5.5

Figure: Housing affordability gap for lower quartile house prices and average house prices.
Source: ONS House Price Statistics for Small Areas Oct16-Sep17; ONS earnings data 2015/2016



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Housing: Central heating, household overcrowding and dwelling size

What information is shown here?

The information on this page details indicators of the built environment: overcrowded housing, vacant housing, population density, the size of housing units and the proportion of households lacking central heating.

A household's accommodation is described as 'without central heating' if it had no central heating in any of the rooms (whether used or not). The data also shows breakdowns by tenure. This enables users to compare differences in the proportion of households with inadequate heating supply in the owner occupied, social rented and private rented sectors.

Households are classified as overcrowded if there is at least one room fewer than needed for household requirements using standard definitions. The standard used to measure overcrowding is called the 'occupancy rating' which relates to the actual number of rooms in a dwelling in relation to the number of rooms required by the household, taking account of their ages and relationships. The room requirement states that every household needs a minimum of two common rooms, excluding bathrooms, with bedroom requirements that reflect the composition of the household. The occupancy rating of a dwelling is expressed as a positive or negative figure, reflecting the number of rooms in a dwelling that exceed the household's requirements, or by which the home falls short of its occupants' needs.

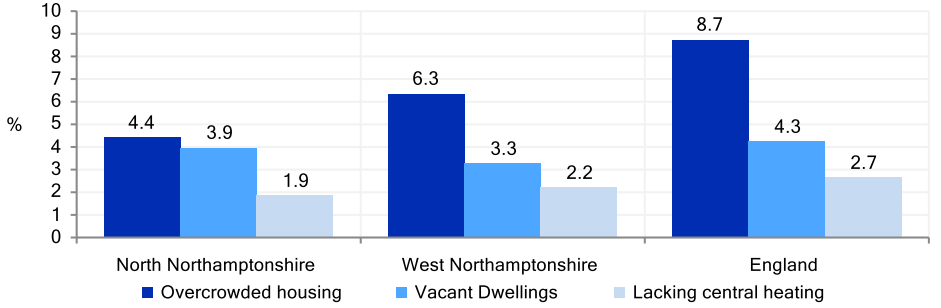
Vacant dwellings are households that do not have any usual residents. This includes households that may still be used by short-term residents, visitors who were present on census night, or a combination of short-term residents and visitors. It also includes vacant household spaces and household spaces that are used as second addresses.

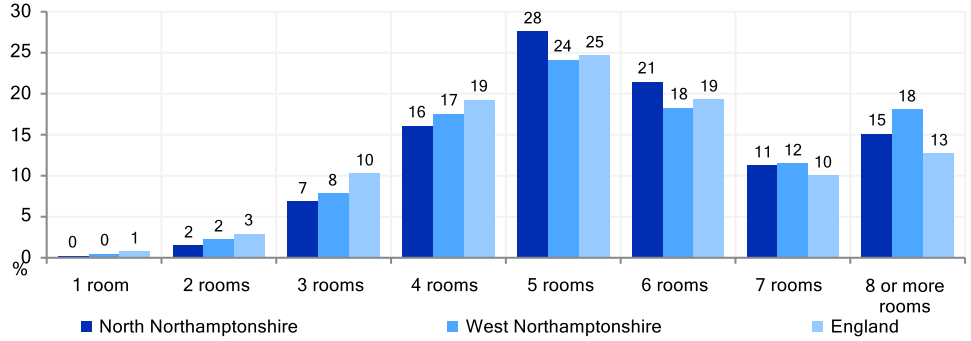
Population density (persons / hectare)	Houses lacking central heating	Overcrowded Housing	Vacant Dwellings
3.5	2,465	5,861	5,454
England average = 4.3	1.9% (England average = 2.7%)	4.4% (England average = 8.7%)	3.9% (England average = 4.3%)

Dwellings with 2 rooms or fewer	Dwellings with 8 or more rooms	Average dwelling size (persons)
2,333	19,927	2.36
1.8% (England average = 3.7%)	15.0% (England average = 12.7%)	England average = 2.36 people)

Source: Census 2011. Population density data – Office for National Statistics (ONS) 2016

Figure: Top - Housing Environment; Bottom - Dwelling size (number of rooms per household)
Source: Census 2011





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Housing: Domestic gas and electricity consumption

What information is shown here?

The Department for Business, Energy and Industrial Strategy publishes small area estimates of domestic gas and electricity consumption in megawatt hours (Mwh). Gas consumption data are weather corrected annual estimates of consumption for all domestic meters. A similar methodology is used for collecting domestic electricity consumption data; however, these values are not weather corrected. The methodologies are sufficiently similar that summing the electricity consumption and gas consumption gives an estimate of total annual energy consumption.

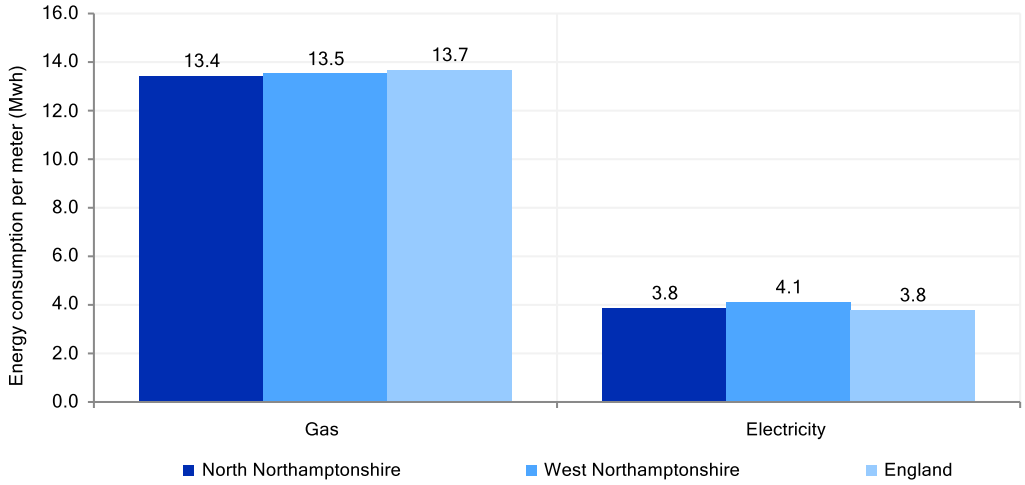
The data on this page were originally published by BEIS at postcode level and have been designated as experimental statistics. Experimental statistics are statistics that are new and subject to possible changes to meet user needs or that do not meet the rigorous quality standards of National Statistics. To avoid disclosure, postcodes are excluded if they contain less than 6 meters or that have average consumption figures of 0 or 1.

The estimated number households not connected to the gas network is based on the difference between the number of households and the number of domestic gas meters.

To read more about the data and methodology here please visit https://www.gov.uk/government/collections/sub-national-electricity-consumption-data

Electricity consumption (Mwh)	Gas consumption (Mwh)	Households not connected to the gas network
450,838	1,836,024	12,760
(3.85 Mwh per meter) England average = 3.78 Mwh per meter	(13.42 Mwh per meter) England average = 13.66 Mwh per meter	(8.36% of households) England average = 12.43%

Source: Department for Business, Energy and Industrial Strategy, 2020 (consumption), Not connected to gas network, 2020
Figure: Domestic gas and electricity consumption, 2020



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Housing: Energy efficiency of domestic buildings

What information is shown here?

This page details the energy efficiency ratings of domestic buildings within North Northamptonshire.

The data are taken from Energy Performance Certificates (EPC) for domestic buildings published by MHCLG at postcode level and have been aggregated to Output Areas. These include those recorded between January 2017 and December 2021.The definitions of the measures on the right are given below.

The energy efficiency rating, expressed in Standard Assessment Procedure (SAP) points, is a score between 1-100 with 1 being poor energy efficiency and 100 being excellent energy efficiency. The current average rating of buildings is given alongside the potential rating (if improvements to the buildings were made) and the difference between the two - the 'energy efficiency gap'.

The number and proportion of buildings have been split into three bands of energy efficiency rating; A-C, D-E and F-G, where band 'A' EPC rating is the most efficient. Please be aware that these figures do not account for all domestic buildings in an area.

Only homes that have been built, bought, sold or retrofitted since 2008 have an EPC, which represents about 50 to 60 per cent of homes within a local authority area. Additionally, data has not been published where the holder of the energy certificate has opted-out of disclosure, energy certificates are excluded on grounds of national security or energy certificates are marked as "cancelled" or "not for issue". Only postcodes that match the ONS postcode file directory have been included.

Energy efficiency rating, current (SAP points)	Energy efficiency rating, potential (SAP points)	Energy efficiency gap (SAP points)
65.74	83.43	17.69
England average = 64.15	England average = 81.65	England average = 17.51

Band A-C buildings	Band D-E buildings	Band F-G buildings
38903	30509	1635
(54.76%) England average = 47.19%	(42.94%) England average = 49.47%	(2.30%) England average = 3.34%

Source: MHCLG. Data collected between Jan 2017- Dec 2021.

Figure: Energy efficiency rating (SAP points)

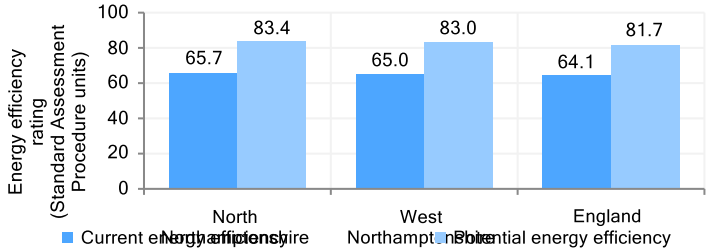
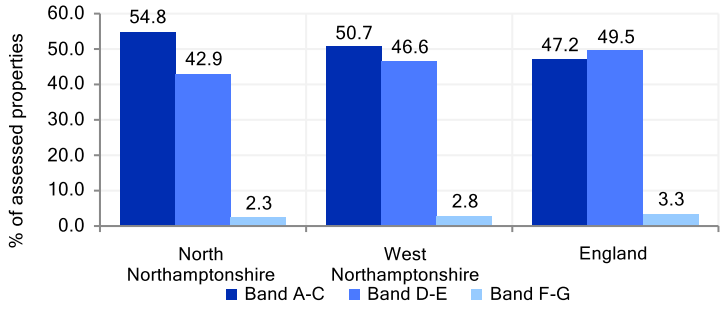


Figure: Energy efficiency rated buildings by band



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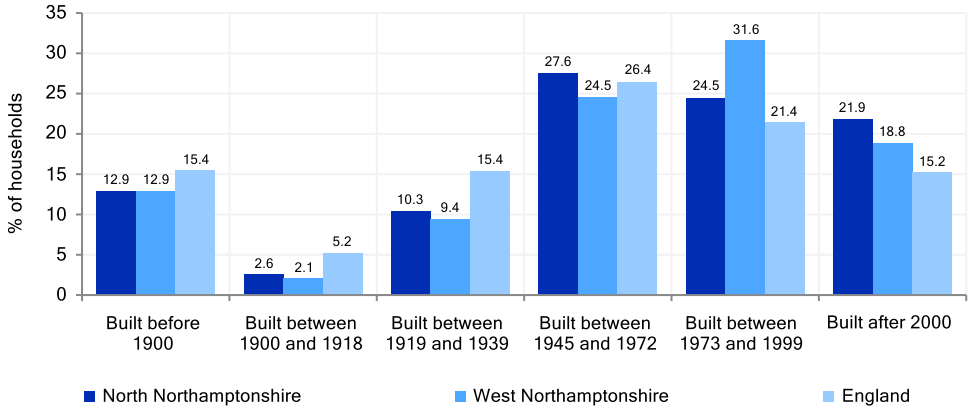
Housing: Dwellings by age of dwelling

What information is shown here?

The information on this page shows the number of domestic properties (the 'dwelling stock') broken down by age of property (when the property was constructed). The rate figures refer to the proportion of all properties whose build age is known.

Built before 1900	Built between 1900 and 1939	Built between 1945 and 1999	Built after 2000
19,790	19,840	80,080	33,640
12.9% (England average = 15.4%)	12.9% (England average = 20.6%)	52.0% (England average = 47.8%)	21.9% (England average = 15.2%)

Figure: Dwellings by age of dwelling (year property was constructed)
Source: Valuation Office Agency (VOA) 2021



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Housing: Communal establishment residents

What information is shown here?

The information on this page shows the number of people living in communal establishments, with breakdowns by the main types.

A communal establishment is defined as an establishment providing managed (full-time or part-time supervised) residential accommodation.

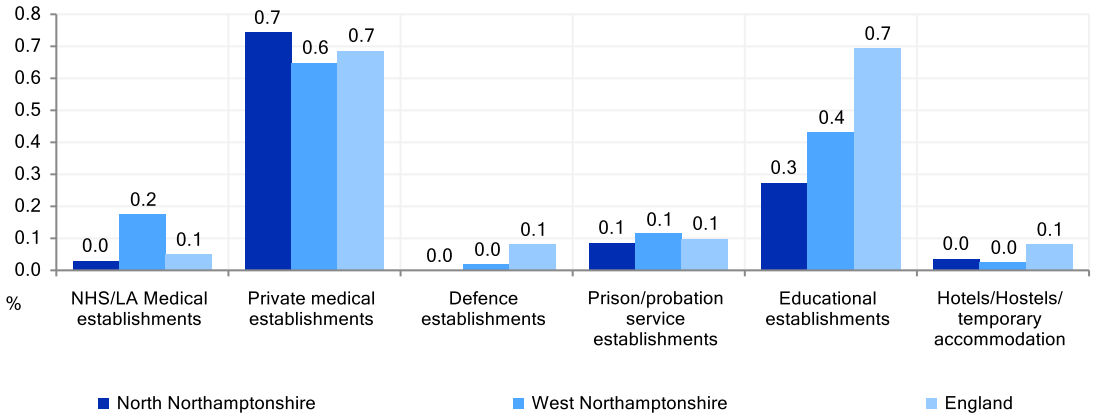
The information boxes on the right show the number and proportion of people in communal establishments by main type of establishment. Medical and care establishments include psychiatric hospital / homes, other hospital homes children's homes, residential care homes, nursing homes managed by the NHS, Local Authority or private organisation; Educational establishments include primarily University halls of residence; Defence establishments include barracks, air bases and naval ships; Other establishments include prison service establishments, bail hostels, hotels, boarding houses or guest houses, hostels and civilian ships.

The chart on the top right provides the same information with associated comparator areas.

All in communal establishments	Medical and care establishments	Education establishments	Defence establishments	Other establishments
3,847	2,472	867	00	125
1.2% (England average = 1.8%)	0.8% (England average = 0.7%)	0.3% (England average = 0.7%)	0.0% (England average = 0.1%)	0.0% (England average = 0.1%)

Source: Census 2011

Figure: Communal establishments by type
Source: Census 2011



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Crime and safety: Recorded crime (1)

What information is shown here?

The information on this page and the following shows the level of recorded crime in North Northamptonshire and comparator areas. This is based on data for individual crime incidents published via the www.police.uk open data portal, which has been linked by Local Insight to selected neighbourhoods. Further information on how these crimes and incidents have been categorised, as well as which crimes and incidents have been mapped and why, is available at: www.police.uk/about-this-site/faqs/#why-are-some-crimes-not-displayed-on-the-map

The information boxes show counts and rates for the main crime types and anti-social behaviour incidents. The overall crime rate is presented for monthly, quarterly and annual snapshots, with the underlying crime types shown as annual totals.

The line charts to the right and on the following page track monthly change in recorded crime across five key offences (violent crime, anti-social behaviour, burglaries, criminal damage and vehicle crime) across North Northamptonshire and comparator areas.

Note: Police.uk crime counts were not recorded for Greater Manchester Police due to a change in IT systems no crime, outcome or stop and search data is available from July 2019 onwards. West Midlands: Due to recent major system changes Crime and Stop & Search data is unavailable from April 2021 onwards. Please see https://data.police.uk/changelog/ for more details.

All crimes May 2022 monthly total	All crimes Mar-22 to May-22	All crimes Jun-21 to May-22
3,103	8,846	35,307
9.3 per 1,000 population (England average = 8.8)	26.3 per 1,000 population (England average = 26.9)	100.7 per 1,000 population (England average = 94.3)
Violent crimes Jun-21 to May-22	**Criminal damage incidents Jun-21 to May-22**	**Anti-social behaviour incidents Jun-21 to May-22**
14,209	2,879	6,814
40.5 per 1,000 population (England average = 32.5)	8.2 per 1,000 population (England average = 7.7)	19.4 per 1,000 population (England average = 17.8)
Burglaries Jun-21 to May-22	**Robberies Jun-21 to May-22**	**Vehicle crimes Jun-21 to May-22**
1,228	360	1,309
8.9 per 1,000 households (England average = 9.3)	1.0 per 1,000 population (England average = 0.9)	3.7 per 1,000 population (England average = 5.3)

Source: Recorded crime offences – https://data.police.uk/ (2021/2022)

Figure: Violent crime offences
Source: https://data.police.uk/

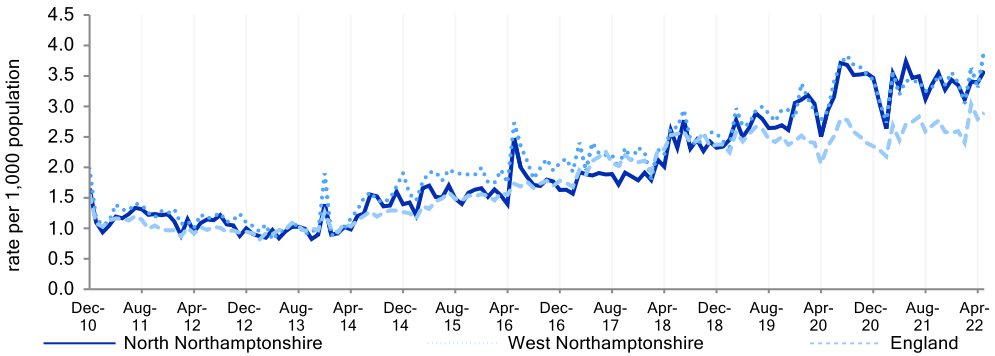

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Figure: Anti-social behaviour offences
Source: https://data.police.uk/

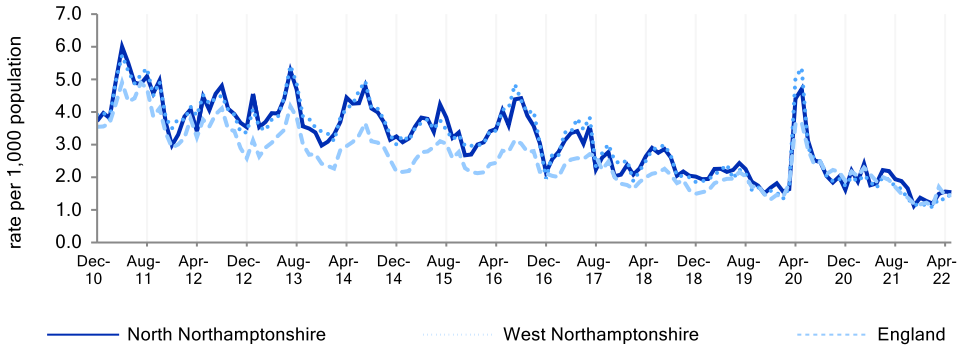


Figure: Burglary offences
Source: https://data.police.uk/

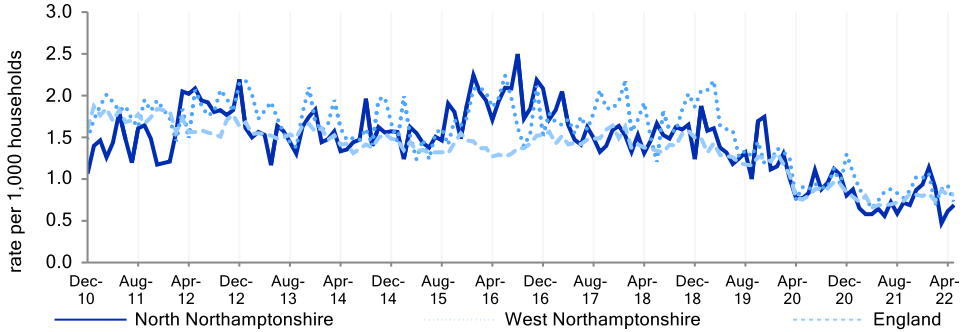


Figure: Criminal damage offences
Source: https://data.police.uk/

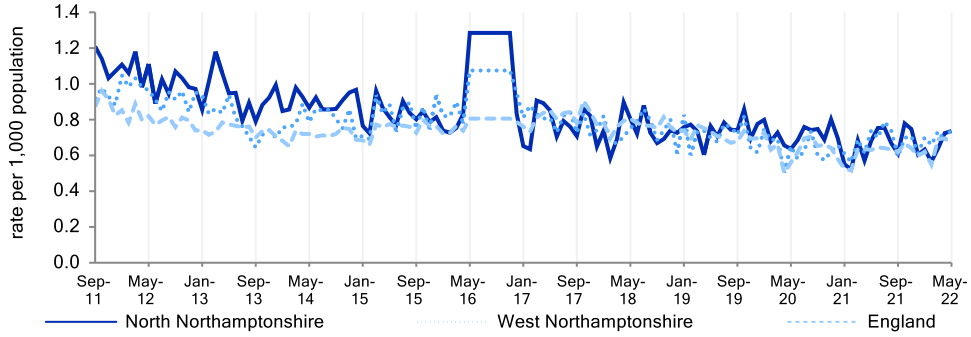
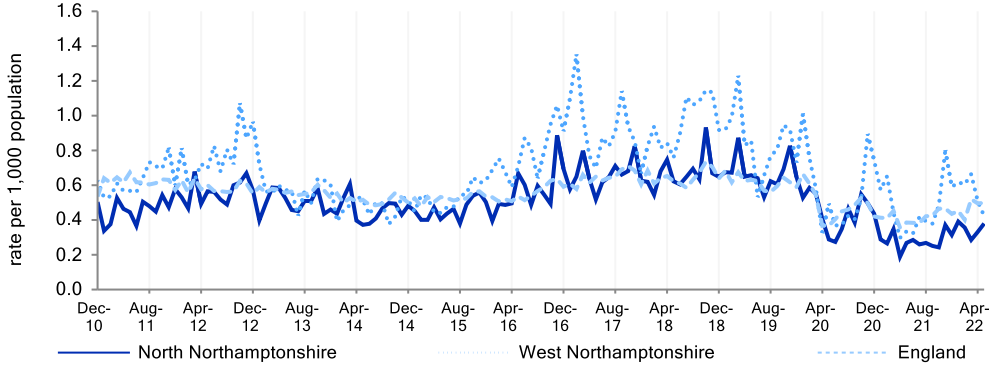


Figure: Vehicle crime offences
Source: https://data.police.uk/



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What information is shown here?

The information in this section explores variations in life expectancy and premature mortality. Life expectancy is a measure of the age a person born today can expect to live until, if they experience current mortality rates throughout their life. The chart on the right shows life expectancy at birth for females and males in North Northamptonshire and comparator areas.

The first chart on the following page shows the standardised mortality ratio for all causes and all ages for North Northamptonshire. This indicator highlights the ratio of observed to expected deaths (given the age profile of the population). A mortality ratio of 100 indicates an area has a mortality rate consistent with the age profile of the area, less than 100 indicates that the mortality rate is lower than expected and higher than 100 indicates that the mortality rate is higher than expected.

The second chart on the following page show incidence of cancer (with breakdowns for the most common forms of cancer). The data is presented as an incidence ratio (ratio of observed incidence vs expected incidence given the age profile of the population).

Figure: Life expectancy
Source: Office for National Statistics (2015-2019)

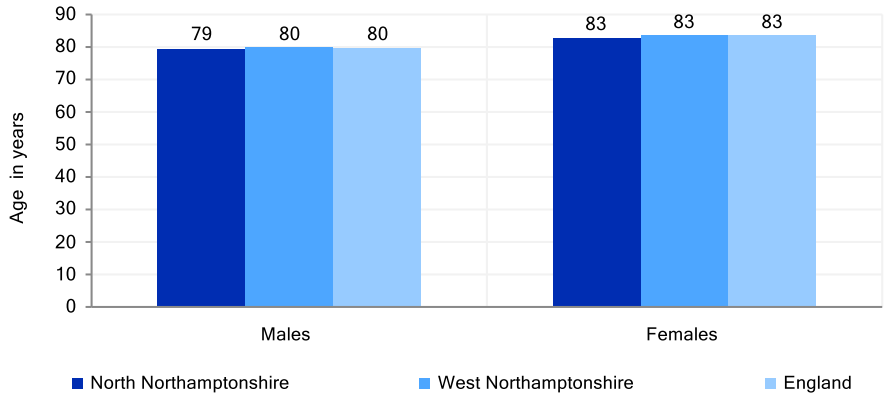

Figure: Healthy Life Expectancy
Source: Office for National Statistics (2009-2013)

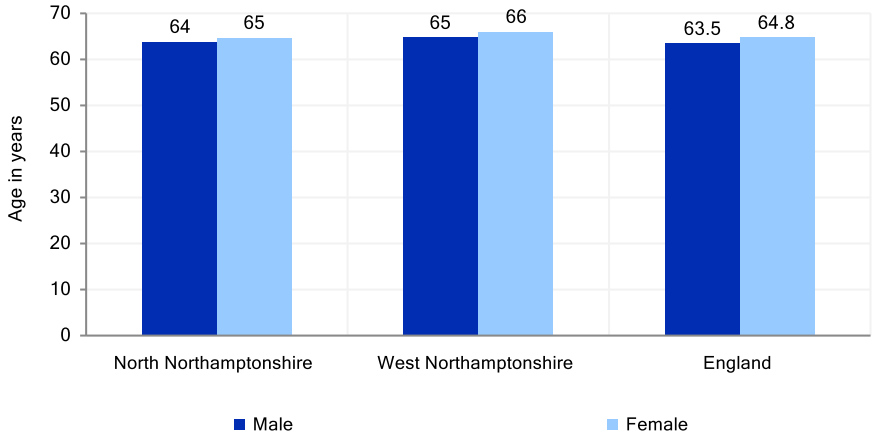

Figure: Disability-free Life Expectancy
Source: Office for National Statistics (2009-2013)

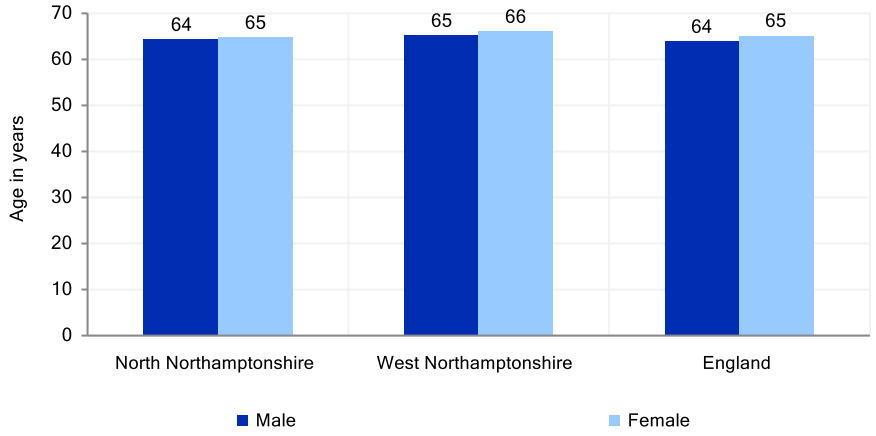

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Figure: Incidence of cancer: Standardised incidence ratio (select causes)
Source: Office for National Statistics (2012-2016)

If an area is above 100, there is a higher incidence of cancer than had been expected. If it is below 100, there is a lower incidence of cancer than expected.

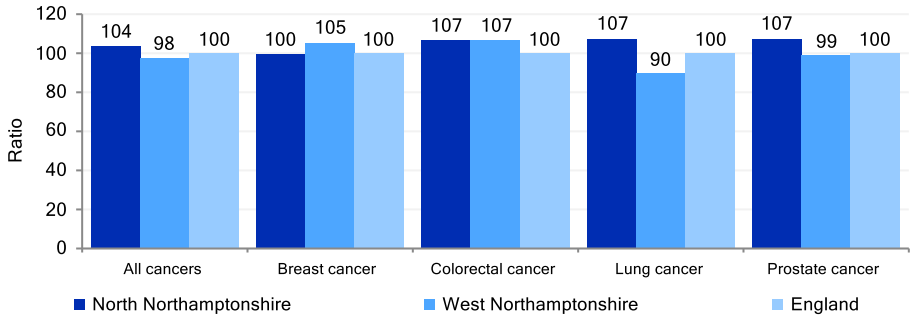
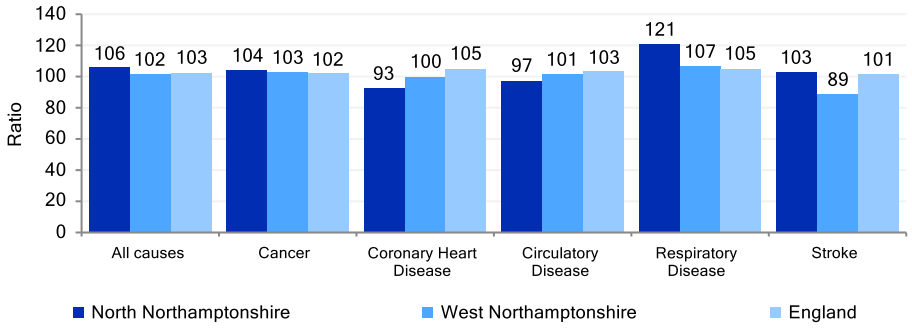


Figure: Standardised mortality ratio (select causes)
Source: Office for National Statistics (2015-2019)

If an area is above 100, there is a higher proportion of deaths than had been expected. If it is below 100, there is a lower proportion of deaths than expected.



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What information is shown here?

The information in this section looks at general levels of health, focusing on the number of people living in neighbourhoods with poor levels of overall health (health deprivation hotspots) and the number of people with a limiting long-term illness.

Limiting long-term illness is defined as any long-term illness, health problem or disability which limits someone's daily activities or the work they can do. Health deprivation 'hotspots' are neighbourhoods ranked among the most deprived 20% of neighbourhoods in England on the Indices of Deprivation 2015 Health domain. The domain measures morbidity, disability and premature mortality. All neighbourhoods in England are grouped into ten equal sized groups "deciles"; the 10% of neighbourhoods with the highest level of health deprivation are grouped in decile 10, and so on with the 10% of neighbourhoods with the lowest levels of health deprivation grouped in decile 1.

The chart on the right shows the number of people in North Northamptonshire living in each health decile. The charts below shows the proportion of residents in North Northamptonshire with a limiting long-term illness by age.

Number of people living in health deprivation 'hotspots' (Indices of Deprivation 2015)	People with a limiting long-term illness (Census 2011)	People aged 16-64 with a limiting long-term illness (Census 2011)	Babies born with a low birth weight (ONS 2011-2015)
64,217	54,407	25,530	475
18.4% (England average = 19.6%)	17.2% (England= 17.6%)	12.6% (England= 12.7%)	2.5% (England= 2.8%)

Figure: Number of people in each deprivation decile, Health domain
Source: Indices of Deprivation 2015

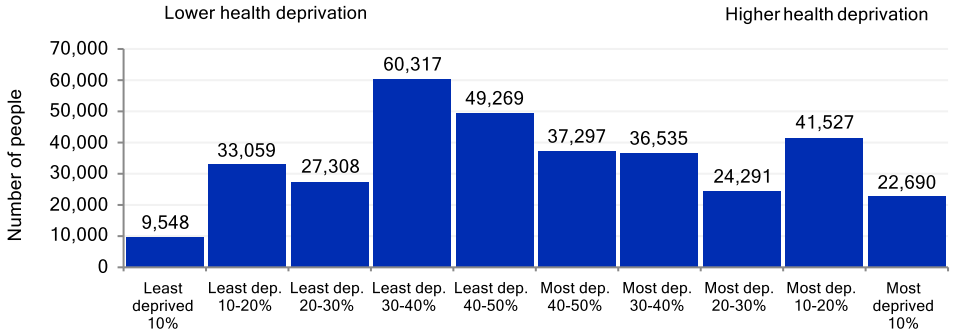
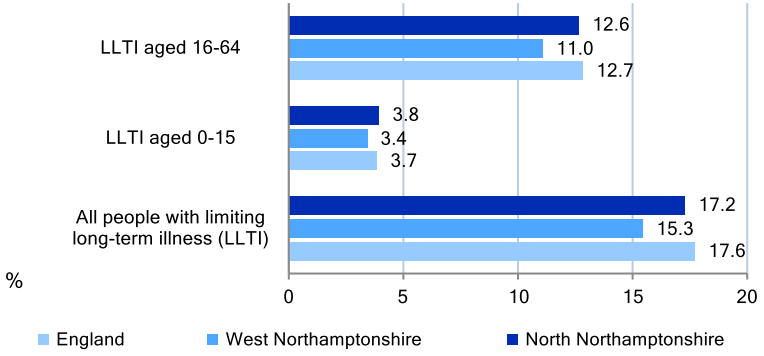


Figure: People with a limiting long-term illness
Source: Census 2011



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What information is shown here?

The information in this section looks at admissions to hospital by main health condition and hospital admissions and A&E attendance rates for children (aged under 5 years). The chart on the top right shows emergency admissions to hospital across North Northamptonshire and comparators. The chart on the bottom right shows elective in-patient hospital admissions (admissions that have been arranged in advance).

The data are presented as standardised ratios; a ratio of 100 indicates an area has an admission rate consistent with the national average, less than 100 indicates that the admission rate is lower than expected and higher than 100 indicates that the admission rate is higher than expected.

The information boxes at the bottom show the rate of emergency hospital admissions and A&E attendances for children (aged under 5 years) per 1,000 resident population in North Northamptonshire. Approximately 35% of all admissions in the NHS in England are classified as emergency admissions, costing approximately £11 billion a year. Over one quarter of emergency hospital admissions in children aged under 5 years in 2014/15 was for respiratory infections. A&E attendances in children aged under five years are often preventable, and commonly caused by accidental injury or by minor illnesses which could have been treated in primary care.

Emergency hospital admissions for children under 5 (per 1,000 population)	A&E attendance for children under 5 (per 1,000 population)
169	687
(England = 162)	(England = 630)

Source: Hospital Episode Statistics, Information Centre for Health and Social Care, Office for National Statistics (2017/2018 - 2019/2020)

Figure: Emergency hospital admissions: Standardised ratio (select causes)
Source: Hospital Episode Statistics, Information Centre for Health and Social Care, Office for National Statistics (2015/2016 - 2019/2020)

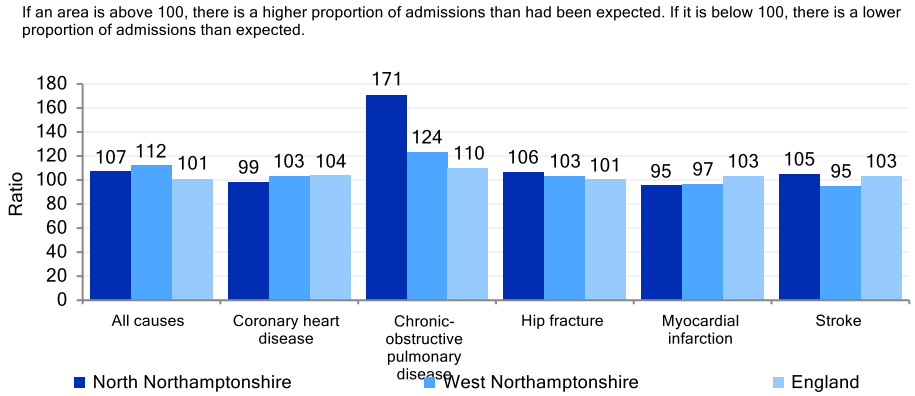
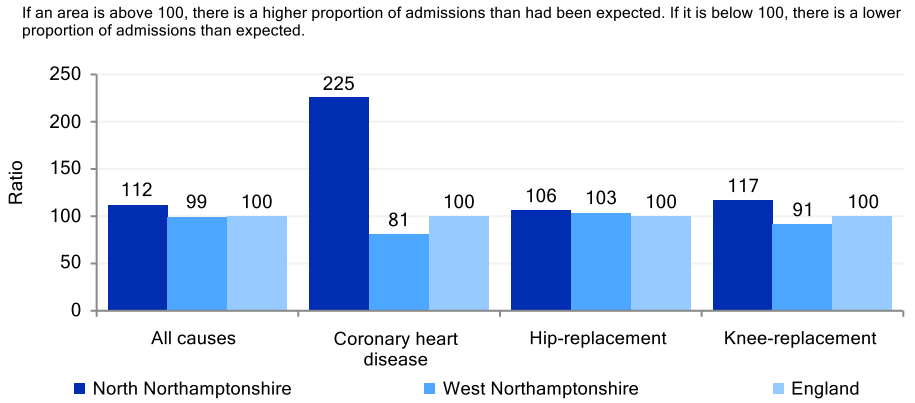


Figure: Elective hospital admissions: Standardised ratio (select causes)
Source: Hospital Episode Statistics, Information Centre for Health and Social Care, Office for National Statistics (2011/12-2014/15)



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What information is shown here?

Arthritis UK have partnered with Imperial College London to produce modelled estimates of the prevalence of musculoskeletal conditions for MSOAs in England. The estimates were calculated by identifying risk factors, sourcing suitable data sources and using statistical techniques to produce synthetic estimates of the numbers of people with hip osteoarthritis, knee osteoarthritis and back pain.

We have defined percentages consistently with Arthritis UK's methodology. **Knee and hip osteoarthritis figures are expressed as a percentage of the population aged 45 and over. Back pain figures are express as a percentage of the total population.**

People are deemed to have severe pain if they have pain most of the time or they are unable to walk a quarter of a mile unaided or they have previously undergone hip or knee replacement due to arthritis.

For more information visit https://www.arthritisresearchuk.org/arthritis-information/data-and-statistics/musculoskeletal-calculator.aspx

© Arthritis Research UK

Number of people with knee osteoarthritis (Arthritis UK 2011)	Number of people with hip osteoarthritis (Arthritis UK 2011)	Number of people with back pain (Arthritis UK 2011)
26343	15507	56850
19.0% (England= 18.2%)	11.2% (England= 10.9%)	17.7% (England= 16.9%)
Number of people with severe knee osteoarthritis (Arthritis UK 2011)	Number of people with severe hip osteoarthritis (Arthritis UK 2011)	Number of people with severe back pain (Arthritis UK 2011)
8828	4501	35998
6.4% (England= 6.1%)	3.2% (England= 3.2%)	11.2% (England= 10.3%)

Figure: Prevalence of hip and knee arthritis in people aged 45 and over
Source: Arthritis UK (2011)

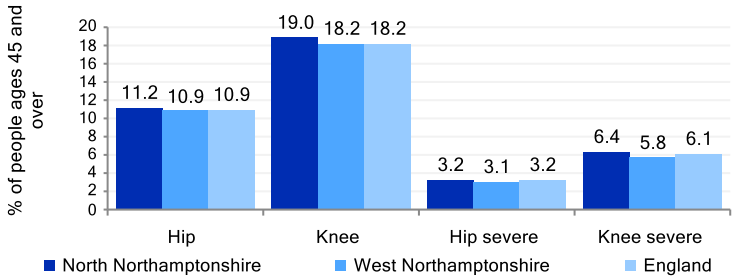
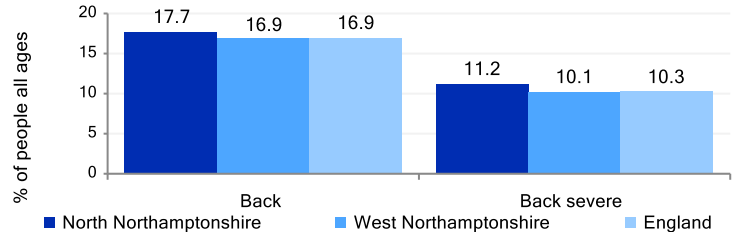


Figure: Prevalence of back pain in people of all ages
Source: Arthritis UK (2011)



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What information is shown here?

The information on this page looks at lifestyle behaviours of people living in North Northamptonshire. Lifestyle behaviours are risk factors which play a major part in an individual's health outcomes and will have varying physical and psychological consequences.

The chart on the top right shows the healthy eating levels (consumption of five or more portions of fruit and vegetables a day among adults) in North Northamptonshire. It also shows smoking prevalence and levels of binge drinking in these areas. Binge drinking is defined as the consumption of at least twice the daily recommended amount of alcohol in a single drinking session (8 or more units for men and 6 or more units for women).

The chart on the bottom right shows the percentage of people children (in reception year and year 6) and adults classified as obese in North Northamptonshire. People are considered obese when their body mass index (BMI) a measurement obtained by dividing a person's weight by the square of the person's height, exceeds 30 kg/m2.

Data for adult health are modelled estimates created from Health Survey for England 2006-2008. This is due to a lack of alternative small-area data for these indicators.

Figure: "Healthy eating" (consumptions of 5+ fruit and veg a day), binge drinking and smoking
Source: Health Survey for England 2006-2008

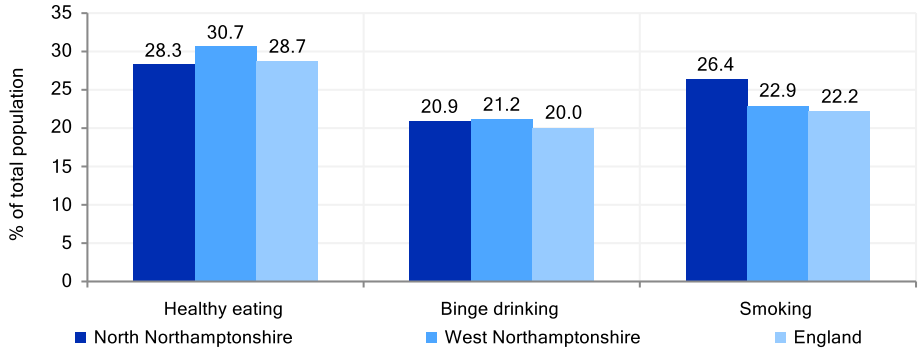
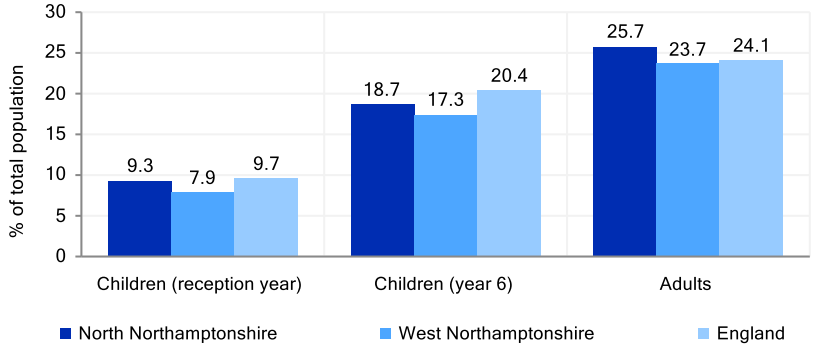


Figure: Children and adults classified as obese
Source: National Child Measurement Programme (NCMP) (2017/18-2019/20), Health Survey for England 2006-2008



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What information is shown here?

The information on this page looks at further lifestyle behaviours of people living in North Northamptonshire.

The chart on the top right shows the percentage of children (in reception year and year 6) classified as overweight or obese in North Northamptonshire. This indicator shows the number of children classified as overweight (including obese) where their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex. The indicator can be used to estimate and monitor excess weight and obesity in children in order to reduce prevalence, inform planning and delivery of services for children, and ensure the proper targeting of resources to tackle obesity.

The chart on the bottom right shows the modelled prevalence of smoking status for people aged 15 in North Northamptonshire. It shows the percentage of those aged 15 who are regular smokers or regular or occasional smokers. There is a large body of evidence showing that smoking behaviour in early adulthood affects health behaviours later in life. The Government's Tobacco Control Plan (2017) sets out their aim to reduce the number of 15 year olds who regularly smoke from 8% to 3% or less. This indicator will ensure that as well as focusing on reducing the prevalence of smoking among adults (primarily through quitting) local authorities will also address the issue of reducing the uptake of smoking among children.

Figure: Children classified as overweight or obese
Source: National Child Measurement Programme, NHS Digital (http://www.localhealth.org.uk/) (2017/18-2019/20)

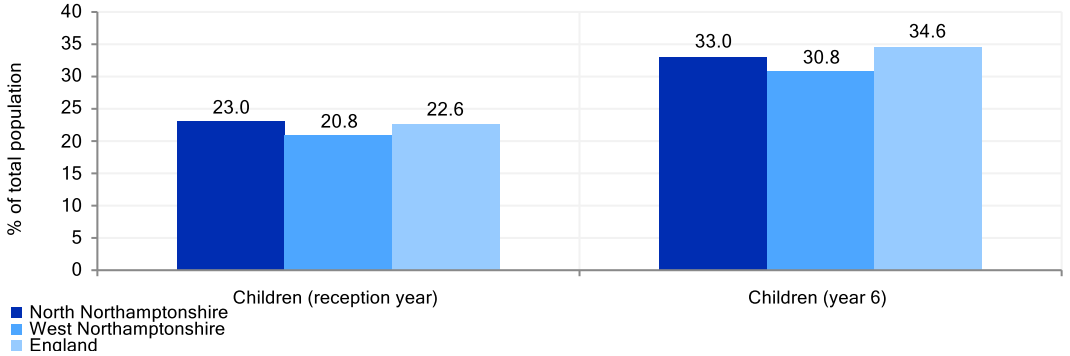
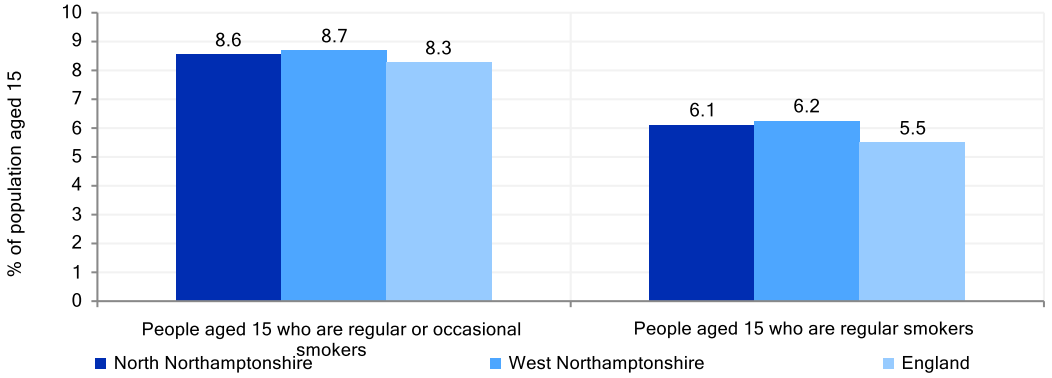


Figure: Prevalence of people aged 15 smoking status
Source: Department of Geography, University of Portsmouth and Geography and Environment, University of Southampton (http://www.localhealth.org.uk/) (2014)



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What information is shown here?

This chart shows estimates of the levels of physical activity among adults. The data have been produced by Sport England using a Small Area Estimation technique - modelling down from a National Survey (the Active Lives Survey 2020) to Middle Layer Super Output Area (MSOA) based on the local demographic characteristics of the local population. For more information on the modelling method see https://www.sportengland.org/know-your-audience/data/active-lives/active-lives-data-tables

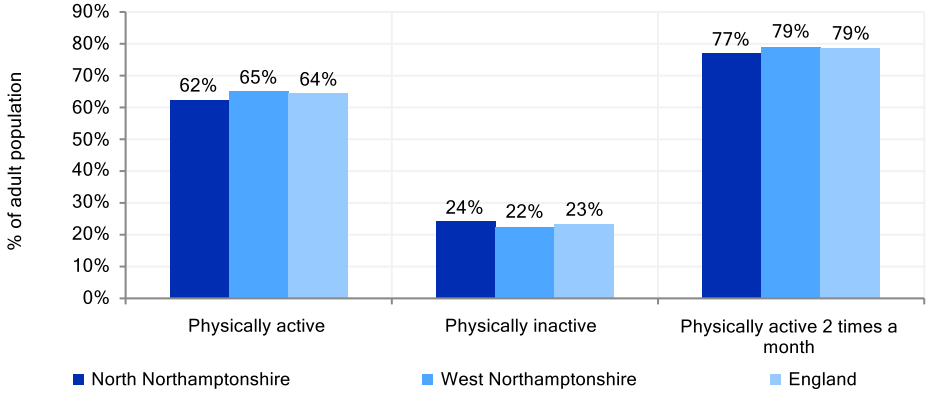
The categories of physical activity follow the guidelines set by the Chief Medical Officer and are defined below:

Physically active: undertaking at least 150 minutes per week in the past month excluding gardening

Physically inactive: undertaking less than 30 minutes in the past month excluding gardening

Physical activity at least twice a month: undertaking physical activity on at least two occasions in the past month

Figure: Physical activity among adults
Source: Sport England (Active Lives Survey 2020) – small area data 2018/2019



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What information is shown here?

The information on this page looks at the estimated prevalence of a different health conditions in North Northamptonshire.

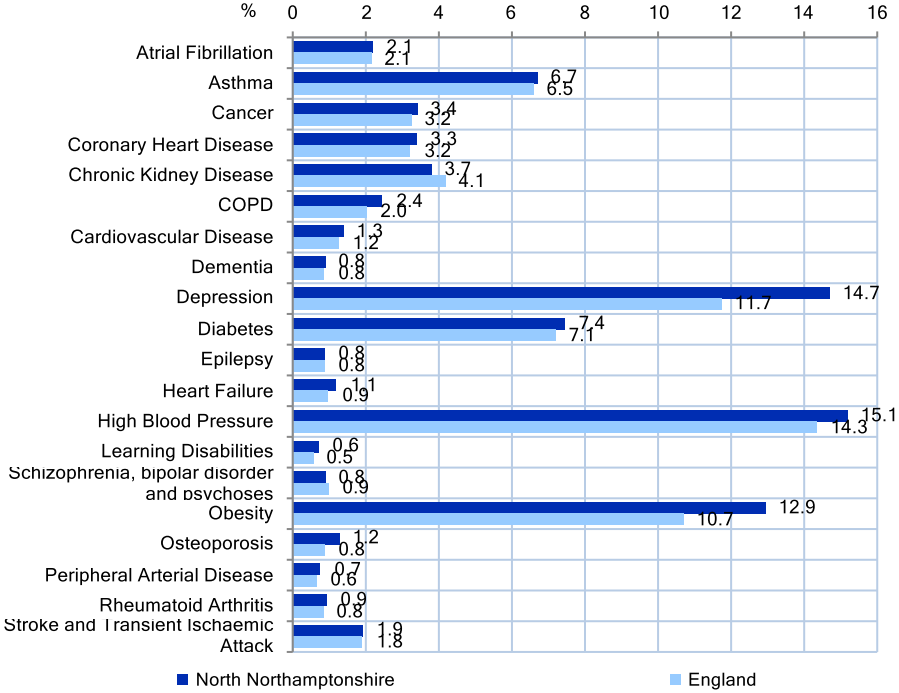
The estimates calculated are based on the number of people listed on GP registers in 2019/20, and the number of people recorded as having the relevant health conditions. The data from England's GP practices was published by NHS digital. As the data is for 2019/20, it may be affected by the beginning of the COVID-19 pandemic.

It should be noted that these are only estimates and that they are sensitive to the accuracy of GP data reporting. For some conditions (e.g. obesity and dementia), GP-recorded prevalence is lower than the proportion of people living with the condition.

For full notes, methodology, and limitations, please see https://commonslibrary.parliament.uk/social-policy/health/diseases/constituency-data-how-healthy-is-your-area for more details.

The bar chart on the right shows a detailed breakdown of the estimated percentage of prevalence by category of health condition.

Figure: % of estimated disease prevalence
Source: House of Commons Library (2019/20)



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What information is shown here?

The information on this page looks at the index of 'Access to Health Assets and Hazards' (AHAH) Version 3, a multidimensional index produced by the CDRC that measures how 'healthy' neighbourhoods are by looking at accessibility and geographical determinants of health. It combines indicators under four different domains of accessibility:

- Retail environment: access to fast food outlets, pubs, off-licences, tobacconists and vape stores, gambling outlets,
- Health services: access to GPs, hospitals, pharmacies, dentists, leisure services, and
- Physical environment: access to Blue Spaces, Green Spaces - Passive (total green space areas available to each postcode in a range of a 900-metre buffer prior to creating LSOA averages),
- Air Quality: three air pollutants (Nitrogen Dioxide, Particulate Matter 10 and Sulphur Dioxide).

The information boxes on the top right show the score on each of the four domains of accessibility and the overall AHAH index score for North Northamptonshire. A higher score indicates a poorer health-related environment.

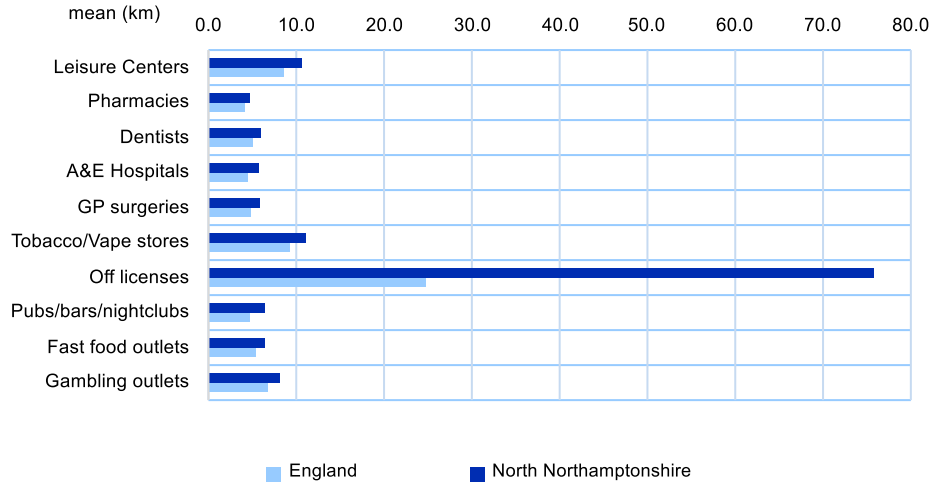
The bar chart on the right shows a detailed breakdown of the inputs for the retail environment and health services domains all of which show the mean distance in kilometres to each of these outlets and services.

For full notes, methodology, and limitations please see https://data.cdrc.ac.uk/dataset/access-healthy-assets-hazards-ahah for more details.

AHAH Retail Environment domain (CDRC 2022)	AHAH Health Services domain (CDRC 2022)	AHAH Physical Environment domain (CDRC 2022)
-0.4	0.1	0.1
(England = 0.1)	(England = -0.1)	(England = 0.1)

AHAH Air quality domain (CDRC 2022)	AHAH Index (CRDC 2022)
0.1	19.9
(England = 0.3)	(England = 23.2)

Figure: Inputs for retail environment and health services domain
Source: CDRC (2022)



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What information is shown here?

The information boxes and chart on the right show the education levels of residents in North Northamptonshire, showing the number and proportion of adults (aged 16+) by highest level of qualification. *Note, figures in the table and charts may not add up to 100% because they do not include figures for those for who with other qualifications or unknown qualifications.*

The Chart on the bottom left shows the proportion of people turning 18 between 2010-11 and 2014-15 who went on to enter higher education.

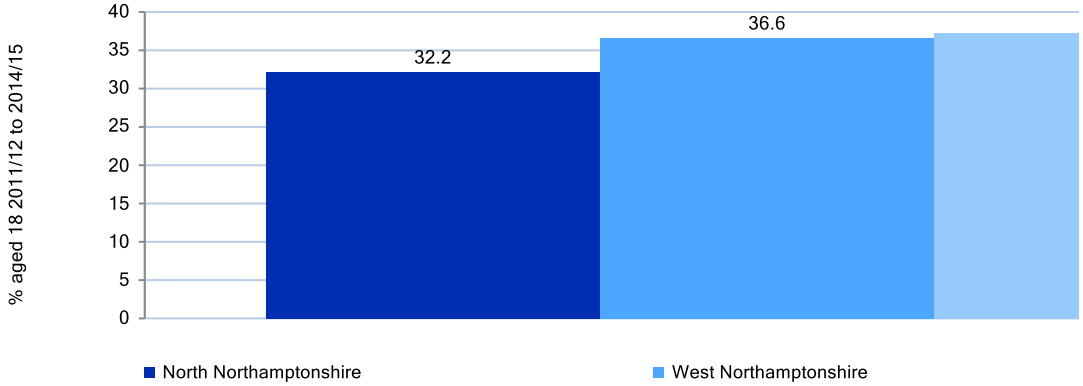
People with no qualifications	People with highest qualification level 1	People with highest qualification level 2	People with highest qualification level 3
61,558	40,260	43,204	28,971
24.3% of working age people (England= 22.5%)	15.9% of working age people (England= 13.3%)	17.1% of working age people (England= 15.2%)	11.4% of working age people (England= 12.4%)

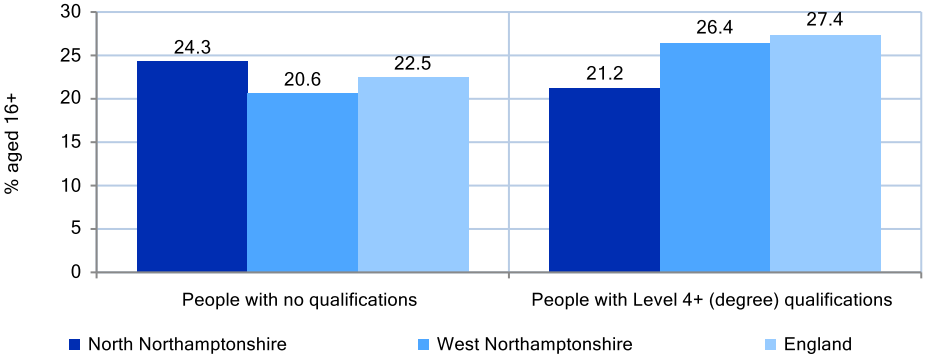
People with highest qualification level 4+ (degree)	
53,833	'Level 1' qualifications are equivalent to a single O-level, GCSE or NVQ. 'Level 2' qualifications are equivalent to five O-levels or GCSEs. 'Level 3' qualifications are equivalent to two A levels. 'Level 4' qualifications are equivalent to degree level or higher.
21.2% of working age people (England= 27.4%)	

Source: Census 2011

Figure: People with no qualifications and degree level qualifications
Source: Census 2011

Figure: Participation in higher education (Proportion of a young cohort that has entered higher education by age 19)
Source: Office for Students (OFS)





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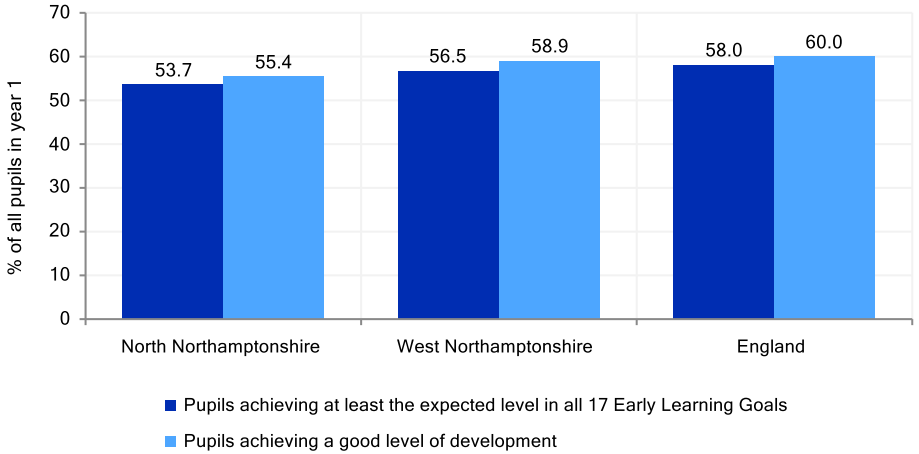
What information is shown here?

The information on this page shows the outcomes of children in the Early Years Foundation Stage (EYFS), a series of tests measuring children's progress in terms of Personal, Social and Emotional Development (PSED) and Communication, Language and Literacy (CLL). These are typically 5-year-old pupils; however, a minority of slightly older and younger pupils may have been assessed.

The new Early Years Foundation Stage Profile requires practitioners to make a best fit assessment of whether children are emerging, expected or exceeding against each of the new 17 Early Learning Goals (ELGs). Children have been deemed to have reached a Good Level of Development (GLD) in the new profile if they achieve at least the expected level in the ELGs in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and in the specific areas of mathematics and literacy. These are 12 of the 17 ELGs. The Department for Education has also introduced a supporting measure which measures the total number of points achieved across all 17 ELGs and reports the average of every child's total point score.

The chart on the right shows the percentage of pupils achieving 17 ELG and the percentage of pupils achieving a good level of development.

Figure: Early years foundation stage profile
Source: Department for Education (2013-2014)



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What information is shown here?

The chart on the top right show the education levels of pupils in North Northamptonshire, showing the examination results at Key Stage 1 (tests set at aged 7) Key Stage 2 (tests set at aged 11) and Key Stage 4 (GCSEs).

The figures show the Average Point Score of pupils from each of the Key Stage examinations. This adjusts for high achieving pupils as well as pupils achieving expected levels.

The chart on the top right shows Average Point Score (across all examinations) per pupil at Key Stage 1 and Key Stage 2. The chart on the bottom right compares the gap in Average Point Score at Key Stage 4 (GCSE) per pupil between North Northamptonshire and the national average over time. The gap is measured as the point difference against the England average. Areas with a score of greater than 1 are performing better than the national average, while areas with a score of less than 1 are performing below.

Figure: Pupil attainment at Key Stage 1 and Key Stage 2
Source: Department for Education (2013-2014)

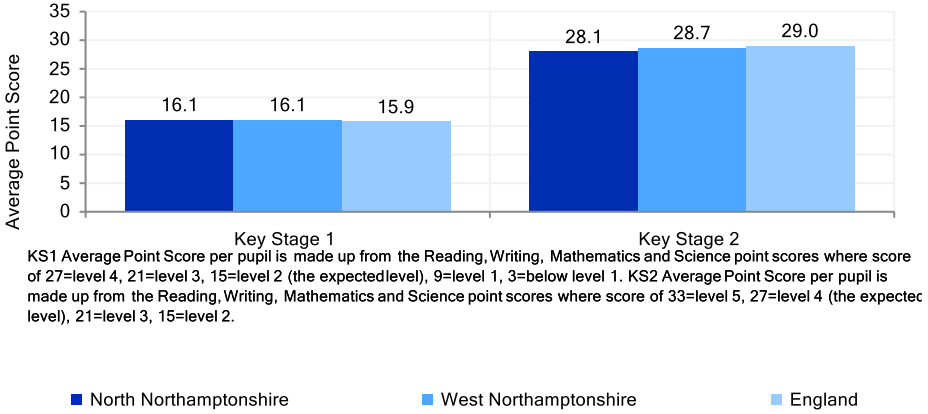


Figure: Pupil attainment at Key Stage 4
Source: Department for Education (2013-2014)

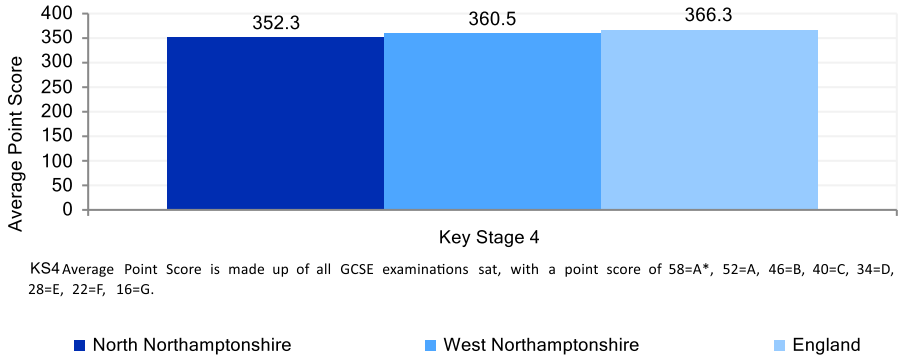
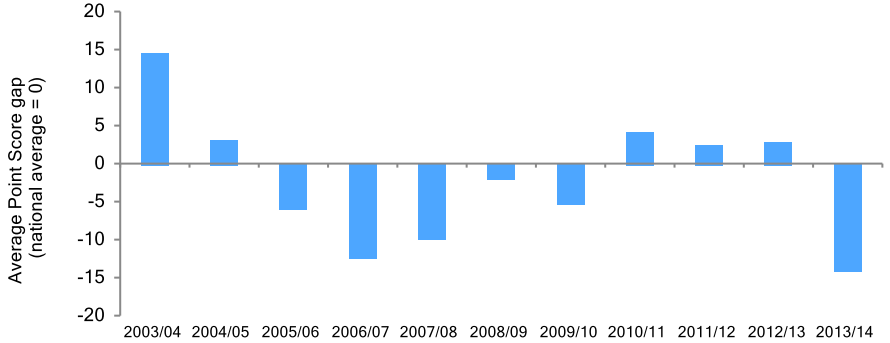


Figure: Gap in pupil attainment at Key Stage 4 (difference from the national average)
Source: Department for Education



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What information is shown here?

The information on this page looks at four types of income category: average household income; average equivalised household income after housing costs; households living in fuel poverty and median net equivalised household PAYE and benefits income. Fuel poverty is said to occur when in order to heat its home to an adequate standard of warmth a household needs to spend more than 10% of its income on total fuel use.

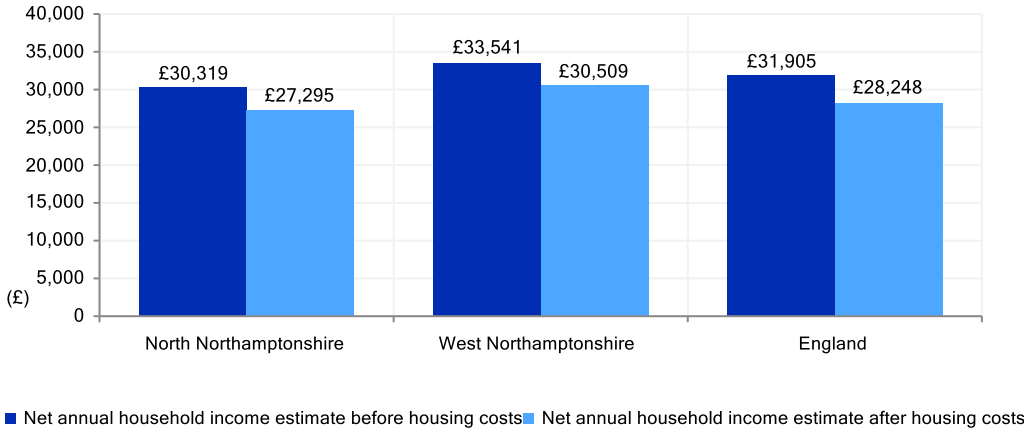
The information boxes on the top right provide an estimate of the number of households in North Northamptonshire below the poverty line and an estimate for the number of households in fuel poverty.

The chart on the right shows the average annual household income estimate (equivalised to take into account variations in household size) across North Northamptonshire and comparator areas before and after housing costs.

Annual household income (Office for National Statistics 2017/18)	Annual household income, after housing costs (Office for National Statistics 2017/18)	Households living in 'Fuel Poverty' Department for Business, Energy and Industrial Strategy (2020)
£40,438	£27,295	18,315
England Average = £43,966	England Average = £28,248	12.9% of households (England = 13.2%)

Median net equivalised household PAYE and benefits income (Office for National Statistics 2015/16)
£24,192
England Average = £24,577

Figure: Annual household earnings (£)
Source: Office for National Statistics (2017/18)



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What information is shown here?

The levels of private debt, in the form of unsecured loans and mortgage debt per head, for North Northamptonshire are displayed here.

These figures, available at postcode sector level, are published by UK Finance and account for around 60% of borrowing in the UK. OCSI have modelled this data to Output Areas using an address-based lookup from postcode sector to Output Area in combination with the number of local households and the local population.

The personal debt figure is the total amount of borrowing outstanding on customer accounts divided by the population aged 18+. Personal debt includes all unsecured loans such as credit cards, credit for new cars (eg when buying on finance) and other personal loans. Student debt is not included.

The mortgage debt figure is the total borrowing outstanding on customer accounts for residential mortgages divided by the total number of households.

The SME debt figure is the total amount of borrowing outstanding on customer accounts for Small and Medium-sized enterprises divided by the population aged 18+.

Personal debt per head	Residential mortgage debt per head	SME lending debt per head
£808.2	£41510.9	£1602.5
England Average = £575.8	England Average = £44001.7	England Average = £2101.0

Source: UK Finance (Sep-21)

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What information is shown here?

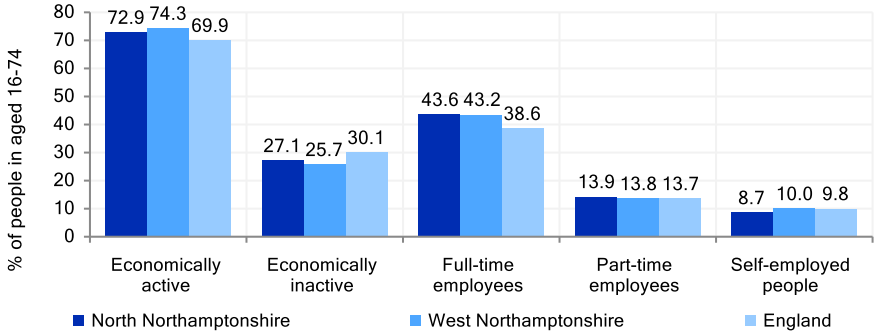
The information on this page shows economic activity breakdowns for adults aged 16-74 in North Northamptonshire.

The data in the information boxes shows the number and proportion of residents who are economically active, with breakdowns for those working part time, full time or are self-employed (*note, these figures do not add up to all those economically active as it excludes those economically active who are unemployed or full-time students*).

Economically active	Full-time employees	Part-time employees	Self-employed people	Economically inactive
168,246	100,543	32,163	19,979	62,546
72.9% (England average = 69.9%)	43.6% (England average = 38.6%)	13.9% (England average = 13.7%)	8.7% (England average = 9.8%)	27.1% (England average = 30.1%)

Source: Census 2011

Figure: Economic Activity
Source: Census 2011



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What information is shown here?

The information on this page shows breakdowns of the main industry sectors people in North Northamptonshire are working in, and their occupational status.

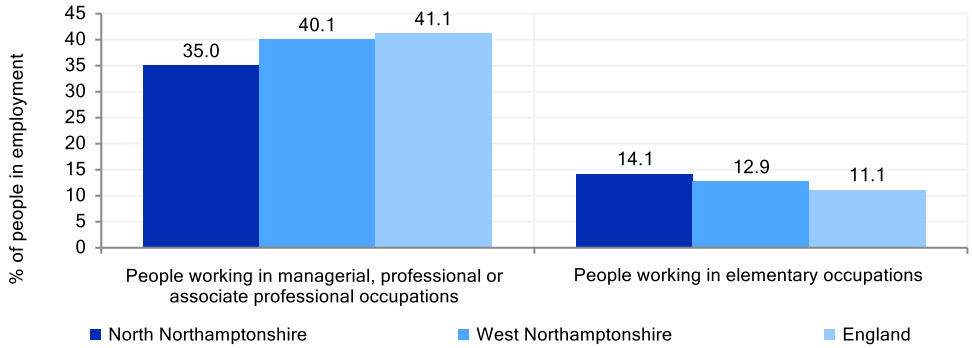
The data in the top information boxes shows the three largest employment sectors for residents in the local area, also the number and percentage of employed people working in each of these sectors. The lower information boxes and the chart on the right show the numbers of residents in North Northamptonshire by type of occupation (e.g., managers, professional, administrative).

Largest employment sector	Second largest employment sector	Third largest employment sector
Retail	Manufacturing	Health & social work
31,843 employees (20% of 157,386 of people in employment)	23,988 employees (15% of 157,386 of people in employment)	17,341 employees (11% of 157,386 of people in employment)

Managerial occupations	Professional (or associate) occupations	Administrative or secretarial occupations	Skilled trades occupations	Elementary occupations
16,875	38,288	17,157	19,392	22,179
10.7% of 157,386 people in employment (England = 10.9%)	24.3% of 157,386 people in employment (England = 30.3%)	10.9% of 157,386 people in employment (England = 11.5%)	12.3% of 157,386 people in employment (England = 11.4%)	14.1% of 157,386 people in employment (England = 11.1%)

Source: Census 2011

Figure: People in professional and elementary occupations
Source: Census 2011



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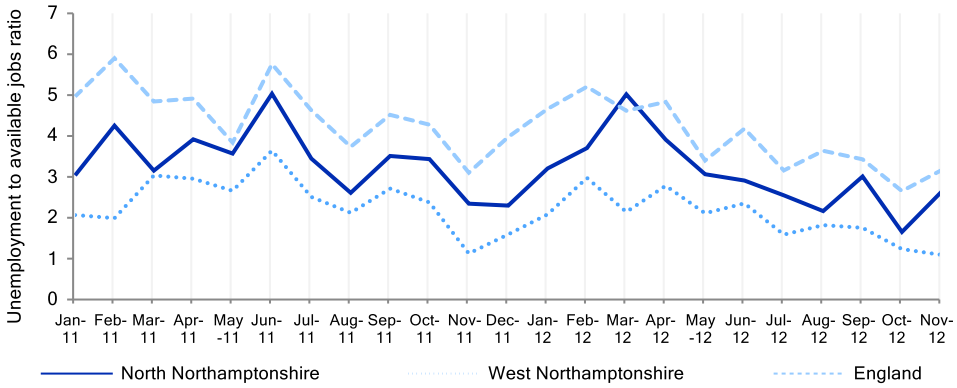
What information is shown here?

The information on this page shows the number of vacant jobs in North Northamptonshire compared against the overall unemployment levels in the area.

The 'Unemployment to 'Available Jobs' ratio, shown in the information box on the right and the line chart below is the total number of people claiming unemployment benefit (Jobseekers Allowance) divided by the total number of job vacancies notified to Jobcentre Plus expressed as a ratio.

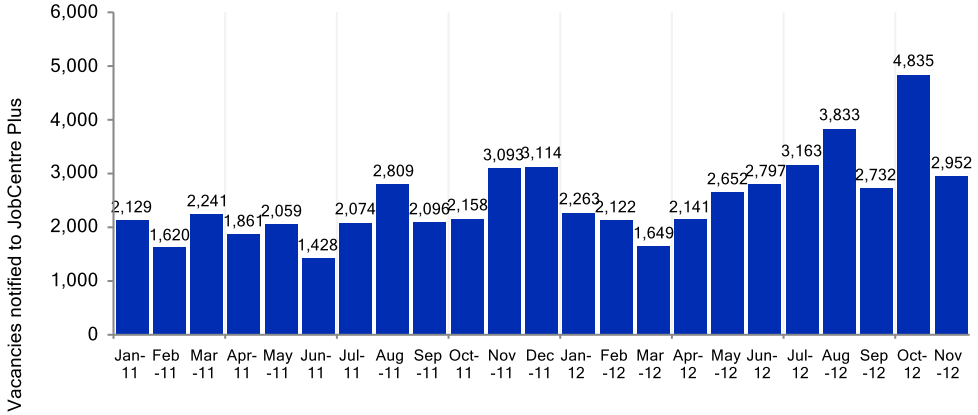
The bar chart on the bottom right shows month-on-month changes in the number of job vacancies notified to Jobcentre Plus, that are located in the area covering North Northamptonshire (based on postcode location of the job). *Note, this data was last updated by Jobcentre Plus for November 2012.*

Figure: Ratio of unemployment (JSA claimants) to jobs (vacancies notified to Jobcentre Plus
Source: Office for National Statistics/Job Centre Plus, Department for Work and Pensions



Unemployment to 'Available Jobs' ratio	Source: Job Centre Vacancies - Office for National Statistics/Jobcentre Plus (Nov-12), Jobseekers Allowance claimant count – Department for Work and Pensions (Nov-12)
2.30 claimants per job	
England average = 3.43	

Figure: Total number of vacancies notified to Job Centre
Source: Office for National Statistics/Job Centre Plus



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What information is shown here?

The information in this section shows the concentration of workforce jobs in North Northamptonshire. Workforce jobs are taken from the Business Register and Employment Survey (BRES) which publishes employee and employment estimates based on a survey of approximately 80,000 businesses and weighted to represent all sectors of the UK economy.

The information boxes show the three largest industry groups for workforce jobs based in North Northamptonshire. The bar chart on the top right shows the change in 'Jobs Density' (the number of jobs as a % of working age population) across North Northamptonshire over time. The bar chart on the bottom right shows the share of jobs broken down by public and private sector.

Largest industry sector	Second largest industry sector	Third largest industry sector
Transport	Manufacturing	Health
14.0% of all people in employment	12.7% of all people in employment	10.8% of all people in employment

Source: Business Register and Employment Survey (BRES) (2020)

Figure: Jobs Density (jobs as a % of working age population) (2020)
Source: Business Register and Employment Survey (BRES)

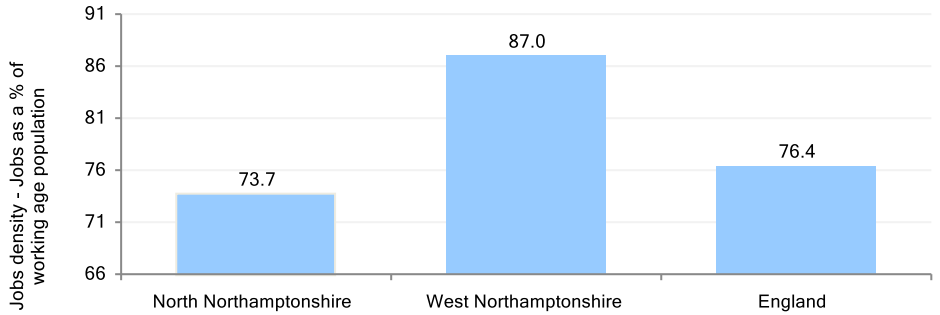
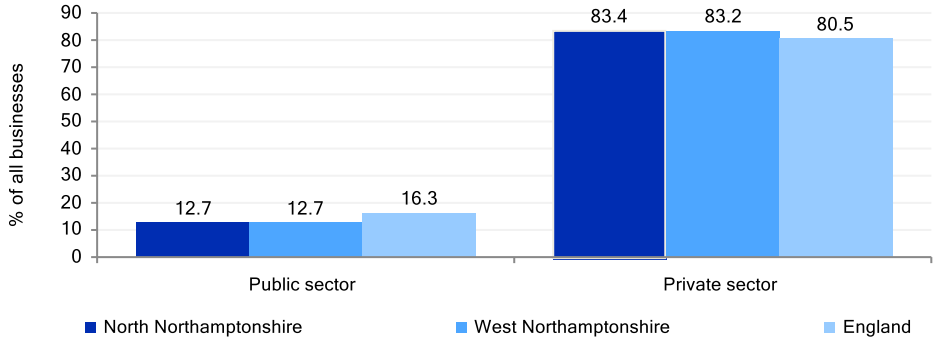


Figure: Jobs by public sector/private sector (2020)
Source: Business Register and Employment Survey (BRES)



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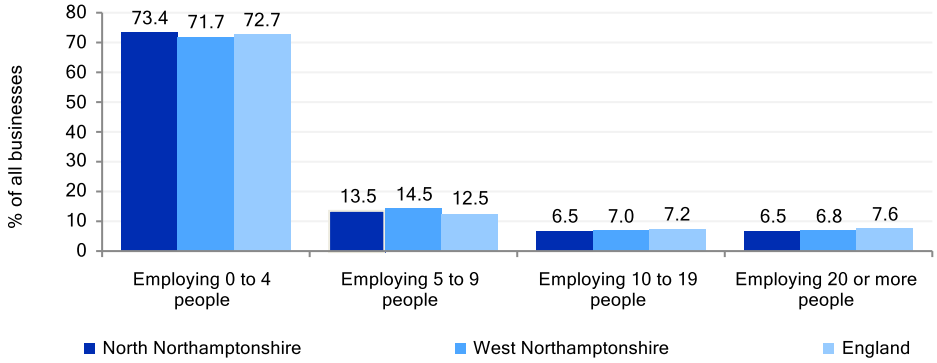
What information is shown here?

The information in this section shows the concentration of 'local business units' in North Northamptonshire. 'Local business units' are counts of businesses based on the location of an operational unit. Though larger businesses such as supermarket chains may have their head office in a large city, these figures measure all subsidiaries of that larger enterprise based on where subsidiaries are located. The figures cover all business eligible for VAT (1.7 million businesses in the UK are registered for VAT). These businesses are categorised into 16 broad industry groups derived from the Standard Industrial Classification (UKSIC (2003)).

The information boxes show the three largest industry groups for businesses based in North Northamptonshire. The line chart shows the change in the number of businesses per head of the population across North Northamptonshire over time. The bar chart shows the count of local business broken down by size of business. Businesses are broken down into four employment size bands based on the number of paid employees (0-4, 5-9, 10-19 and 20+ paid employees).

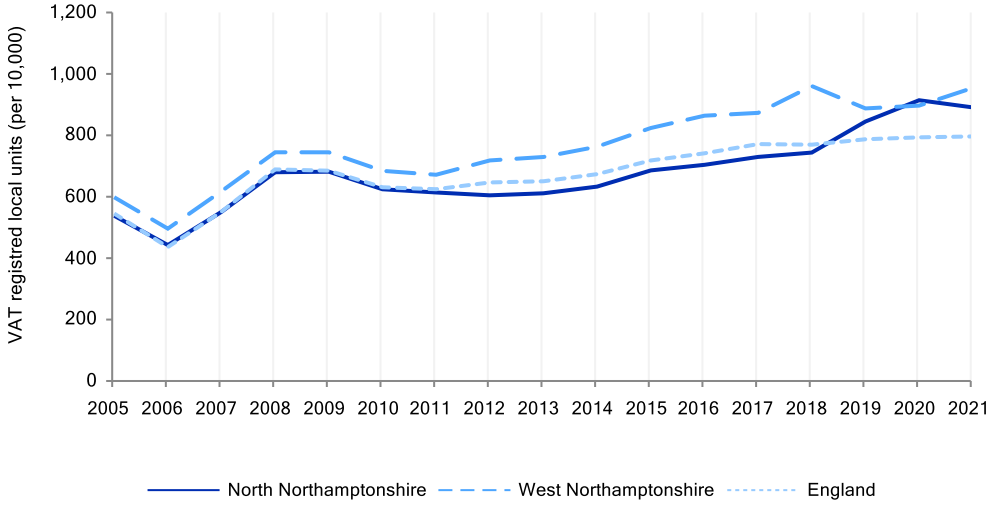
Figure: Businesses (VAT based local units) by employment size band (2021)
Source: Office for National Statistics



Largest business sector	Second largest business sector	Third largest business sector
Transport	Arts, entertainment, recreation & other services	Construction
14.2% of all local businesses	13.6% of all local businesses	11.1% of all local businesses

Source: Office for National Statistics (2021)

Figure: Businesses (VAT based local units) per 10,000 working age population
Source: Office for National Statistics



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What information is shown here?

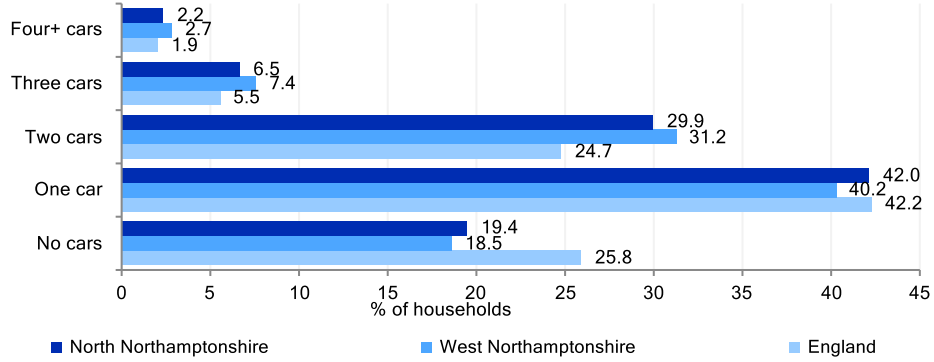
The information on the right shows details of the number of cars and vans in each household in North Northamptonshire. The count of cars or vans in an area is based on details for private households only. Cars or vans used by residents of communal establishments are not counted.

The information boxes show the number of households by number of cars owned across North Northamptonshire, while the charts show the same information (expressed as a percentage) against comparator areas.

No cars	One car	Two cars	Three cars	Four + cars
25,675	55,745	39,605	8,675	2,935
19.4% of 132,635 households (England = 25.8%)	42.0% of 132,635 households (England = 42.2%)	29.9% of 132,635 households (England = 24.7%)	6.5% of 132,635 households (England = 5.5%)	2.2% of 132,635 households (England = 1.9%)

Source: Census 2011

Figure: Car ownership
Source: Census 2011



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What information is shown here?

The information on this page shows the accessibility of key services and amenities to people living in North Northamptonshire. Accessibility is measured both in terms of distance and travel times to key services.

The information boxes on the right show average distances (in kilometres) to five key services. The chart on the right shows average travel times in minutes to key services when walking or taking public transport.

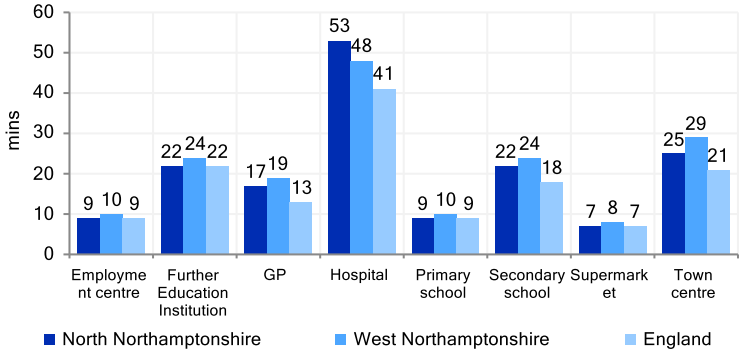
The final information box on the right shows the overall Job access score. This measure of connectivity developed by UK Onward includes the number of jobs accessible by car and public transport from every local area (LSOA) in the country across different time horizons. The metric provides the reachable number of jobs and distance with 15 minutes, 30 minutes, 60 minutes and 90 minutes by both driving and public transport for each LSOA.The data incorporates a “door-to-workplace” measure, including every journey stage from time spent walking to the car, driving, to parking and walking to an office - as well as average delays, timetabling and actual journey time on public transport. These measures have been combined into an overall Jobs access score, the weighted average job count, combining driving and public transport. A higher score indicates greater levels of job accessibility. For more information and a link to the research paper please see here: https://www.ukonward.com/reports/network-effects/

Average road distance from Job Centre	Average road distance from Secondary School	Average road distance from GP	Average road distance from Pub	Average road distance from Post Office
4.5km	2.4km	1.4km	0.9km	1.2km
England average = 4.6km	England average = 2.1km	England average = 1.2km	England average = 0.7km	England average = 1.0km

Job Access Score (2021)
423952.0
698519.5 average = 698519.5

Source: Road distances - Commission for Rural Communities: Distance to Service dataset (2010); UK Onward (2021)

Figure: Average travel time (mins) by walking or public transport to the nearest key service
Source: Department for Transport: Core Accessibility Indicators (2019)



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What information is shown here?

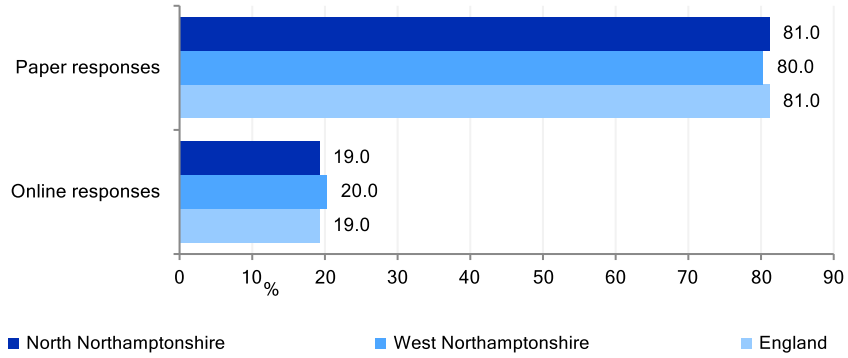
The information on this page shows two measures of access to the internet. The first measure shows information on broadband take-up, speeds and availability. It has been produced by Ofcom and contains data provided by communications providers. The data shows the average broadband line speed in North Northamptonshire and the proportion of premises in North Northamptonshire with broadband speeds below the Universal Service Obligation (USO) (download speeds at or above 10Mbit/s and upload speeds at or above 1Mbit/s including non-matched records and zero predicted speeds).

The chart on the right shows the proportion of people who responded to the 2011 Census online, compared with the proportion that filled in the Census form on paper in North Northamptonshire. This is a proxy measure of digital engagement as areas with a high proportion of online Census responses are more likely to be digitally engaged than those in areas with low levels of online responses.

Premises with broadband speeds below the USO (2019)	Average broadband download speed (Mbit/s) (2020)	Average broadband upload speed (Mbit/s) (2020)
1,135	78.24	16.32
0.7% (England average = 1.8%)	England average = 73.40	England average = 12.74

Source: Ofcom 2019 & 2020

Figure: Census online and paper responses
Source: Census 2011



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What information is shown here?

The information on this page looks at the characteristics of neighbourhoods across North Northamptonshire as defined using the Output Area Classification (OAC). OAC classifies every area in the country based on a set of socio-demographic characteristics, to provide a profile of areas to identify similarities between neighbourhoods. The information boxes on the right show the number and proportion of neighbourhoods in North Northamptonshire that fall within the eight supergroup categories, detailed below. The chart on the right shows the proportion of areas falling within supergroup categories across North Northamptonshire and comparators.

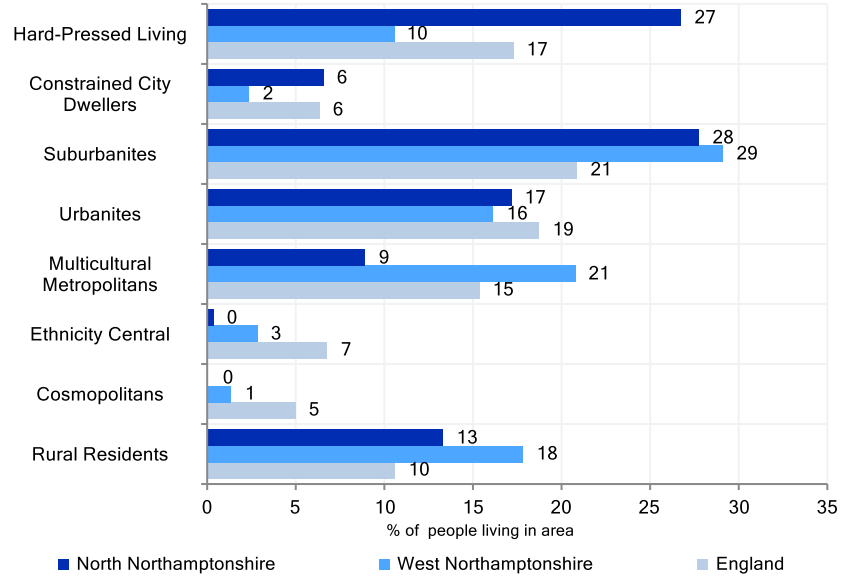
Rural residents	Rural areas, sparsely populated, above average employment in agriculture, higher number owning multiple cars, an older married population, a high provision of unpaid care and an above average number of people living in communal establishments.
Cosmopolitans	Residing in densely populated urban areas, high ethnic integration, high numbers of single young adults without children including students, high public transport use, above average qualification levels
Ethnicity central	Concentrated in Inner London and other large cities, high ethnic diversity, high proportion of rented accommodation, high proportion of people living in flats, low car ownership.
Multicultural metropolitans	Concentrated in larger urban conurbations in the transitional areas between urban centres and suburbia, high proportion of BME groups, high proportion of families.
Urbanites	Predominantly in urban areas with high concentrations in southern England. More likely to live in either flats or terraces that are privately rented.
Suburbanites	Located on the outskirts, in areas with high owner occupation, high numbers of detached houses, low unemployment, high qualifications and high car ownership.
Constrained city dwellers	Higher proportion of older people, households are more likely to live in flats and to rent their accommodation, and there is a higher prevalence of overcrowding, higher proportion of people in poor health, lower qualification levels and high unemployment
Hard-pressed living	Mostly on the fringe of the UK's urban areas, particularly in Wales and the North of England. High levels of people in terraced accommodation, high unemployment, low ethnic diversity, high levels of people employed in manufacturing

Rural residents	Cosmopolitans	Ethnicity central	Multicultural metropolitans
41,746	0	782	27,874
13.2% (England average = 10.5%)	0.0% (England average = 4.9%)	0.2% (England average = 6.6%)	8.8% (England average = 15.3%)

Urbanites	Suburbanites	Constrained city dwellers	Hard-pressed living
54,106	87,504	20,507	84,332
17.1% (England average = 18.6%)	27.6% (England average = 20.8%)	6.5% (England average = 6.2%)	26.6% (England average = 17.2%)

Source: Office for National Statistics Output Area Classification 2011

Figure: Area Classification 2011: Proportion of people living in different types of neighbourhood (by classification type)
Source: Output Area Classification (2011)



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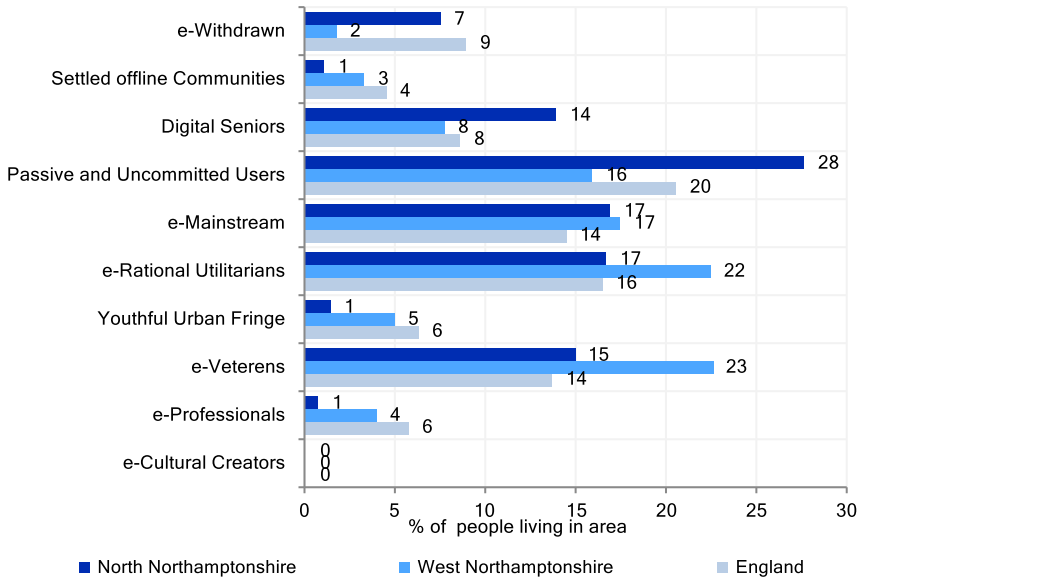
What information is shown here?

The information on this page looks at the classification of neighbourhoods across North Northamptonshire in terms of how they interact with the Internet. The Consumer Data Research Centre (CDRC) have developed an Internet User Classification using data from the British Population Survey (BPS), which provides info on the behavioural characteristics of the population regarding various aspects of internet use, which could be linked with demographic data from the census and supplemented with data from online retailers, on online transactions and infrastructure data from OfCom on download speed. Every LSOA in England has been classified into 10 groups (summarised in the table below). The chart on the right shows the proportion of areas falling within each group across North Northamptonshire and comparators.

Source: *Alexiou, A. and Singleton, A. (2018). ESRC Consumer Data Research Centre; Contains National Statistics data Crown copyright and database right (2017); Ofcom data (2016). CDRC data from Data Partners (2017)*

Figure: Internet User Classification 2018: Proportion of people living in different types of neighbourhood (by classification type)



e-Cultural Creators	High levels of Internet engagement, particularly regarding social networks, communication, streaming and gaming, but relatively low levels of online shopping, besides groceries.
e-Professionals	High levels of Internet engagement, and comprises fairly young populations of urban professionals, typically aged between 25 and 34. They are experienced users and engage with the Internet daily and in a variety of settings.
e-Veterans	Affluent families, usually located within low-density suburbs, with populations of mainly middle-aged and highly qualified professionals. Higher levels of engagement for information seeking, online services and shopping, less for social networks or gaming.
Youthful Urban Fringe	Reside at the edge of city centres and deprived inner city areas, ethnically diverse, young, large student and informal household populations, access via mobile devices. High levels of Internet engagement are average over-all, with high levels of social media usage
e-Rational Utilitarians	Comprising mainly rural/semi-rural areas with higher than average retired populations, constrained by poor infrastructure. Users undertake online shopping, the Internet is used as a utility rather than a conduit for entertainment.

e-Mainstream	Exhibit typical Internet user characteristics in heterogeneous neighbourhoods at the periphery of urban areas or in transitional neighbourhoods.
Passive and Uncommitted Users	Limited or no interaction with the Internet. They tend to reside outside city centres and close to the suburbs or semi-rural areas. Higher levels of employment in semi-skilled and blue-collar occupations.
Digital Seniors	Typically White British, retired and relatively affluent. Average use of the Internet, typically using a personal computer at home. Despite being infrequent users, they are adept enough to use the Internet for information seeking, financial services and online shopping.
Settled offline Communities	Elderly, White British, in semi-rural areas. They undertake only limited engagement with the Internet, they may have only rare access or indeed no access to it at all.
e-Withdrawn	Least engaged with the Internet. Deprived neighbourhoods of urban regions. Highest rate of unemployment and social housing among all Lowest rates of engagement in terms of information seeking and financial services, as well as the lowest rate in terms of online access via a mobile device.

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Communities and environment: Neighbourhood satisfaction & local participation (1) 61

What information is shown here?

The information on this page shows different measures of people's satisfaction with their neighbourhood and their sense of community cohesion in the neighbourhood. It also shows different measures of people's participation in volunteering and political decision making in the local area. In addition, the information box on the far bottom right shows the number of registered charities per 1,000 population. This is based on location of charities rather than areas where they operate, some of which will have a global focus.

Figures are self-reported and taken from the Place Survey. *The Place survey is collected at Local Authority level so does not include neighbourhood information, and ceased nationally in 2008 so is increasingly out of date.*

"People from different backgrounds get on well together in the local area"	People who feel that they belong to their neighbourhood	People who are satisfied with local area as a place to live	Aged 65+ "satisfied with both home and neighbourhood"
75%	57%	75%	82%
(England = 76%)	(England = 58%)	(England = 79%)	(England = 83%)

People involved in decisions that affect the local area in the past 12 months	People who believe they can influence decisions in their local area	People who have given unpaid help at least once per month over the last 12 months	Total registered charities (2021)
13%	26%	23%	2.4 per 1,000 population
(England = 14%)	(England = 29%)	(England = 23%)	(England = 2.8 per 1,000)

Source: Place Survey / Charity Commission

Figure: Indicators of civic engagement
Source: Place Survey (2008)

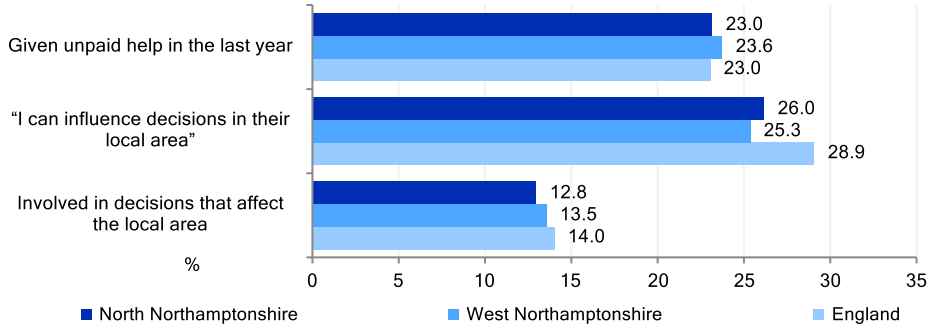
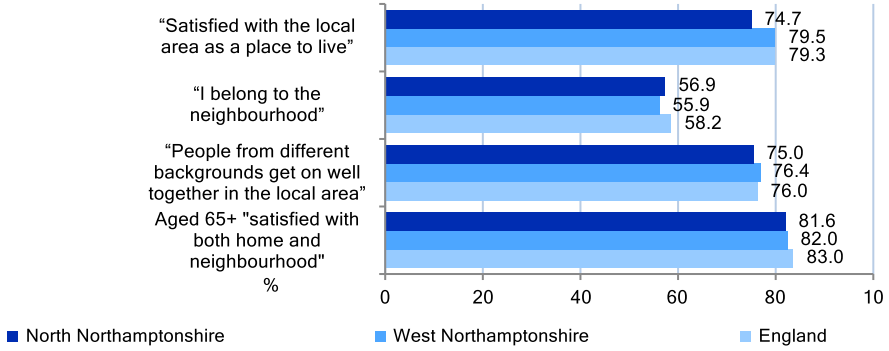


Figure: Indicators of community strength
Source: Place Survey (2008)



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What information is shown here?

The page shows the Community Dynamics indicators for North Northamptonshire. The Community Dynamics data set (https://www.communitydynamics.social-life.co/) has been developed by Social Life with the aim of quantifying how people feel about the area they live in.

By modelling responses from the annual Community Life Survey and Understanding Society Survey to Output Areas, Social Life have created small area measures of: **strength of local social relationships**, **strength of belonging to a local area** and **satisfaction with a local area as a place to live**. Positive values represent greater belonging/relationship strength/satisfaction than the national average. Negative figures represent less belonging/relationship strength/satisfaction than the national average.

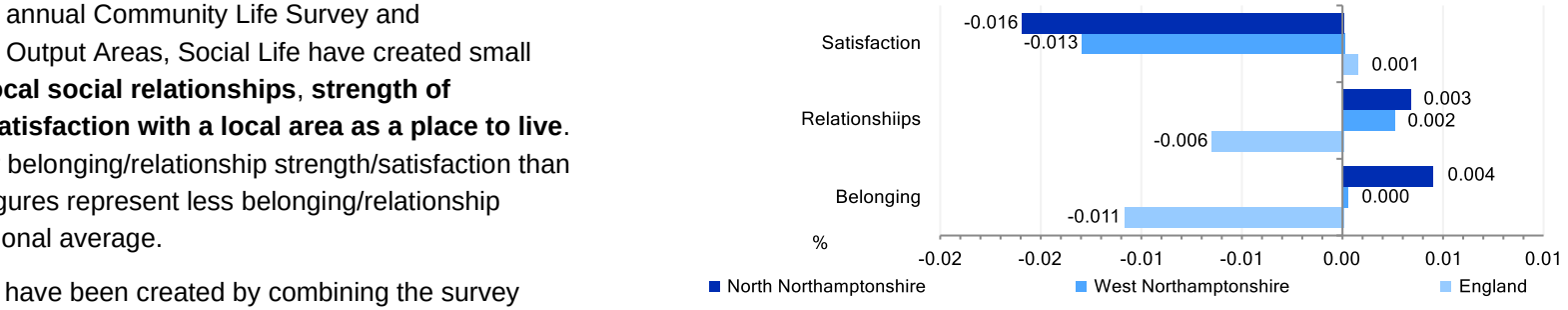
Please note that these indicators have been created by combining the survey responses of samples of the population and modelling these to Output Areas by linking survey sample demographics to the demographics of Output Areas. As a result, many implicit assumptions are built into the data which will not hold for all areas. The values presented here offer an indication of community belonging, strength and satisfaction rather than an absolute measure.

The fourth information box shows the valid voter turnout (%) at the most recent Local Council Elections. Because the electoral cycle varies in different parts of the country (with associated impacts on turnout) the turnout figures from previous years have been adjusted either upwards or downwards from the 2019 average. This is in order to reflect variation in turnout across different years. For example if turnout was 30% in 2018 and 35% in 2019 than each area in 2018 would be revised upwards using the following calculation 35/30 = 1.166*2018 turnout.

Local social relationships	Belonging	Satisfaction with local area as a place to live	Voter Turnout at Local Elections (%)
0.003	0.004	-0.016	31.3
(England = -0.006)	(England = -0.011)	(England = 0.001)	(England = 33%)

Figure: Community Dynamic scores for belonging, relationships and satisfaction
Source: Social Life (modelled from the annual Community Life Survey), 2015/2016

Electoral Commission (2019)



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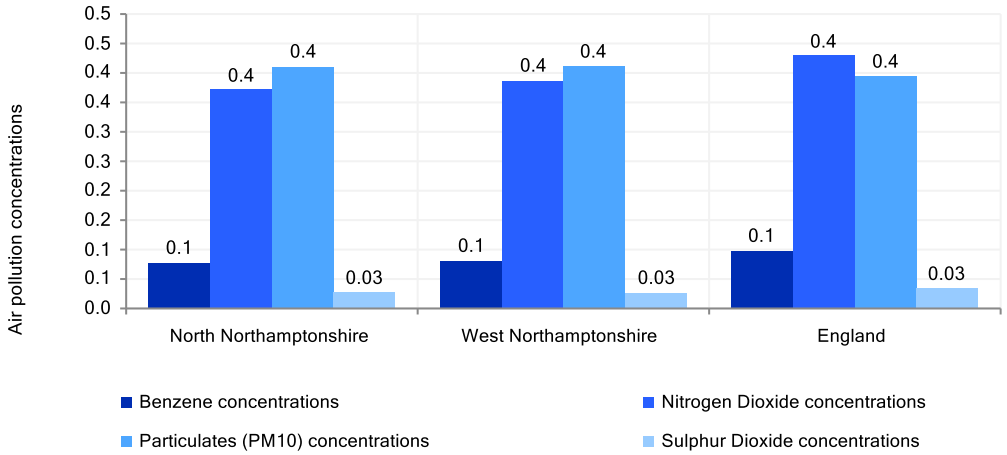
What information is shown here?

The information on this page shows background concentrations from four air pollutants: nitrogen dioxide, benzene, sulphur dioxide and particulates. The air quality data was collected for 2016 on a 1km grid and obtained from the UK National Air Quality Archive for use in the Indices of Deprivation 2019. A higher score indicates a higher concentration of the pollution with a score of greater than 1 indicating that the levels of pollution exceed national standards of clean air.

The fifth information box shows the total carbon footprint per person in units of kilogrammes of carbon dioxide equivalent. This data is sourced from the place-based carbon calculator. For more information please visit: https://www.carbon.place/.

Figure: Air pollution concentrations for four pollutants

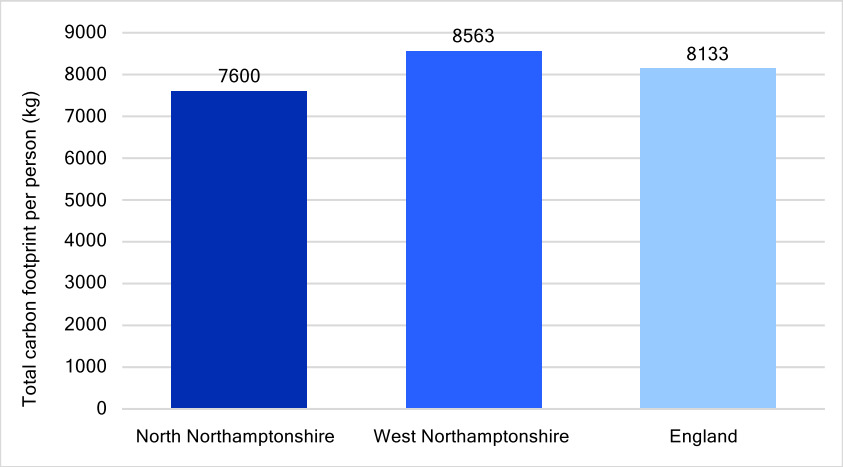


Source: Communities and Local Government (Indices of Deprivation 2019 – from National Air Quality Archive 2016)

Benzene concentrations	Nitrogen Dioxide concentrations	Particulates (PM10) concentrations	Sulphur Dioxide concentrations	Total carbon footprint per person (kg)
0.08	0.4	0.4	0.03	7600
(England average = 0.10)	(England average = 0.4)	(England average = 0.4)	(England average = 0.03)	(England average = 8133)

Source: Communities and Local Government (Indices of Deprivation 2019 - from National Air Quality Archive 2016), PBCC 2021, Morgan, Malcolm, Anable, Jillian, & Lucas, Karen. (2021). A place-based carbon calculator for England (https://www.carbon.place/about/)

Figure: Total carbon footprint per person (kg), Source: PBCC 2021



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What information is shown here?

Ordnance Survey (OS) publish the locations and extent of green spaces that are likely to be accessible to the public. The data include the following types of green spaces: allotments or community growing spaces, bowling greens, cemeteries, religious grounds, golf courses, other sports facilities, play spaces, playing fields, public parks or gardens and tennis courts.

OCSI have intersected OS Open Greenspaces data with Output Area boundaries to produce data for the greenspace per standard geographical area (eg OA, LSOA, LA).

Two green space measures are shown here. The **total green space** (which includes all types of green space) and the **public parks and gardens green space** (only public parks and gardens).

Large rural areas such as National Parks are not included in the OS Greenspace dataset. Religious grounds are included where there is seen to be a significant amount (>500m2) of accessible greenspace. Sports stadiums and grounds which are primarily for spectating rather than participating in sports are not included. Playing fields should only be included in OS Greenspace dataset where they are used by the public at least some of the time. Playing fields such as school fields which are entirely enclosed and only for use of the school, would not be expected to be included.

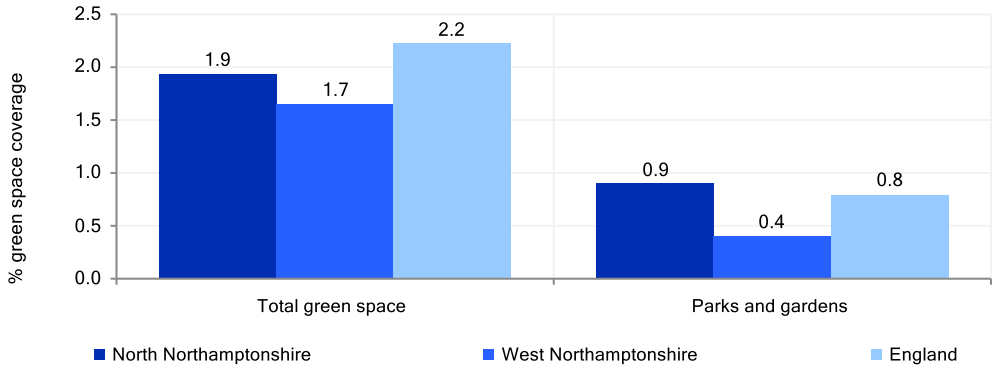
Wooded areas that function as public parks (i.e. are freely accessible to the public in their entirety and are managed for recreation) should be included, however, the constraints of the capture method employed to create the data mean that in many cases these may not yet be included.

OS data © Crown copyright and database right 2017

Total green space	Public parks and gardens greenspace
1.9%	0.90%
1909.0 hectares (England average = 2.2%)	886.8 hectares (England average = 0.8%)

Source: OS data © Crown copyright and database right 2017

Figure: Percentage of green space coverage
Source: OS data © Crown copyright and database right 2017



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What information is shown here?

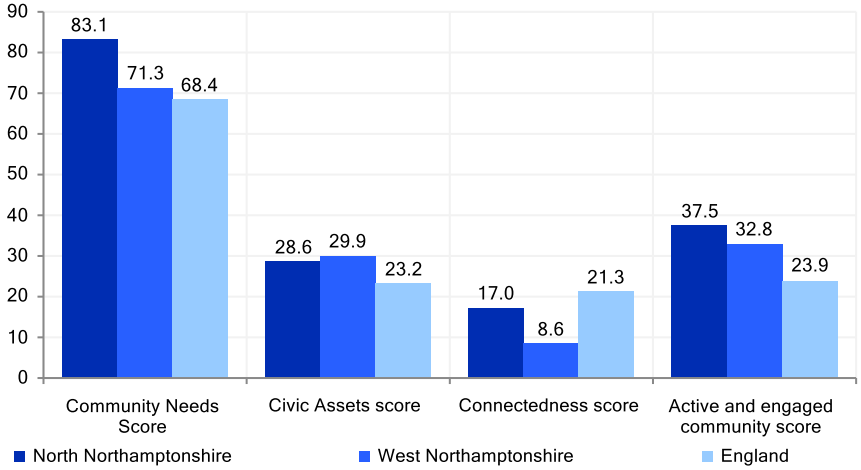
The Community Needs Index that was developed to identify areas experiencing poor community and civic infrastructure, relative isolation and low levels of participation in community life. The index was created by combining a series of 19 indicators, conceptualised under three domains: Civic Assets, Connectedness and Active and Engaged Community. A high score indicates that the area has high levels of need.

- Civic Assets: measures the presence of key community, civic, educational and cultural assets in a close proximity of the area. These include pubs, libraries, green space, community centres, swimming pools – facilities that provide things to do often, at no or little cost, which are important to how positive a community feels about its area.
- Connectedness: measures the connectivity to key services, digital infrastructure, isolation and strength of the local jobs market. It looks at whether residents have access to key services, such as health services, within a reasonable travel distance. It considers how good public transport and digital infrastructure are and how strong the local job market is.
- Active and Engaged Community: measures the levels of third sector civic and community activity and barriers to participation and engagement. It shows whether charities are active in the area, and whether people appear to be engaged in the broader civic life of their community.

Community Needs Score	Civic Assets score	Connectedness score	Active and engaged community score
83.1	28.6	17.0	37.5
(England average = 68.4)	(England average = 23.2)	(England average = 21.3)	(England average = 23.9)

Source: Oxford Consultants for Social Inclusion (OCSI) and Local Trust (https://localtrust.org.uk/insights/research/left-behind-understanding-communities-on-the-edge/)

Figure: Community Needs Index
Source: Oxford Consultants for Social Inclusion (OCSI) and Local Trust (2019)



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What information is shown here?

This page looks at funding and includes data on the National Lottery Fund and grant funding from national grant giving organisations.

National Lottery Community Fund figures on this page are taken from data on grants made to projects and organisations in local areas in the UK by the National Lottery Fund, modelled down to standard statistical geographies from ward grants data published by Big Lottery in conjunction with the 360Giving initiative. National Lottery used the 360Giving standard to produce a dataset of all the grants made from 2004-2021. Please note this excludes grants greater than 1 million in order to focus on community grants.

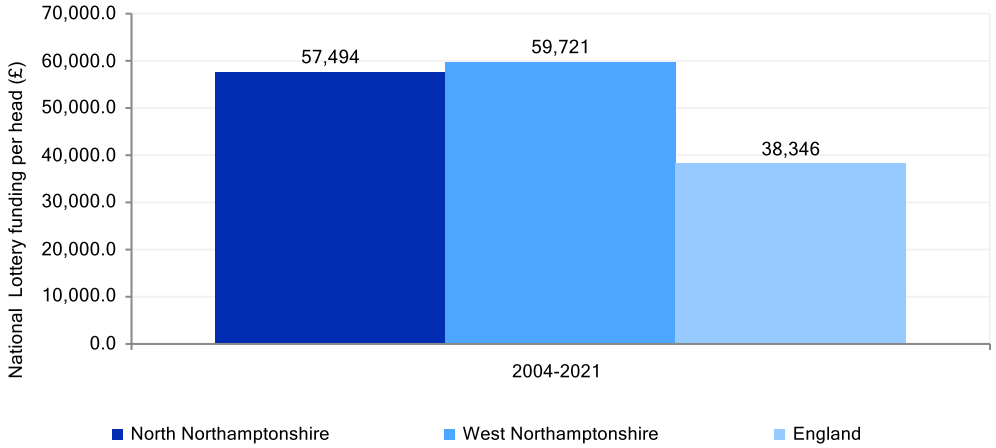
The fourth information box shows the total combined grant funding from the largest national grant giving organisations whose data has been subject to the 360giving standard. The data is based on the location of grant recipients rather than the location of beneficiaries. Organisations included: Sport England, The Henry Smith Charity, The Tudor Trust, Lloyds Bank Foundation for England and Wales, Barrow Cadbury Trust, Department for Transport, Esmée Fairbairn Foundation, Masonic Charitable Foundation, Nationwide Foundation, Co-operative Group, Paul Hamlyn Foundation, Woodward Charitable Trust, Power to Change, The Dulverton Trust, Virgin Money Foundation, The Clothworkers Foundation, A B Charitable Trust, Seafarers UK, Three Guineas Trust, Nesta, The Joseph Rank Trust, National Churches Trust, LandAid Charitable Trust, True Colours Trust, Pears Foundation, Wates Family Enterprise Trust, The Blagrave Trust, Tuixen Foundation, Samworth Foundation, Tedworth Charitable Trust, Road Safety Trust, Wates Foundation, Staples Trust, The David & Elaine Potter Foundation, Gatsby Charitable Foundation and ZING.

For more information on the 360Giving data format and initiative please visit www.threesixtygiving.org/

National Lottery Community funding per 1,000 population (2004-2021)	National Lottery Community Fund (Individual grants issued per 10,000 population) (2004-2021)	Total grants awarded from major funders (in £1000s) (2019)
£20,148,692	0,809	£03,839,043
(£57494 per 1,000) England average = £38346 per 1,000	(23 per 10,000) England average = 30 per 10,000	(£11 per head) England average = £34 per head

Source: National Lottery, 360Giving

Figure: National Lottery grant funding per 1,000 population, 2004-2021
Source: National Lottery, 360Giving, 2021



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How we have identified the "North Northamptonshire" area

This report is based on the definition of the "North Northamptonshire" area (this area can be viewed on the Local Insight map, through finding the area on the 'show services' dropdown in the top left hand corner of the map. We have aggregated data for all the neighbourhoods in "North Northamptonshire" to create the data used in this report.

Alongside data for the "North Northamptonshire" neighbourhood we also show data for selected comparator areas.

Data in this report is based on regularly updated open data published by government sources

All the data in this report is based on open data published by more than 50 government agencies, collected and updated by OCSI on weekly basis. Data is updated on regular basis, with the reports and mapped data on the website reflecting the latest available data.

Details of the individual datasets are provided on the pages where the data is presented, with information on dates and sources presented alongside the charts and tables. On the website, information about each source is available on the popup "About the indicator" link at the top-right of the map.

Standard geographies used in this report

Super Output Areas (SOAs): SOAs are a statistical geography created for the purpose of presenting data such as the Census, Indices of Deprivation, and other neighbourhood statistics. There are two layers to the SOA geography: 'lower layer' (LSOA) and 'middle layer' (MSOA). SOAs are designed to produce areas of roughly equal population size - 1,500 people for LSOAs and 7,200 for MSOAs. The majority of data used in this report is based on LSOA boundaries; of which there are 32,844 in England (there were changes to around 4% of LSOA definitions in Census 2011).

Output Areas (OAs): OAs are a more detailed statistical geography than SOAs, with each covering around 300 people, or 120 households. There are 171,372 OAs in England (there were changes to around 5% of OA definitions in Census 2011).

Wards: A small number of datasets are published at ward level. These are on average four times larger than LSOAs. Data is less detailed than LSOA level datasets and wards vary greatly in size, from less than 200 residents (Isles of Scilly), to more than 36,000 residents (in Sheffield).

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Appendix B: Data source details by theme

Theme	Data	Data source/ time period	Date published	Date next update
Population	Total population and by age	Mid-Year Estimates (ONS) 2020	Annually (published September 2021)	Sep-22
	Population by ethnicity	Census 2011	10 yearly (published August 2013)	2023
	Population by country of birth	Census 2011	10 yearly (published August 2013)	2023
	Population by household language	Census 2011	10 yearly (published August 2013)	2023
	People who have moved address within the last 12 months	Census 2011	10 yearly (published August 2013)	2023
	National Insurance no. registrations of overseas nationals	DWP 2020/21	Annually (published May 2021)	Temporarily suspended
	Level of inward and outward migration (by age)	ONS 2010	Irregular (published 2011)	No publication date confirmed
	Population by household composition	Census 2011	10 yearly (published August 2013)	2023
	Population by religion	Census 2011	10 yearly (published August 2013)	2023
Vulnerable groups	Unemployment benefit (JSA and Universal Credit)	DWP Jun-22	Monthly (published July 2022)	Aug-22
	Jobseekers Allowance claimants, claiming for over 12 months	DWP Jun-22	Monthly (published July 2022)	Aug-22
	Youth unemployment (18-24 receiving JSA or Universal Credit)	DWP Jun-22	Monthly (published July 2022)	Aug-22
	Older person unemployment (50+ receiving JSA or Universal Credit)	DWP Jun-22	Monthly (published July 2022)	Aug-22
	Unemployment benefit (JSA and Universal Credit), male	DWP Jun-22	Monthly (published July 2022)	Aug-22
	Unemployment benefit (JSA and Universal Credit), female	DWP Jun-22	Monthly (published July 2022)	Aug-22
	Universal Credit claimants: Employment indicator	DWP Apr-22	Monthly (published June 2022)	Jul-22
	Working age workless benefit claimants	DWP Nov-21	Quarterly (published May 2022)	Aug-22
	Incapacity Benefit claimants	DWP Nov-21	Quarterly (published May 2022)	Aug-22
	Disability Living Allowance claimants	DWP Nov-21	Quarterly (published May 2022)	Aug-22
	Attendance Allowance claimants	DWP Nov-21	Quarterly (published May 2022)	Aug-22
	Personal Independence Payments (PIP)	DWP Jan-22	Quarterly (published December 2021)	Apr-22
	Universal Credit household breakdowns	DWP Feb-22	Quarterly (published May 2022)	Aug-22
	Universal Credit by Conditionality	DWP Jun-22	Monthly (published July 2022)	Aug-22
	Income Support (IS) claimants	DWP Nov-21	Quarterly (published May 2022)	Aug-22
	Housing Benefit claimants	DWP Nov-21	Quarterly (published May 2022)	Aug-22
	Universal Credit claimants	DWP Jun-22	Monthly (published July 2022)	Aug-22
	Indices of Deprivation (ID) 2019 by domain	MHCLG (Indices of Deprivation 2019)	Irregular (September 2019)	
	Children in low income families	DWP 2020	Annual (published March 2022)	Apr-23
	Children in lone parent households	DWP 2012	Irregular	No publication date confirmed
	Children in poverty	DWP 2016	Annually (published December 2018)	Delay in publication
	Child Wellbeing Index	CLG (Child Wellbeing Index 2009)	Irregular (published 2009)	No publication date confirmed
	Private pensioner households with no car or van	Census 2011	10 yearly (published August 2013)	2023

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	Households of one pensioner	Census 2011	10 yearly (published August 2013)	2023
	Pension credit claimants	DWP Nov-21	Quarterly (published May 2022)	Aug-22
	State Pension total claimants	DWP Nov-21	Quarterly (published May 2022)	Aug-22
	Loneliness index	Age UK 2011	Irregular (published January 2016)	No publication date confirmed
	Mental health related benefits	DWP Nov-21	Quarterly (published May 2022)	Aug-22
	Households suffering multiple deprivation	Census 2011	10 yearly (published August 2013)	2023
	Household is not deprived in any dimension	Census 2011	10 yearly (published July 2014)	No publication date confirmed
	Household is deprived in 1 dimension	Census 2011	10 yearly (published July 2014)	No publication date confirmed
	Household is deprived in 2 dimensions	Census 2011	10 yearly (published July 2014)	No publication date confirmed
	Household is deprived in 3 dimensions	Census 2011	10 yearly (published July 2014)	No publication date confirmed
	People providing unpaid care	Census 2011	10 yearly (published August 2013)	2023
	Unpaid care (50+ hours per week)	Census 2011	10 yearly (published August 2013)	2023
Housing	Dwelling type breakdowns	Census 2011	10 yearly (published August 2013)	2023
	Housing tenure breakdowns	Census 2011	10 yearly (published August 2013)	2023
	Average house prices by housing type	Land registry Jun-21 to May-22	Quarterly (published July 2022)	Oct-22
	Households by Council Tax Band	Valuation Office Agency (VOA) 2021	Annually (published September 2021)	Sep-22
	Housing affordability gap, average house prices and savings ratio	ONS House Price Statistics for Small Areas; ONS earnings data 2015/2016	Irregular (published April 2018)	Earnings data April-19
	Population density (persons / hectare)	ONS 2016	Annually (published November 2018)	
	Housing Environment	Census 2011	10 yearly (published August 2013)	2023
	Dwelling size	Census 2011	10 yearly (published August 2013)	2023
	Electricity and Gas consumption	Department for Business, Energy and Industrial Strategy, 2020	Annually (published January 2022)	Jan-23
	Households not connected to the gas network	Department for Energy and Climate Change (DECC) 2019	Annually (published January 2021)	January 2022
	Energy efficiency ratings	MHCLG. Data collected between 2017-2021	Irregular (published Apr-22)	
	Communal establishments by type	Census 2011	10 yearly (published August 2013)	2023
Crime and safety	Recorded crime offences	Police UK Jun-21 to May-22	Quarterly (published July 2022)	Oct-22
Health and wellbeing	Life expectancy	ONS 2015-2019	Irregular (published 2021)	No publication date confirmed
	Healthy Life Expectancy	ONS 2009-2013	Annually (published 2016)	No longer updated
	Disability-free Life Expectancy	ONS 2009-2013	Annually (published 2016)	No longer updated
	Incidence of cancer by cause	ONS 2012-2016	Annually (published 2019)	No publication date confirmed
	Cancer mortality by cause	ONS 2013-2017	Annually (published 2019)	No publication date confirmed
	Number of people living in health deprivation ‘hotspots’	CLG (Indices of Deprivation 2015)	Irregular (September 2015)	2019
	People with a limiting long-term illness	Census 2011	10 yearly (published August 2013)	2023
	Babies born with a low birth weight	ONS 2011-2015	Annually (published 2017)	No publication date confirmed

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	Hospital admissions	ONS 2015/2016 - 2019/2020	Irregular (published 2021)	No publication date confirmed
	Musculoskeletal conditions by type	Arthritis UK (2011)	Irregular (published 2017)	No publication date confirmed
	“Healthy eating” (consumptions of 5+ fruit and veg a day), binge drinking and smoking	Health Survey for England 2006-2008	Irregular (published 2014)	No publication date confirmed
	Children classified as obese	National Child Measurement Programme (NCMP) (2017/18 - 19/20)	Irregular (published 2020)	No publication date confirmed
	Adults classified as obese	Health Survey for England 2006-2008	Irregular (published 2014)	No publication date confirmed
	Physical activity among adults	Sport England (Active Lives Survey) 2020	Irregular (published April 2020)	No publication date confirmed
	Index of Access to Health Assets and Hazards (AHAH)	2016	No update planned (published 2017)	No plans to update
Education and skills	Qualifications by level	Census 2011	10 yearly (published August 2013)	2023
	Participation in Higher Education	Office for Students (OFS)	Irregular	No publication date confirmed
	Early years foundation stage profile	DfE 2013-2014	Annually (published June 2015)	Delay in publication
	Pupil attainment at Key Stage 1, Key Stage 2 and Key Stage 4	DfE 2013-2014	Annually (published June 2015)	Delay in publication
Economy	Annual household income	ONS 2017/18	Irregular (published March 2020)	March-21
	Annual household income, after housing costs	ONS 2017/18	Irregular (published March 2020)	March-21
	Households living in ‘Fuel Poverty’	Department for Business, Energy and Industrial Strategy (2019)	Annually (published April 2021)	April-22
	Debt	UK Finance (Sep-21)	Biannually (published Mar 2022)	Oct-22
	Economic activity by type	Census 2011	10 yearly (published August 2013)	2023
	Employment type by sector	Census 2011	10 yearly (published August 2013)	2023
	Job centre vacancies	ONS/Jobcentre Plus (Nov-12)	Irregular (published December 2012)	No publication date confirmed
	Jobs by sector	Business Register and Employment Survey (BRES) (2020)	Annually (published November 2020)	Nov-22
	Business VAT based local units by sector and size	ONS 2021	Annually (published September 2021)	Sep-22
Access and transport	Car ownership by number	Census 2011	10 yearly (published August 2013)	2023
	Road distances to key services by type	Commission for Rural Communities: Distance to Service dataset (2010)	Irregular (published 2011)	No publication date confirmed
	Average travel time (mins) by walking or public transport to the nearest key service	DfT 2017	Annually (published July 2018)	Nov-22
	Broadband speed	Ofcom 2020	Annually (published June-2020)	Irregular
	Census online and paper responses	Census 2011	10 yearly (published August 2013)	2023
Communities and environment	Area classifications by type	ONS Output Area Classification 2011	10 yearly (published July 2014)	No publication date confirmed
	Internet User Classification	Consumer Data Research Centre	Annually (published 2018)	2019
	Indicators of community strength and civic engagement	Place Survey (2008)	Irregular (published June 2009)	No publication date confirmed
	Total registered charities	Charity Commission 2020	Irregular	No publication date confirmed
	Community Dynamic scores for belonging, relationships and satisfaction	Social Life (modelled from the annual Community Life Survey), 2015/2016	Irregular	No plans to update
	Air pollution concentrations for four pollutants	CLG, Indices of Deprivation 2015 - from National Air Quality Archive 2012	Irregular (September 2015)	2019

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	Greenspaces and parks	OS data © Crown copyright and database right 2017	Irregular (published May 2017)	No publication date confirmed
	Big Lottery funding	Big Lottery, 360Giving, 2004-2021	Irregular	No publication date confirmed
	Community Needs Index	OCSI, Local Trust 2019	Irregular (published September 2019)	No publication date confirmed

Local Insight gives you the data and analysis you need to ensure your services are underpinned by the best possible knowledge of local communities, levering the power of information right across your organisation, from high-level visualisations for Board level to detailed reports on local neighbourhoods. Saving you time and money, Local Insight gives you the most relevant and up-to-date data on the communities where you work, with no need to invest in specialist mapping and data staff, consultancy or software. See http://local.communityinsight.org/ for more information.

Local Insight is developed by OCSI, based on a project that was jointly developed by HACT and OCSI.

OCSI work with public and community sector organisations to improve services. We turn complex datasets into engaging stories; making data, information and analysis accessible for communities and decision-makers. See www.ocsi.co.uk for more information.

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Local Insight profile for ‘West Northamptonshire’ area

Demo - LI - West Northamptonshire Council

Report created 24 May 2022

Local Insight

Finding your way around this Local Insight profile

Introduction Page 3 for an introduction to this report

Population	There are 406,733 people living in West Northamptonshire See pages 4-9 for more information on population by age and gender, ethnicity, country of birth, language, migration, household composition and religion	**Education & skills**	21% of people have no qualifications in West Northamptonshire compared with 22% across England See pages 46-48 for more information on qualifications, pupil attainment and early years educational progress
Vulnerable groups	14% of children aged 0-19 are in relative low-income families in West Northamptonshire compared with 19% across England See pages 10-23 for more information on children in poverty, people out of work, people in deprived areas, disability, pensioners and other vulnerable groups	**Economy**	43% people aged 16-74 are in full-time employment in West Northamptonshire compared with 39% across England See pages 49-55 for more information on people's jobs, job opportunities, income and local businesses
Housing	2% of households lack central heating in West Northamptonshire compared with 3% across England See pages 24-33 for more information on dwelling types, housing tenure, affordability, overcrowding, age of dwelling and communal establishments	**Access & transport**	18% of households have no car in West Northamptonshire compared with 26% across England See pages 56-58 for more information on transport, distances services and digital services
Crime & safety	The overall crime rate is higher than the average across England See pages 34-35 for more information on recorded crime and crime rates	**Communities & environment**	The % of people 'satisfied with their neighbourhood' (79.5%) is similar to the average across England (79.3%) See pages 59-66 for more information on neighbourhood satisfaction, the types of neighbourhoods locally, local participation and the environment, air pollution
Health & wellbeing	15% of people have a limiting long-term illness in West Northamptonshire compared with 18% across England See pages 36-45 for more information on limited long-term illness, life expectancy and mortality, general health and healthy lifestyles	**Appendix A**	Page 67 for information on the geographies used in this report, publication dates for new indicators and acknowledgements.

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Local Insight

Local Insight for Demo - LI - West Northamptonshire Council

Local Insight gives you access to interactive maps and reports at small area level. These reports show key social and economic indicators and allow you to compare the area selected to comparator areas.

OCSI

Local Insight is a tool developed by Oxford Consultants for Social Inclusion (OCSI) based on a project developed jointly between OCSI and HACT.

OCSI develop and interpret the evidence base to help the public and community organisations deliver better services. A 'spin-out' from the University of Oxford Social Policy Institute, OCSI have worked with more than 100 public and community sector clients at local, national and international level. See www.ocsi.co.uk for more.

About the indicators

Information published by government as open data – appropriately visualised, analysed and interpreted – is a critical tool for Local Authorities.

OCSI collect all local data published by more than 50 government agencies, and have identified key indicators relevant to local authorities to use in this report and the interactive webtool (local.communityinsight.org).

How we have identified the "West Northamptonshire" area

This report is based on the definition of the "West Northamptonshire" area created by Demo - LI - West Northamptonshire Council, (you can view this area on the Local Insight map, through finding the area on the 'show services' dropdown in the top left hand corner of the map). We have aggregated data for all the neighbourhoods in "West Northamptonshire" to create the charts and tables used in this report.

Alongside data for the "West Northamptonshire", we also show data for selected comparator areas: West Northamptonshire and England.

Local Insight

Population: Age and gender

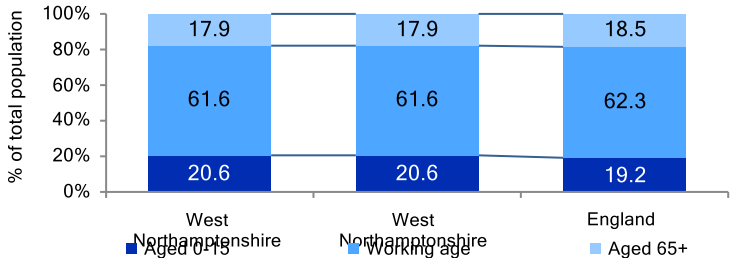
What information is shown here?

The information on this page shows the number of people living in West Northamptonshire. These population figures provide detail of the structure of the population by broad age bands and sex.

The first information box shows the total number of people usually resident in the area, with the male female breakdown. Also shown are numbers by age, and the 'dependency ratio'. This is the ratio of non-working age (those aged 0-15 and over 65) to working age population and is useful in understanding the pressure on a productive population in providing for the costs of services and benefits used by the youngest and oldest in a population. For example, a ratio of 25% would imply one person of non-working age for every four people of working age.

The population pyramid compares the proportion of males and females by five-year age bands. The line chart shows how the population is changing over time in West Northamptonshire and comparator areas. The stacked bar chart, below, shows the age breakdown of the population in West Northamptonshire and comparator areas by broad age band.

Figure: Population by age
Source: Mid-Year Estimates (ONS) 2020



Total Population	Aged 0-15	Working age population	Aged 65+	Dependency ratio
406,733	83,624	250,500	72,609	0.62
49.7% male; 50.3% female	20.6% (England average = 19.2%)	61.6% (England average = 62.3%)	17.9% (England average = 18.5%)	England average = 0.60

Source: Mid-Year Estimates (ONS) 2020

Figure: Population estimates by 5-year age band
Source: Mid-Year Estimates (ONS) 2020

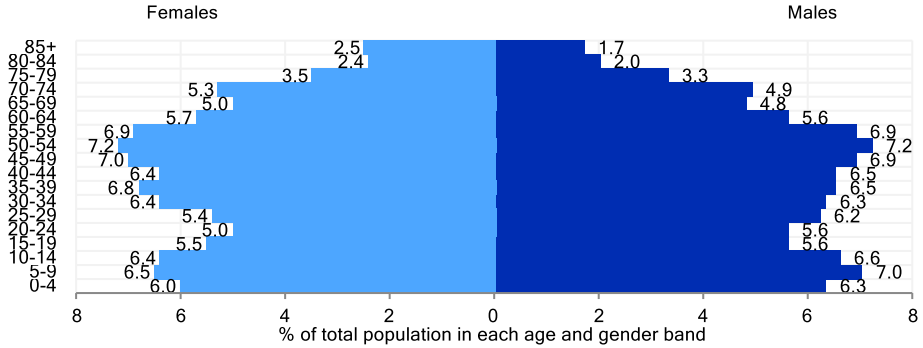
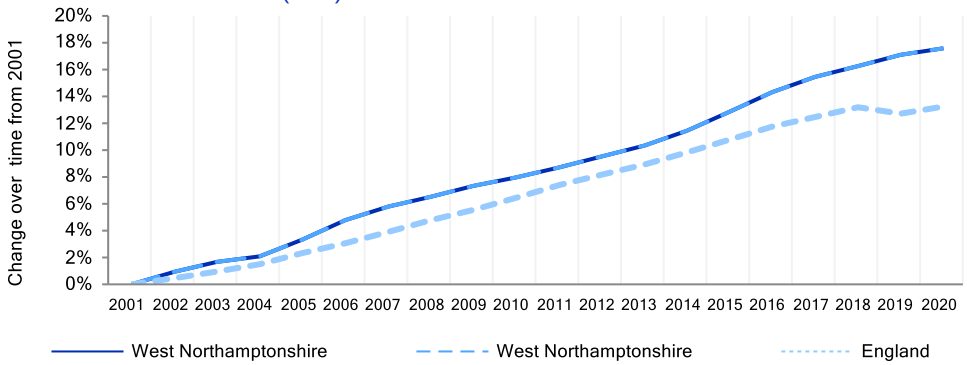


Figure: % change in total population from 2001-2020
Source: Mid-Year Estimates (ONS)



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Population: Ethnicity

What information is shown here?

The information on the right shows the number of people in West Northamptonshire by ethnicity, based on each person's perceived ethnic group and cultural background.

The information boxes display the number of people who have identified themselves as White British and the number from non-White ethnic minority groups, as well as the five broad ethnic minority groups (White non-British, Mixed, Asian, Black and other ethnic groups.

The final information box shows the proportion of households where not all household members are of the same ethnicity (households with multiple ethnic groups).

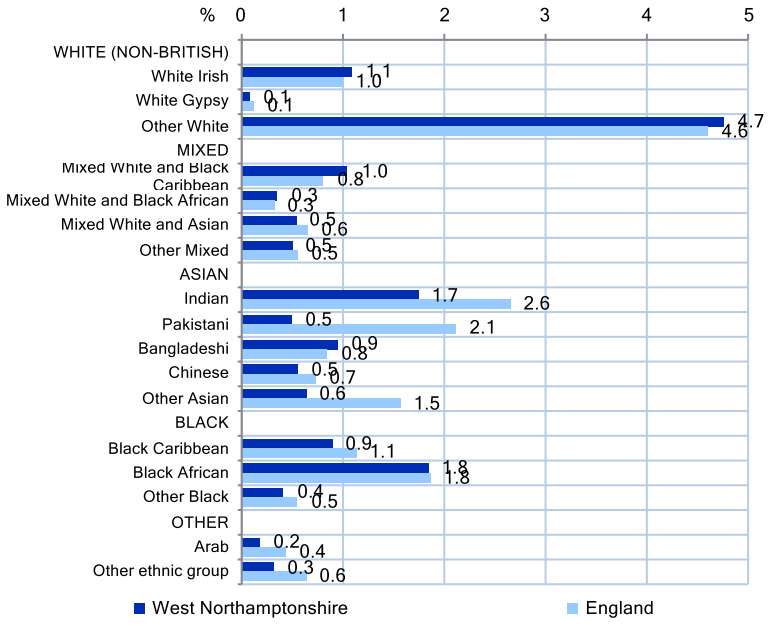
The bar chart on the right shows a detailed breakdown of the percentage of people in ethnic minority groups by ethnic category.

White British	Non-White	White-non-British	Mixed
314,924	38,168	22,009	8,823
84.0% (England average = 79.8%)	10.2% (England average = 14.6%)	5.9% (England average = 5.7%)	2.4% (England average = 2.3%)

Asian	Black	Other ethnic group	Households with multiple ethnicities
16,063	11,598	1,684	12,345
4.3% (England average = 7.8%)	3.1% (England average = 3.5%)	0.4% (England average = 1.0%)	8.0% (England average = 8.9%)

Source: Census 2011

Figure: Population by ethnic group (excluding White British)
Source: Census 2011



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Population: Country of birth and household language

What information is shown here?

The information on the right shows the number of people in West Northamptonshire by country of birth.

The top row information boxes display the number of people in West Northamptonshire who were born in England and outside the UK as well as the number of people with a UK passport and non-UK passport.

The second row information boxes show the language breakdown of households, identifying the number of households in West Northamptonshire with one or more members who cannot speak English.

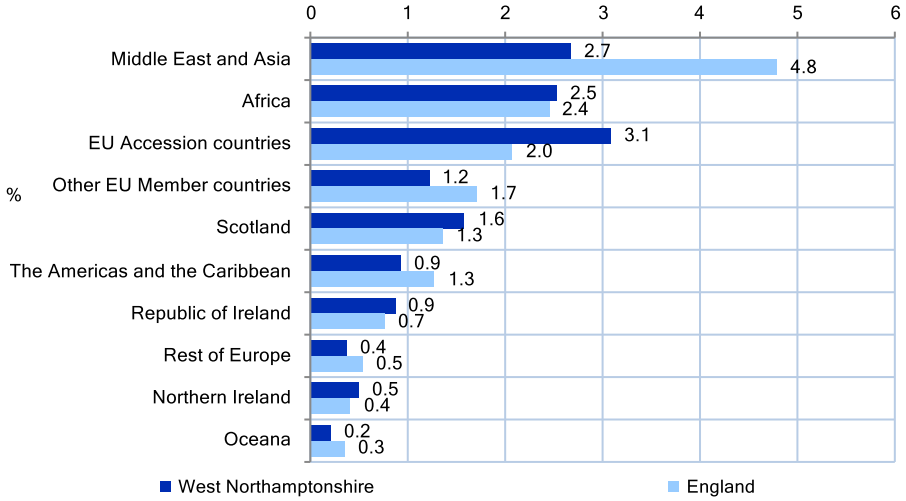
The bar chart on the right shows a detailed breakdown of the percentage of people in West Northamptonshire born outside of England by the geographic region of birth.

Born in England	Born Outside the UK	With a UK passport	With a non-UK passport
319,519	44,242	285,596	29,703
85.2% (England average = 83.5%)	11.8% (England average = 13.8%)	76.1% (England average = 75.8%)	7.9% (England average = 8.8%)

All people in households have English as main language	At least one adult (not all) has English as main language	No adults but some children have English as main language	No household members have English as main language
143,969	3,952	873	6,301
92.8% (England average = 90.9%)	2.5% (England average = 3.9%)	0.6% (England average = 0.8%)	4.1% (England average = 4.4%)

Source: Census 2011

Figure: Population born outside England
Source: Census 2011



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What information is shown here?

The information box shows the number and percentage of migrants in West Northamptonshire and across England as a whole. A migrant is defined as a person with a different address one year before Census day. The migrant status for children aged under one in households is determined by the migrant status of their 'next of kin' (defined as in order of preference, mother, father, sibling (with nearest age), other related person, Household Reference Person).

The chart on the right shows the population turnover rate by age band. This is calculated as the rate of in or out migratory moves within England and Wales per 1,000 resident population.[1] Figures are based on GP patient register records. The left-hand bars (lighter colour) show people moving *out of* the area – higher values for a particular group indicate that this age-group is more likely to move away from the area. The right-hand bars (darker colour) show people moving *into* the area – higher values for a particular group indicate that this age-group is more likely to move into the area.

The data table on the top right and the chart on the bottom right show the total number of people registering with a National Insurance number who have come from overseas. This is a measure of the number of people who have migrated to the UK from overseas to work, who have registered for a National Insurance number in the local area.

Note: For the year 20/21 The NINO allocation process was disrupted as a result of the coronavirus (COVID-19) pandemic. This has resulted in a significant reduction in the number of NINOs allocated.

People who have moved address within the last 12 months (Census 2011)	Overseas migrants (National Insurance no. registrations of overseas nationals) (DWP 2020/21)
44,122	2,235
11.8% (average = 12.3%)	0.9% (average = 0.6%)

Figure: Level of inward and outward migration (by age)
Source: Population Turnover Rates – Office for National Statistics (2010)

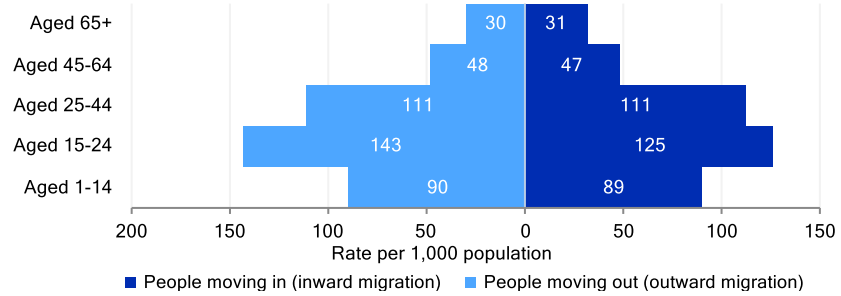
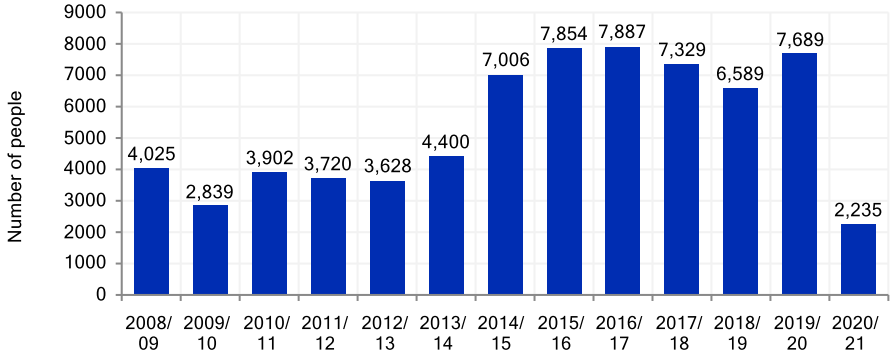


Figure: Number of overseas nationals registering with a National Insurance Number
Source: National Insurance No. registrations – Department for Work and Pensions (2020/21)



[1] Please note that there are currently no planned updates for this dataset, however we still consider it to be relevant.

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Population: All households

What information is shown here?

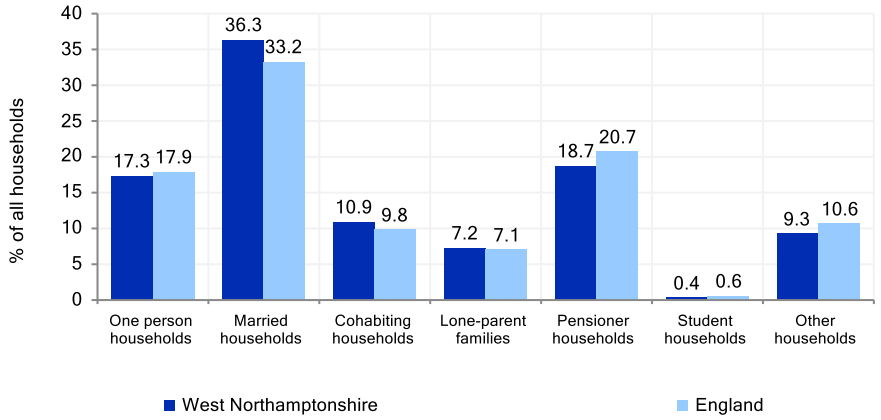
The information on this page shows the composition of household types in West Northamptonshire. The information boxes contain the number of households in West Northamptonshire classified under the main household composition breakdowns. The chart shows the same information as a percentage of all households.

Pensioner households	One person households (aged under 65)	Lone parent families with dependent children
29,013	26,858	11,118
18.7% (England average = 20.7%)	17.3% (England average = 17.9%)	23.5% of all families with dependent children (England average = 24.5%)

Married households	Cohabiting households	Student households
56,252	16,881	581
36.3% (England average = 33.2%)	10.9% (England average = 9.8%)	0.4% (England average = 0.6%)

Source: Census 2011

Figure: Population by household composition
Source: Census 2011



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What information is shown here?

The information on the right shows the number of people living in West Northamptonshire by religious belief, categorised by the six major religions, other religion and no religion.

The bar chart shows the percentage of people in West Northamptonshire and comparator areas who are of non-Christian religious belief, displayed by religion.

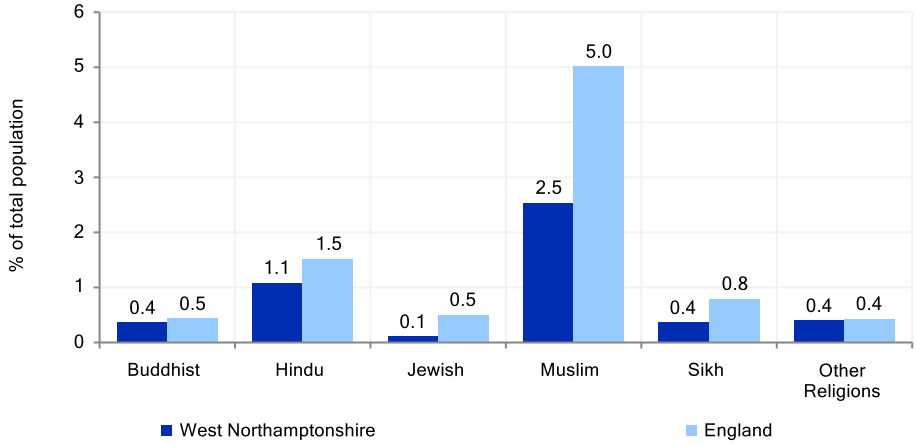
Note, figures in the table and charts may not add up to 100% because they do not include figures for those for who did not reply to the religion question – who were recorded as 'religion not stated' in the census data publication.

Christian	Buddhist	Hindu	Jewish
226,300	1,398	4,043	444
60.3% (England average = 59.4%)	0.4% (England average = 0.5%)	1.1% (England average = 1.5%)	0.1% (England average = 0.5%)

Muslim	Sikh	Other religion	No religion
9,535	1,391	1,553	104,863
2.5% (England average = 5.0%)	0.4% (England average = 0.8%)	0.4% (England average = 0.4%)	28.0% (England average = 24.7%)

Source: Census 2011

Figure: Population with non-Christian religion
Source: Census 2011



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Vulnerable groups: People out of work (1)

What information is shown here?

The information in this section shows counts of people who are out of work and receiving workless benefits: Jobseekers Allowance (JSA)/Universal Credit (UC) and Incapacity Benefit (IB)/Employment and Support Allowance (ESA).

JSA is payable to people under pensionable age who are available for, and actively seeking, work of at least 40 hours a week. A subset of UC claimants (claimants in the 'searching for work' conditionality group) are additionally included in the 'Unemployment Benefit' count, as UC is slowly replacing JSA for new claims. *Note, 'the searching for work' conditionality group includes a small number of claimants who would not be considered unemployed under the previous JSA benefits regime e.g. those with work limiting illness awaiting health checks. Therefore, there is likely to be a slight overcount of the proportion of Unemployed Benefit claimants in areas where the UC rollout is more advanced.*

IB and ESA are workless benefits are payable to people who are out of work and have been assessed as being incapable of work due to illness or disability and who meet the appropriate contribution conditions. *Note, since March 2016, ESA is being replaced by UC for new claimants. It is not possible to capture the total number of claimants of sickness benefits as the UC does not provide a breakdown for health condition; therefore, the total count of ESA/IB claimants presented here is likely to be an underestimate of the full count of those workless and receiving benefits due to sickness or disability.*

The information boxes on the top right show: the total number of adults (aged 16-64) receiving JSA and UC; the total claiming for more than 12 months; claimants aged 18-24 and 50+, the number of people receiving 'Incapacity benefits' (IB or ESA); and the number and proportion of 16-64 year olds receiving workless benefits (UC, JSA, IB or ESA).

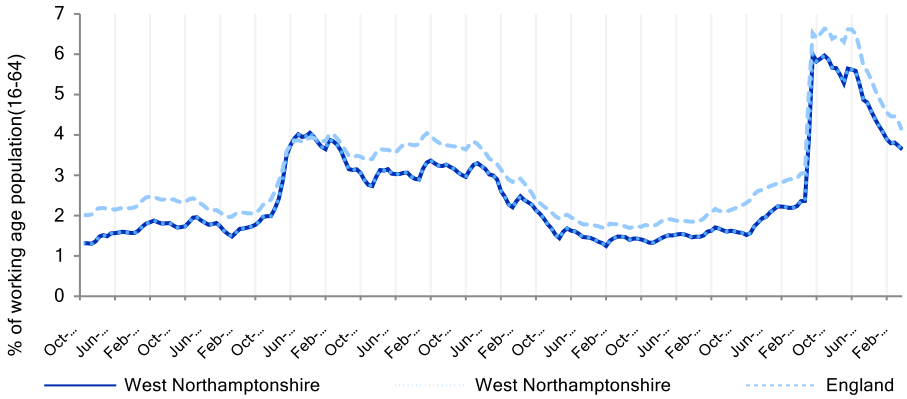
Unemployment Benefit (JSA and UC) claimants (Apr-22)	Youth unemployment (JSA/UC) claimants aged 18-24) (Apr-22)	Older unemployed (JSA/UC claimants aged 50+) (Apr-22)
9,120	1,435	2,330
3.6% (England average = 4.1%)	4.8% (England average = 4.7%)	1.5% (England average = 1.7%)

Male unemployment claimants (JSA and UC) (Apr-22)	Female unemployment claimants (JSA and UC) (Apr-22)	Working age workless benefit claimants * (Nov-21)	Incapacity benefits claimants (Nov-21)
5,210	3,935	18,502	8,312
4.2% (England average = 4.8%)	3.1% (England average = 3.4%)	7.4% (England average = 8.9%)	3.3% (England average = 4.2%)

Source: Department for Work and Pensions

* 'Working age workless benefit claimants' is a combination of 'Unemployment benefit claimants (JSA and Universal Credit)' + and 'Incapacity benefits claimants (IB/ESA)'

Figure: Unemployment benefit (Jobseekers Allowance/Universal Credit) claimants
Source: Department for Work and Pensions



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Vulnerable groups: People out of work (2)

The line charts below show month on month changes in the proportion of people claiming IB or ESA and the proportion claiming JSA or UC in the searching for work conditionality group across West Northamptonshire and comparator areas.

Figure: % of Jobseekers Allowance claimants claiming for more than 12 months
Source: Department for Work and Pensions (Apr-22)

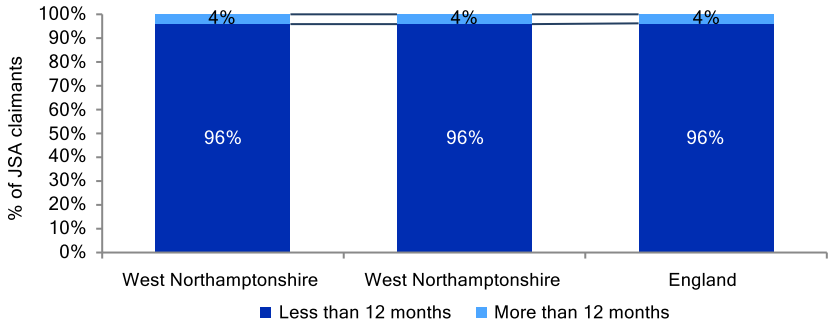


Figure: Workless benefit claimants aged 16-24 (May-16) and 16-64 (Nov-21)
Source: Jobseekers Allowance/Universal Credit/Incapacity benefits/Employment and Support Allowance – Department for Work and Pensions (May-16/ Nov-21)

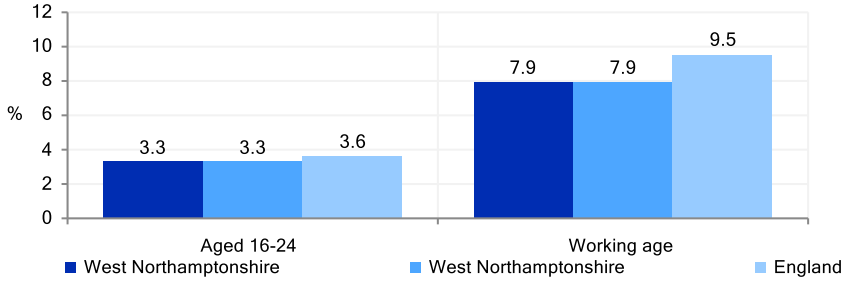


Figure: Working age population (16-64) claiming incapacity benefits (Employment Support Allowance and Incapacity Benefit)
Source: Department for Work and Pensions

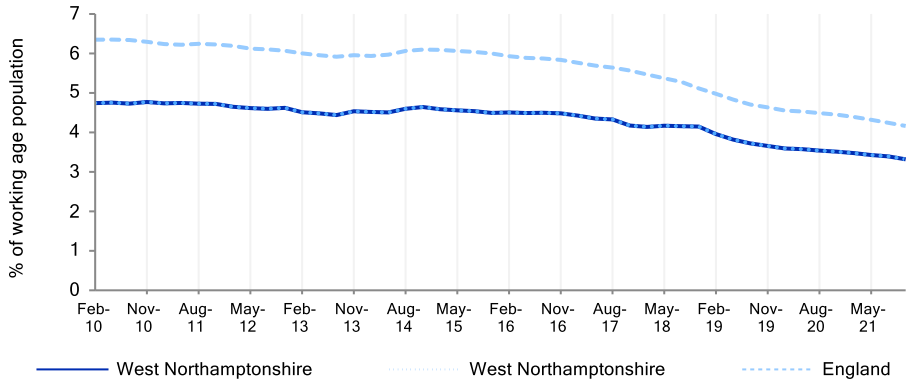
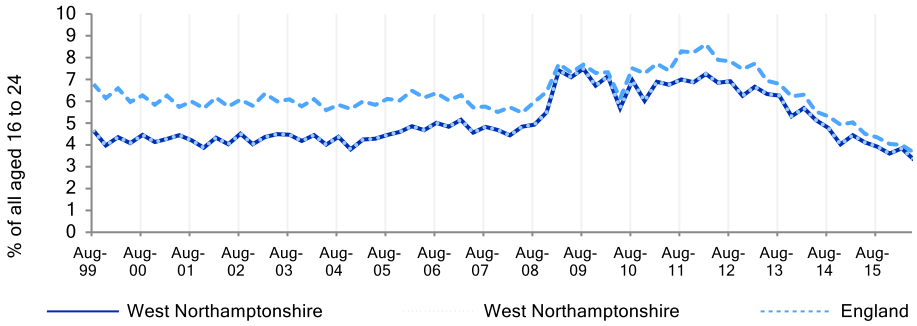


Figure: 16-24-year olds receiving 'Workless' benefits (Incapacity Benefit, Employment Support Allowance, Jobseekers Allowance and Universal Credit)
Source: Department for Work and Pensions



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What information is shown here?

The information in this section looks at the prevalence of disability among people living in West Northamptonshire. There are three measures of disability presented: those claiming Attendance Allowance, Personal Independence Payments and Disability Living Allowance.

Attendance Allowance is payable to people over the age of 65 who are so severely disabled, physically or mentally, that they need a great deal of help with personal care or supervision.

Until April 2013, Disability Living Allowance was payable to children and adults in or out of work who are below the age of 65 and who were disabled, and required help with personal care or had walking difficulties. It is a non-means tested benefit, which means it is not affected by income. From April 2013 Personal Independence Payments (PIP) have been introduced to replace Disability Living Allowance for all new claimants. PIP helps with some of the extra costs caused by long-term disability, ill-health or terminal ill-health.

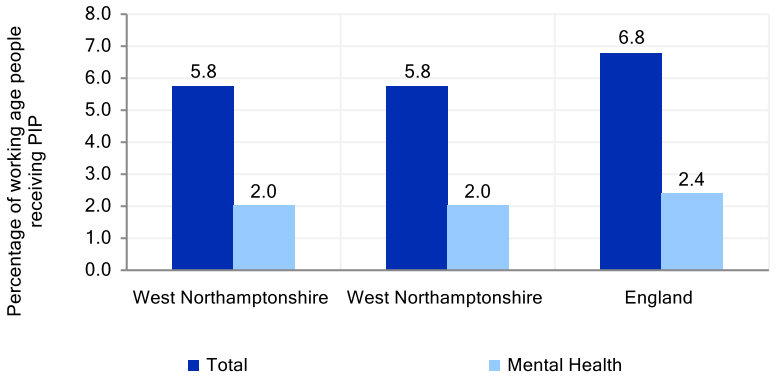
The information boxes on the right show the total number of people receiving Attendance Allowance, Disability Living Allowance and PIP (by key breakdown) and for household receiving Universal Credit due to poor physical or mental health (Limited Capability for Work Entitlement) across West Northamptonshire.

Attendance Allowance claimants (Nov-21)	Personal Independence Payment (PIP) (Oct-21)	PIP Males (Jan-22)	PIP Females (Jan-22)
7,461	14,426	6,575	7,854
10.3% of people (England= 11.4%)	5.8% of people (England= 6.8%)	5.2% of males (England= 6.2%)	6.3% of females (England= 7.3%)

PIP with mental health conditions (Jan-22)	PIP with respiratory disease (Jan-22)	Households on Universal Credit - Limited Capability for Work Entitlement (Feb-22)	Disability Living Allowance claimants (Nov-21)
5,076	429	3,173	5,843
2.0% of people (England= 2.4%)	0.2% of people (England= 0.3%)	2.0% of households (England= 3.0%)	1.4% of people (England= 2.0%)

Source: Department for Work and Pensions

Figure: Personal Independence Payment (PIP) recipients
Source: Department for Work and Pensions (Jan-22)



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What information is shown here?

The information in this page shows the proportion of people in receipt of Universal Credit against six levels of conditionality. Conditionality refers to work-related activities an eligible adult will have to do in order to get full entitlement to Universal Credit.

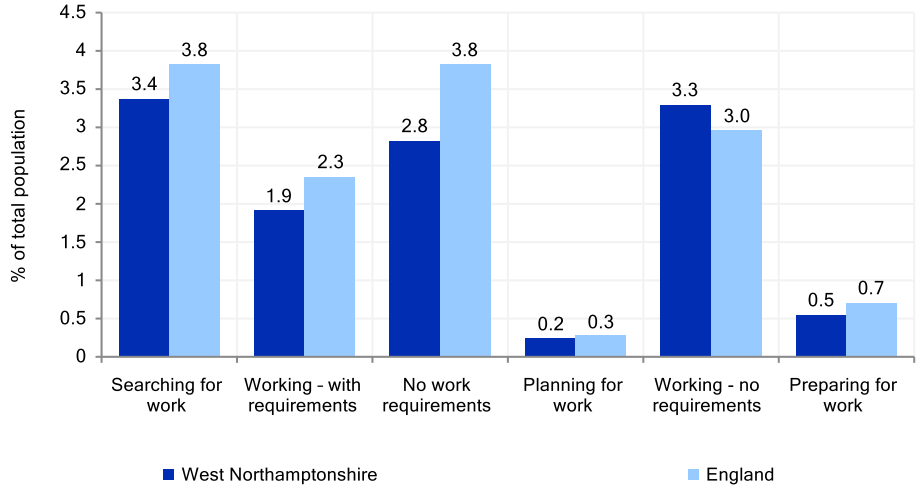
- **Searching for work:** Claimants who are not working, or with very low earnings. The claimant is required to take action to secure work - or more / better paid work. The Work Coach supports them to plan their work search and preparation activity.
- **Working with requirements:** Claimants who are in work but could earn more, or not working but has a partner with low earnings.
- **No work requirements:** Claimants who are not expected to work at present. Health or caring responsibility prevents claimant from working or preparing for work.
- **Planning for work:** Claimants who are expected to work in the future. Lone parent / lead carer of child aged 1 (Aged 1 - 2, prior to April 2017). The claimant is required to attend periodic interviews to plan for their return to work.
- **Working no requirements:** Claimants whose individual or household earnings is over the level at which conditionality applies. Required to inform DWP of changes of circumstances, particularly if at risk of decreasing earnings or losing job.
- **Preparing for work:** Claimants who are expected to start preparing for future even with limited capability for work at the present time or a child aged 2 (Aged 3 - 4, prior to April 2017), the claimant is expected to take reasonable steps to prepare for work including Work Focused Interview.

Universal Credit claimants: Searching for work (Apr-22)	Universal Credit claimants: Working with requirements (Apr-22)	Universal Credit claimants: No work requirements (Apr-22)
8,449	4,813	7,074
3.4% (England average = 3.8%)	1.9% (England average = 2.3%)	2.8% (England average = 3.8%)

Universal Credit claimants: Planning for work (Apr-22)	Universal Credit claimants: Working no requirements (Apr-22)	Universal Credit claimants: Preparing for work (Apr-22)
600	8,244	1,371
0.2% (England average = 0.3%)	3.3% (England average = 3.0%)	0.5% (England average = 0.7%)

Source: Department for Work and Pensions (DWP)

Figure: Working age population claiming Universal Credit by conditionality breakdown
Source: Department for Work and Pensions



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What information is shown here?

The information in this page shows a breakdown of Universal Credit (UC) households by type and criteria.

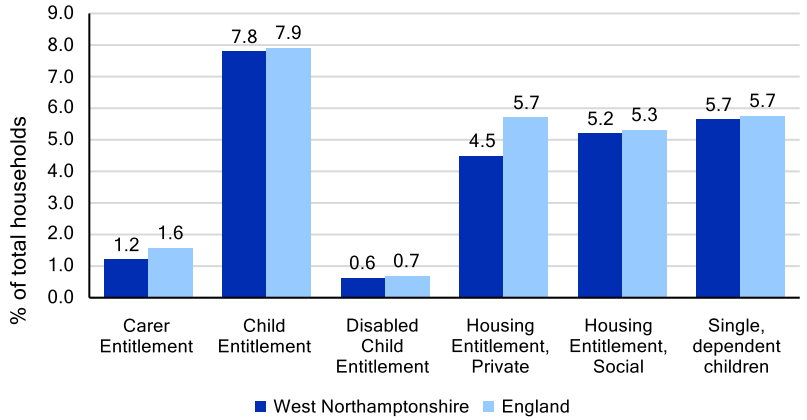
- **Carer Entitlement:** Households on UC containing household members who have regular and substantial caring responsibilities for at least 35 hours per week. Only one carer element is allowed per individual; in joint claims, two carer elements can be included providing both partners are not caring for the same disabled person.
- **Child Entitlement:** Households on UC where a child element is included in a Universal Credit award where there is responsibility for a child or qualifying young person who normally lives in the household.
- **Disabled Child Entitlement:** Households on UC where a child element is included in a Universal Credit award and the child element is increased by a disabled child addition if a child meets the criteria.
- **Housing Entitlement, Private rented:** Households on UC that are renting privately and eligible for housing entitlement. This element is to help with housing costs.
- **Housing Entitlement, Social rented:** Households on UC that are renting social housing and eligible for housing entitlement. This element is to help with housing costs.
- **Single with dependent children:** Households on Universal Credit that comprise a single person with child dependant(s).

UC households: Carer Entitlement (Feb-22)	UC households: Child Entitlement (Feb-22)	UC households: Disabled Child Entitlement (Feb-22)
1,970	12,499	994
1.2% (England average = 1.6%)	7.8% (England average = 7.9%)	0.6% (England average = 0.7%)

UC households: Housing Entitlement, Private (Feb-22)	UC households: Housing Entitlement, Social (Feb-22)	UC households: Single, dependent children (Feb-22)
7,164	8,352	9,051
4.5% (England average = 5.7%)	5.2% (England average = 5.3%)	5.7% (England average = 5.7%)

Source: Department for Work and Pensions (DWP)

Figure: Total households claiming Universal Credit by type and criteria breakdown
Source: Department for Work and Pensions



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Vulnerable groups: Working age benefit claimants (1)

What information is shown here?

The information in this page shows the number of people in receipt of key welfare benefits payable by the Department for Work and Pensions (DWP).

Working age DWP Benefits are benefits payable to all people of working age (16-64) who need additional financial support due to low income, worklessness, poor health, caring responsibilities, bereavement or disability.

Universal Credit (UC) has replaced legacy benefits for new claimants. The UC rollout began in April 2013, with single jobseeker's moving on to the new benefit and by March 2016 the rollout intensified to include other groups who are out of work or on low incomes. The chart on the right shows a breakdown of the proportion of UC claimants that are either in employment or unemployed across West Northamptonshire and comparator areas.

Housing Benefit (HB) can be claimed by a person if they are liable to pay rent and if they are on a low income and provides a measure of the number of households in poverty.

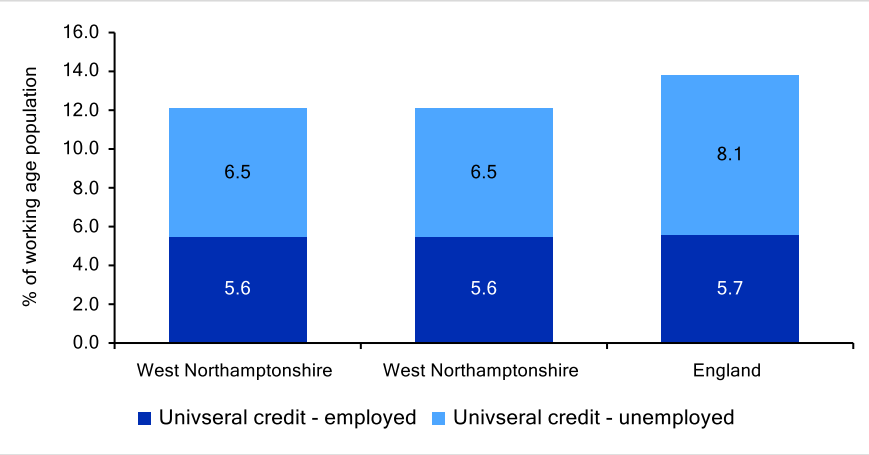
Income Support is a measure of people of working age with low incomes and is a means tested benefit payable to people aged over 16 working less than 16 hours a week and having less money coming in than the law says they need to live on.

The charts on the following page show the change in the proportion of Income Support and Housing Benefits claimants across West Northamptonshire and comparator areas. *Note, recent changes observed in these charts can be partially attributed to the migration of claimants from legacy working age DWP benefits, Housing Benefit and Income Support towards Universal Credit.*

Universal Credit claimants – in Employment (Mar-22)	Universal Credit claimants – Unemployed (Mar-22)		
14,001	16,301		
5.6% (England average = 5.7%)	6.5% (England average = 8.1%)		
Income Support (IS) claimants (Nov-21)	**Housing Benefit claimants (Feb-22)**	**Universal Credit claimants (Apr-22)**	
910	11,785	30,551	
0.4% (England average = 0.5%)	7.4% (England average = 9.7%)	12.2% (England average = 13.9%)	

Source: Department for Work and Pensions (DWP)

Figure: Universal Credit claimants employment indicator
Source: Department for Work and Pensions (Mar-22)



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Vulnerable groups: Working age benefit claimants (2)

Figure: Income Support claimants
Source: Department for Work and Pensions (Nov-21)

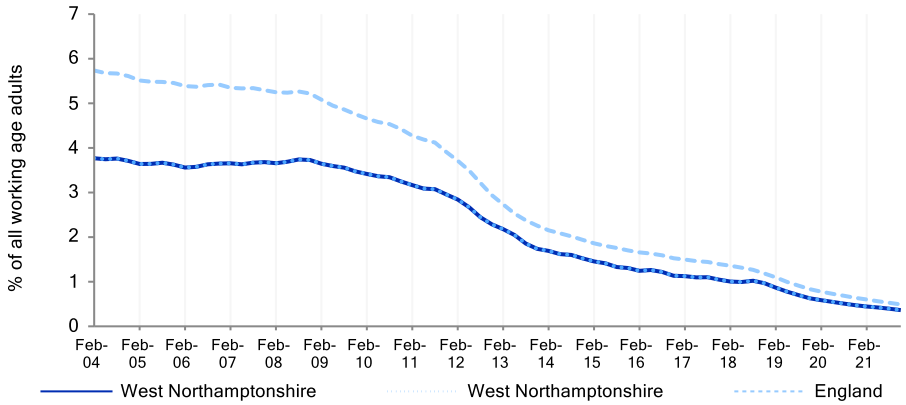
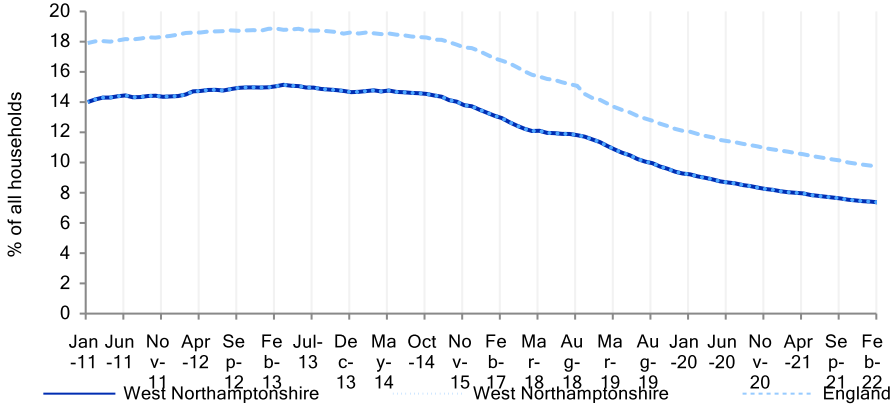


Figure: Housing Benefit claimants



Source: Department for Work and Pensions

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Vulnerable groups: Deprived neighbourhoods (1)

What information is shown here?

The information on this page looks at overall levels of deprivation across West Northamptonshire based on the Index of Multiple Deprivation (IMD) 2019. IMD 2019 is the most comprehensive measure of multiple deprivation available. The concept of multiple deprivation upon which the IMD 2019 is based is that separate types of deprivation exist, which are separately recognised and measurable. The IMD 2019 therefore consists of seven types, or domains, of deprivation, each of which contains a number of individual measures, or indicators.[2]

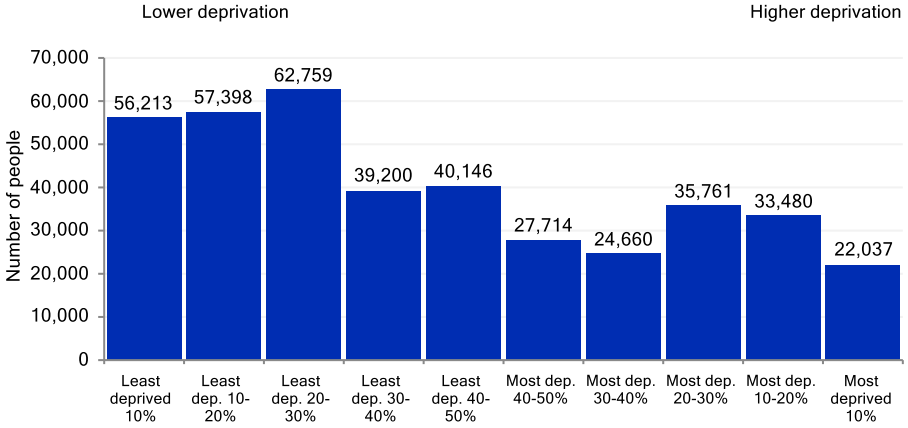
The information boxes on the right show the number of people in West Northamptonshire living in neighbourhoods ranked among the most deprived 20% of neighbourhoods in England on IMD 2019 and the seven IMD domains. The chart on the right shows the number of people living in neighbourhoods grouped according to level of deprivation. The charts on the following pages show the same information for each of the domains. All neighbourhoods in England are grouped into ten equal sized groups "deciles"; the 10% of neighbourhoods with the highest level of deprivation (as measured in the IMD) are grouped in decile 10, and so on with the 10% of neighbourhoods with the lowest levels of deprivation grouped in decile 1.

Number of people in West Northamptonshire living in the most deprived 20% of areas of England by Indices of Deprivation (ID) 2019 domain

Index of Multiple Deprivation	Income domain	Employment domain	Education domain
55,517	38,648	38,939	76,040
13.7% (England average = 20.0%)	9.5% (England average = 20.0%)	9.6% (England average = 19.5%)	18.8% (England average = 19.8%)
Health domain	**Barriers to Housing and Services domain**	**Living Environment domain**	**Crime domain**
67,201	81,489	49,590	104,699
16.6% (England average = 19.6%)	20.1% (England average = 21.4%)	12.2% (England average = 21.0%)	25.8% (England average = 20.4%)

Source: Ministry of Housing, Communities and Local Government (Indices of Deprivation 2019)

Figure: Number of people in each deprivation decile, Index of Multiple Deprivation 2019
Source: Ministry of Housing, Communities and Local Government (Indices of Deprivation 2019)



[2] The seven domains of deprivation included are: Employment deprivation, Income deprivation, Health deprivation and disability, Education, skills and training deprivation, Crime, Living environment deprivation, Barriers to housing and services.

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Figure: Number of people in each deprivation decile, ID 2019 Income domain
Source: Ministry of Housing, Communities and Local Government (Indices of Deprivation 2019)

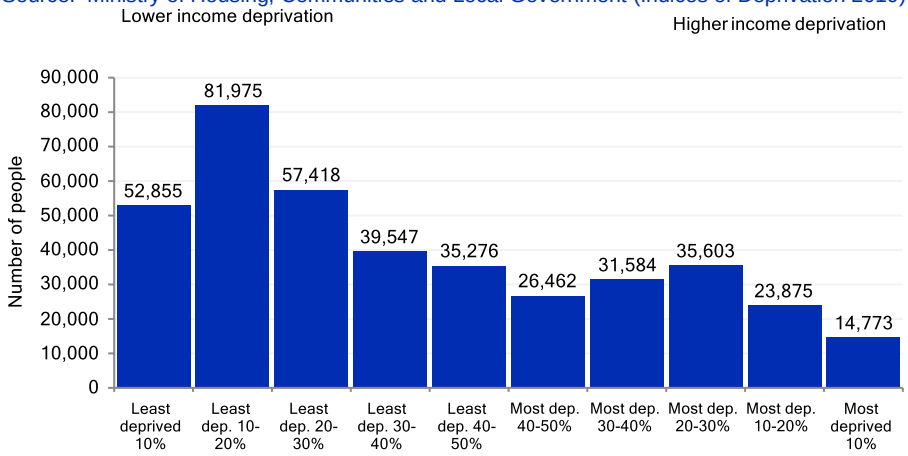


Figure: Number of people in each deprivation decile, ID 2019 Education domain
Source: Ministry of Housing, Communities and Local Government (Indices of Deprivation 2019)

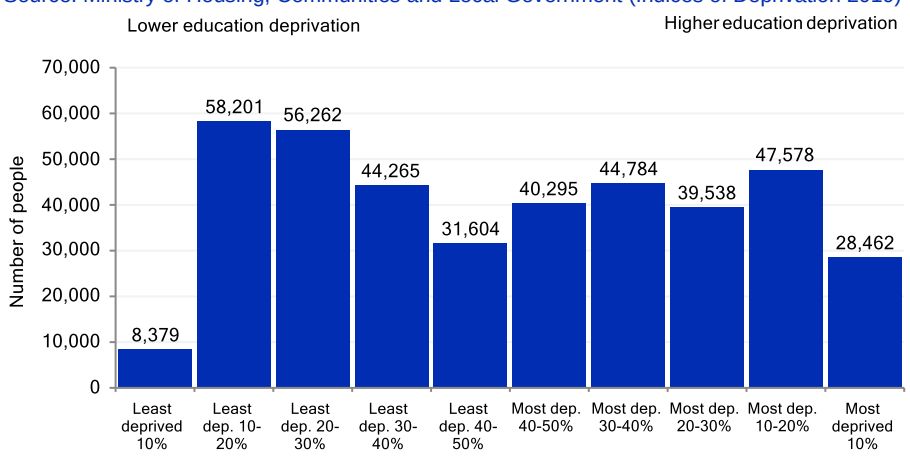


Figure: Number of people in each deprivation decile, ID 2019 Employment domain
Source: Ministry of Housing, Communities and Local Government (Indices of Deprivation 2019)

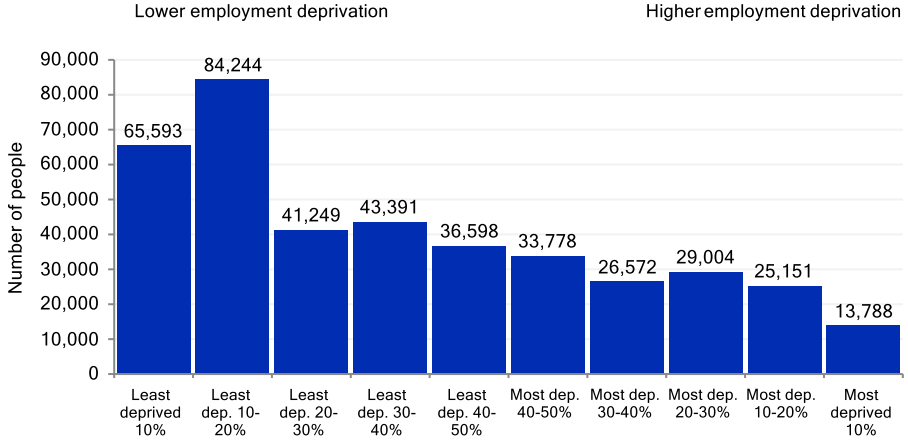
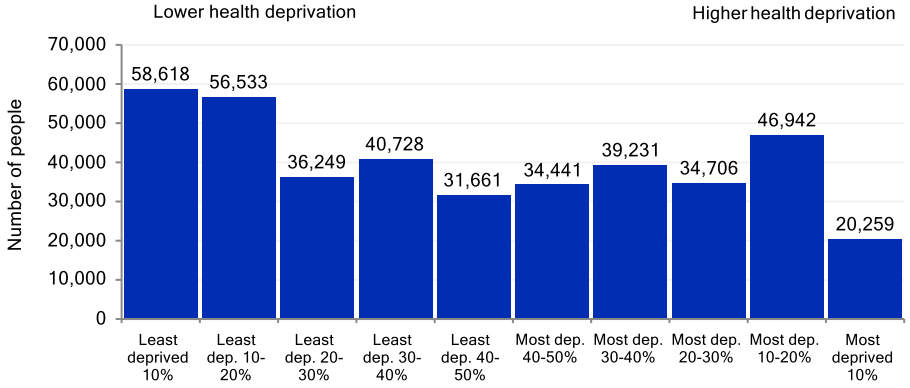


Figure: Number of people in each deprivation decile, ID 2019 Health domain
Source: Ministry of Housing, Communities and Local Government (Indices of Deprivation 2019)



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Vulnerable groups: Deprived neighbourhoods (3)

Figure: Number of people in each deprivation decile, ID 2019 Barriers to Housing and Services domain
Source: Ministry of Housing, Communities and Local Government (Indices of Deprivation 2019)

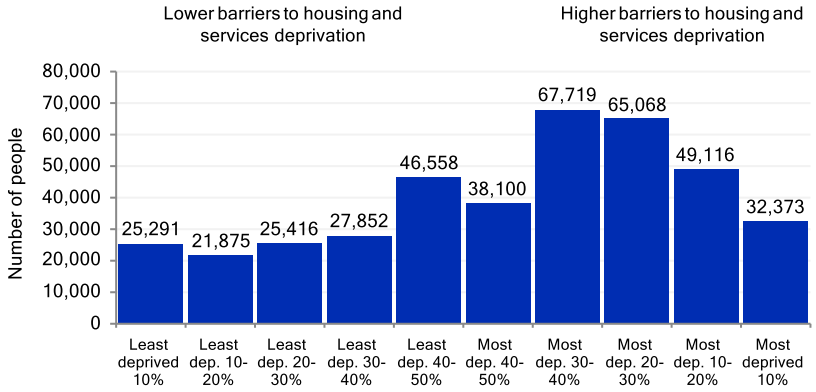


Figure: Number of people in each deprivation decile, ID 2019 Crime domain
Source: Ministry of Housing, Communities and Local Government (Indices of Deprivation 2019)

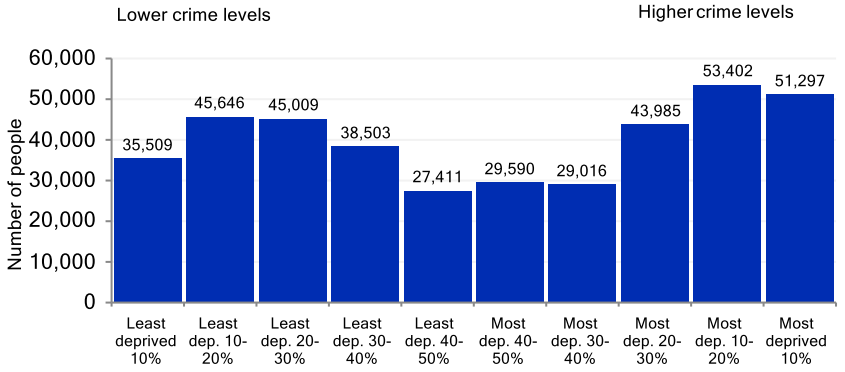
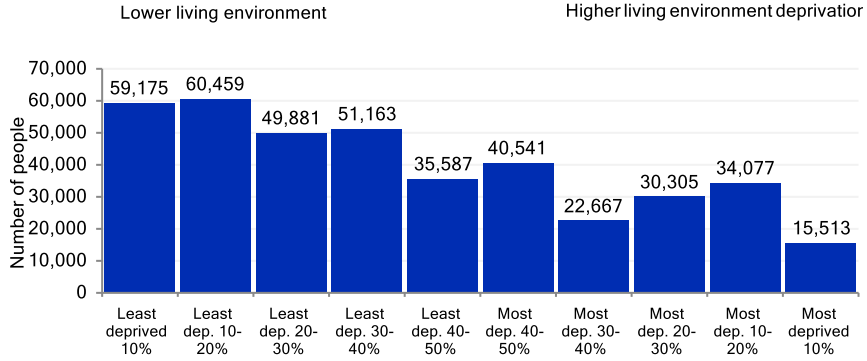


Figure: Number of people in each deprivation decile, ID 2019 Living Environment domain
Source: Ministry of Housing, Communities and Local Government (Indices of Deprivation 2019)



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Vulnerable groups: Children (1)

What information is shown here?

This page looks at children in low-income families, out of work households and lone parent households. Relative low income is defined as a family in low income Before Housing Costs (BHC) in the reference year. Absolute low income is a family in low income Before Housing Costs (BHC) in the reference year in comparison with incomes in 2010/11. A family must have claimed one or more of Universal Credit, Tax Credits or Housing Benefit at any point in the year to be classed as low income in these statistics. Children are dependent individuals aged under 16; or aged 16 to 19 in full-time non-advanced education.

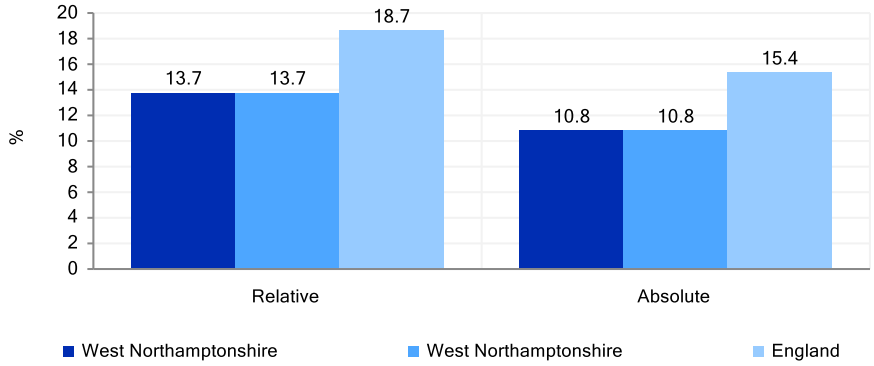
This is the first release of these statistics, which have replaced DWP's Children in out-of-work benefit households and HMRC's Personal Tax Credits: Children in low-income families local measure. See here for more information: https://www.gov.uk/government/collections/children-in-low-income-families-local-area-statistics#release

The information boxes on the right show the count of people in each of these categories in West Northamptonshire. The bar chart shows the percentage of children in relative and absolute low-income families.

Children in relative low income families	Children in absolute low income families	Children in relative low income lone parent families	Children in relative low income out of work families
13,858	10,968	5,622	3,955
13.7% (England average = 18.7%)	10.8% (England average = 15.4%)	40.6% of relative low-income families (England average = 40.2%)	28.5% of relative low-income families (England average = 30.6%)

Source: Children in low-income families, Department for Work and Pensions (2020)

Figure: Children living in low-income families
Source: Department for Work and Pensions (2020)



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What information is shown here?

The information on this page looks at pensioner groups including those that may face greater risks or who may have different types of need. There are three measures included: pensioners without access to transport, pensioner loneliness and pensioners in poverty.

Pensioners without access to transport are those with no access to a car or van. The dataset only includes pensioners living in private households.

There are two indicators of pensioner loneliness. The census provides a measure of the proportion of pensioners living alone (defined as households of one pensioner and no other household members). In addition, Age Concern have developed a Loneliness Index (which predicts the prevalence of loneliness amongst people aged 65+) based on census data. Areas with a value closer to 0 predict a greater prevalence of loneliness amongst those aged 65 and over and living in households compared to areas with a value further away from 0.

Pensioners in poverty are those in receipt of Pension Credit. Pension Credit provides financial help for people aged 60 or over whose income is below a certain level set by the law.

The information boxes present information on the counts of pensioner households or pensioners in each category. The chart on the top right shows the change in the proportion of people receiving Pension Credit across West Northamptonshire and comparator areas.

The chart on the bottom right compares Loneliness Index scores across West Northamptonshire and comparator areas - a value closer to 0 predicts a greater prevalence of loneliness amongst those aged 65.

Private pensioner households with no car or van (Census 2011)	Households of one pensioner (Census 2011)	State pension claimant (DWP Nov-20)	Pension credit claimant (DWP Nov-21)
10,520	16,407	67,390	6,452
36.3% of pensioner households (England average = 40.8%)	56.6% of pensioner households (England average = 59.6%)	92.8% (England average = 92.5%)	8.9% (England average = 11.5%)

Figure: Pension Credit claimants, Source: Department for Work and Pensions (Nov-21)

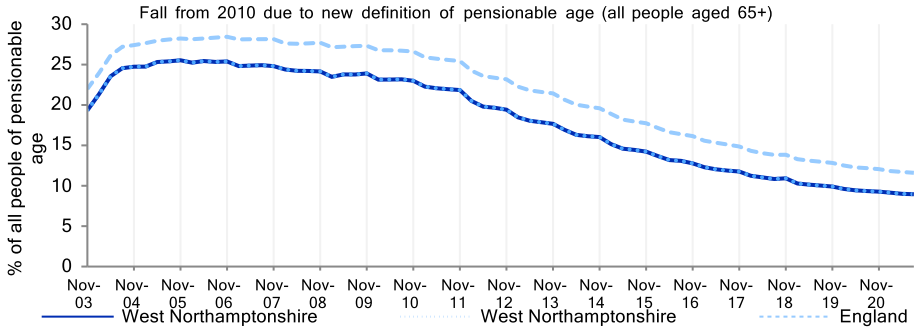
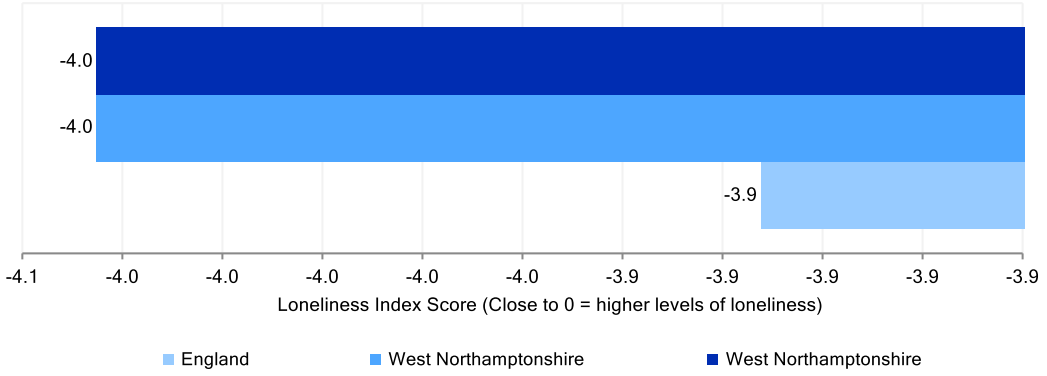


Figure: Loneliness index (probability of loneliness for those aged 65 and over). Source: Age UK (2011)



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Vulnerable groups: Households with multiple needs

What information is shown here?

The information on this page looks at household deprivation and households with multiple deprivation.

The information boxes show the number of households which are deprived in one of the four Census 2011 deprivation dimensions. The Census 2011 has four deprivation dimension characteristics: a) Employment: Any member of the household aged 16-74 who is not a full-time student is either unemployed or permanently sick; b) Education: No member of the household aged 16 to pensionable age has at least 5 GCSEs (grade A-C) or equivalent AND no member of the household aged 16-18 is in full-time education c) Health and disability: Any member of the household has general health 'not good' in the year before Census or has a limiting long term illness d) Housing: The household's accommodation is either overcrowded; OR is in a shared dwelling OR does not have sole use of bath/shower and toilet OR has no central heating. These figures are taken from responses to various questions in census 2011.

Households with multiple deprivation are households experiencing four key measures of deprivation:

- All adult household members have no qualifications
- At least one household member is out of work (due to unemployment or poor health)
- At least one household member has a limiting long-term illness
- The household is living in overcrowded conditions

Household is not deprived in any dimension (Census 2011)	Household is deprived in 1 dimension (Census 2011)	Household is deprived in 2 dimensions (Census 2011)	Household is deprived in 3 dimensions (Census 2011)
73,258	49,663	25,560	6,020
47.2% (England average = 42.5%)	32.0% (England average = 32.7%)	16.5% (England average = 19.1%)	3.9% (England average = 5.1%)

Households suffering multiple deprivation (Census 2011)
594
0.4% (England average = 0.5%)

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What information is shown here?

The information on this page looks at the number and proportion of people in two groups with specific needs: mental health issues and people providing unpaid care.

The figures for people with mental health issues are based on Employment Support Allowance/Incapacity Benefit claimants who are claiming due to mental health related conditions. Incapacity Benefit is payable to persons unable to work due to illness or disability.

Informal care figures show people who provide any unpaid care by the number of hours a week they provide that care. A person is a provider of unpaid care if they give any help or support to another person because of long-term physical or mental health or disability, or problems related to old age.

The line chart on the right shows the change in the number of people claiming Incapacity benefit for mental health reasons as a proportion of the working age population and the chart below it includes figures for children and all people providing unpaid care across West Northamptonshire.

Mental health related benefits (DWP Nov-21)	People providing unpaid care (Census 2011)	Unpaid care (50+ hours per week) (Census 2011)
4,338	36,889	7,538
1.7% of working age adults (England average = 2.1%)	9.8% (England average = 10.2%)	2.0% (England average = 2.4%)

Figure: Receiving Employment Support Allowance (ESA) and Incapacity Benefit (IB) due to mental health
Source: Department for Work and Pensions

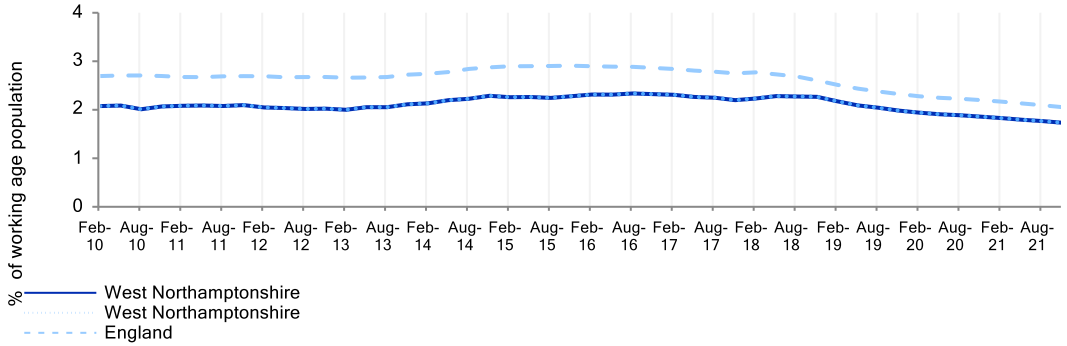
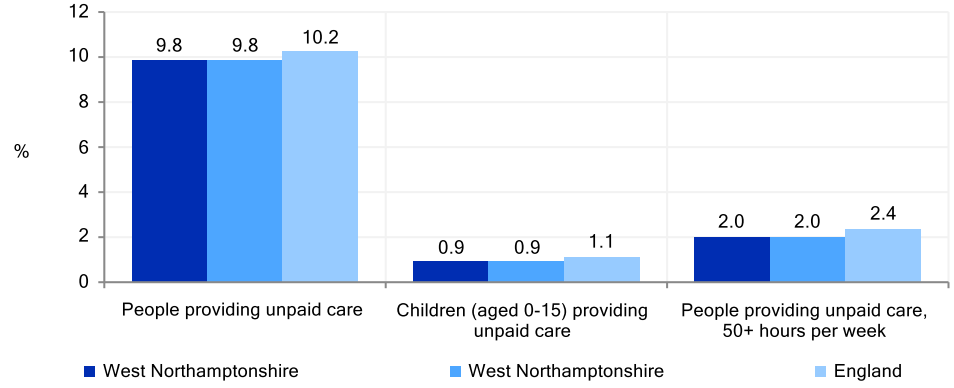


Figure: People providing unpaid care
Source: Census 2011



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Housing: Type

What information is shown here?

The information on this page looks at the type of dwelling space people live in. A dwelling space is the accommodation occupied by an individual household or, if unoccupied, available for an individual household, for example the whole of a terraced house, or a flat in a purpose-built block of flats.

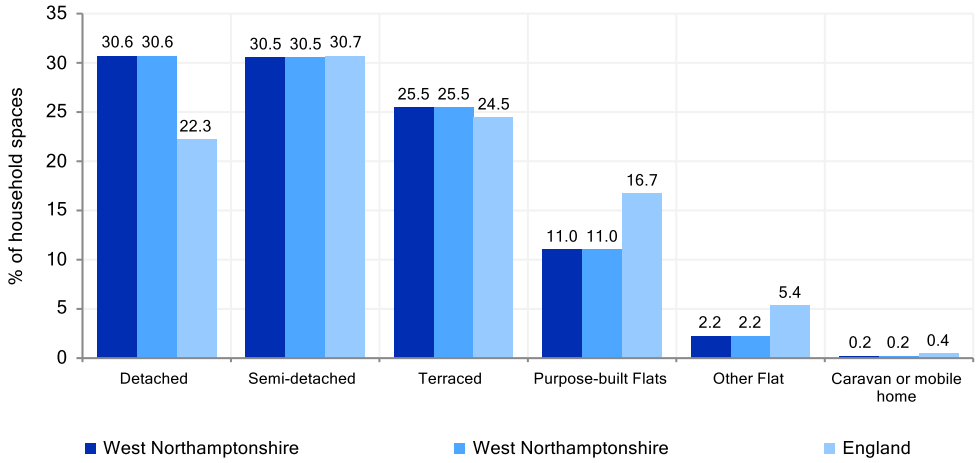
The information boxes to the right show the number of people in West Northamptonshire living in each accommodation type. The chart on the right shows a breakdown of households by accommodation type across West Northamptonshire and comparator areas.

Detached	Semi-detached	Terraced	Purpose built flat
49,144	48,945	40,868	17,656
30.6% (England average = 22.3%)	30.5% (England average = 30.7%)	25.5% (England average = 24.5%)	11.0% (England average = 16.7%)

Flat (in converted house)	Flat (in commercial property)	Caravan or other temporary dwelling	Second homes (2001)
2,396	1,119	245	534
1.5% (England average = 4.3%)	0.7% (England average = 1.1%)	0.2% (England average = 0.4%)	0.4% (England average = 0.6%)

Source: Census 2011

Figure: Dwellings type breakdown
Source: Census 2011



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Housing: Tenure

What information is shown here?

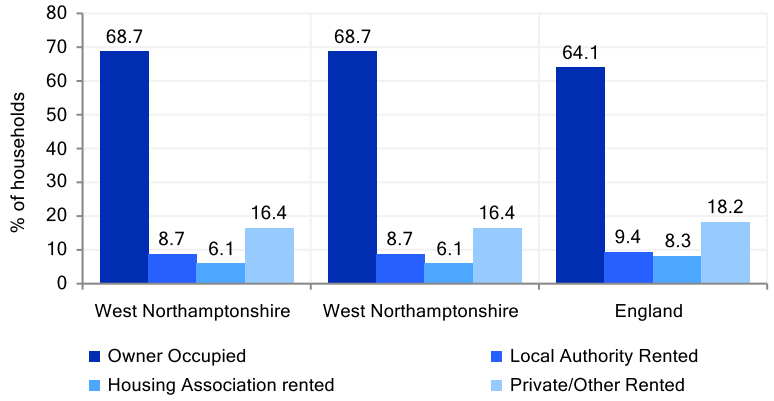
The information on this page looks at the tenure of housing in West Northamptonshire. The information boxes show the number of households broken down by tenure type and the chart shows the tenure breakdown across West Northamptonshire and comparator areas.

- 'Owner occupied' housing includes accommodation that is either owned outright, owned with a mortgage or loan, or shared ownership (paying part rent and part mortgage).
- 'Social rented' housing includes accommodation that is rented from a council (Local Authority) or a Housing Association, Housing Co-operative, Charitable Trust, Non-profit housing company or Registered Social Landlord.
- 'Rented from the Council includes accommodation rented from the Local Authority
- 'Housing Association or Social Landlord' includes rented from Registered Social Landlord, Housing Association, Housing Co-operative, Charitable Trust and non-profit housing Company.
- 'Private rented or letting agency' includes accommodation that is rented from a private landlord or letting agency.
- 'Other Rented' includes employer of a household member and relative or friend of a household member and living rent free.

Owner occupied	Owner-occupied: owned outright	Owner-occupied owned: with mortgage or loan
106,557	44,869	59,926
68.7% (England average = 64.1%)	28.9% (England average = 30.6%)	38.6% (England average = 32.8%)
Owner-occupied: shared ownership	**Social rented households**	**Rented from Council**
1,762	23,030	13,502
1.1% (England average = 0.8%)	14.8% (England average = 17.7%)	8.7% (England average = 9.4%)
Rented from Housing Association or Social Landlord	**Rented from private landlord or letting agency**	**Other rented dwellings**
9,528	21,567	3,941
6.1% (England average = 8.3%)	13.9% (England average = 15.4%)	2.5% (England average = 2.8%)

Source: Census 2011

Figure: Housing tenure breakdowns
Source: Census 2011



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Housing: How affordable is local housing? (1)

What information is shown here?

The information in this section shows measures of housing costs in West Northamptonshire. Data on house prices is from the Land Registry open data price-paid dataset (www.landregistry.gov.uk/market-trend-data/public-data/price-paid-data), which is updated monthly.

House prices by dwelling type

The information boxes on the right and the top-left chart on the following page show the mean house prices by accommodation type across West Northamptonshire and comparator areas for four key dwelling types (detached houses, semi-detached houses, flats and terraced houses). The bottom-left chart on page 25 shows the 10-year inflation adjusted average change in house prices across West Northamptonshire and comparator areas.

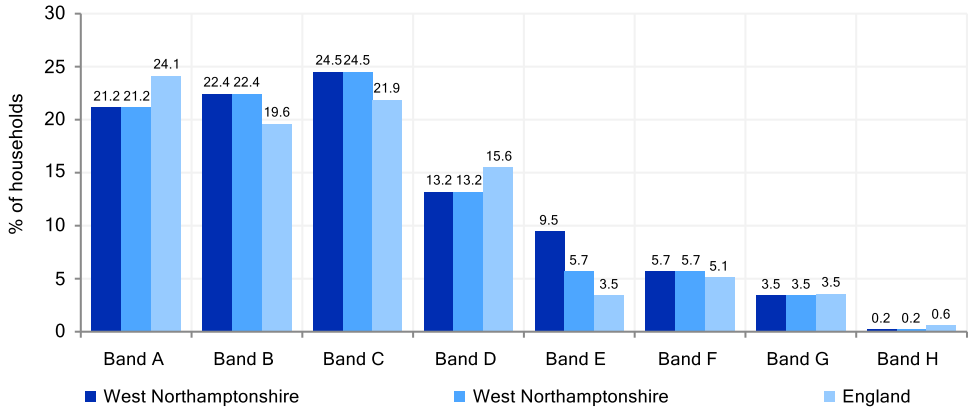
The top-right chart on page 25 displays the monthly change in the number of transactions and average price across West Northamptonshire and the bottom-right chart displays the ratio of the number of residential property transactions (Land Registry Mar-21 to Feb-22) to the number of owner occupied and privately rented dwellings (Census 2011) – an approximate measure of the proportion of housing stock that has change hands of the year, or the housing 'churn'.

Council tax bands

The data on Council Tax bands shows the number and proportion (as a percentage of all rateable households) of houses in bands A, B or C (the lowest price bands) and F, G and H (the highest price bands) locally. These price bands are set nationally, so can be used to show how the cost of all local property (not just those properties that have recently been sold) compares with other areas; the chart on the right compares West Northamptonshire and comparator areas for these Council Tax bands.

Average house price (all types of housing) (Land registry Mar-21 to Feb-22)	Average house price (detached) (Land registry Mar-21 to Feb-22)	Average house price (flats) (Land registry Mar-21 to Feb-22)
£302,939	£438,686	£145,099
England average = £346,603	England average = £502,127	England average = £303,955
Average house price (semi-detached) (Land registry Mar-21 to Feb-22)	**Average house price (terraced) (Land registry Mar-21 to Feb-22)**	**Households in Council Tax Band A (Valuation Office Agency (VOA) 2021)**
£262,798	£231,674	37,650
England average = £304,556	England average = £288,117	21.2% (England average = 24.1%)
Households in Council Tax Band B (VOA 2021)	**Households in Council Tax Band C (VOA 2021)**	**Households in Council Tax Band F-H (VOA 2021)**
39,810	43,530	16,770
22.4% (England average = 19.6%)	24.5% (England average = 21.9%)	9.4% (England average = 9.2%)

Figure: Dwelling stock by council tax band
Source: Valuation Office Agency (2021)



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Housing: How affordable is local housing? (2)

Figure: Average property price by dwelling type
Source: Land registry

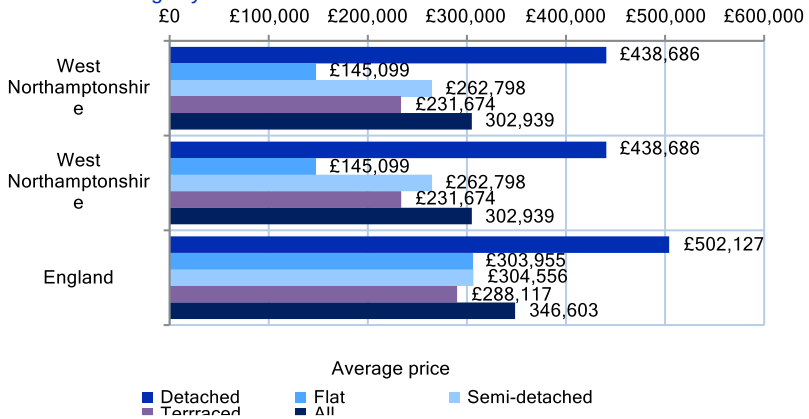


Figure: Average house prices and no. of transactions (note: there were no recorded transactions during the COVID-19 lockdown period so figures are shown as zero for this period), Source: Land Registry

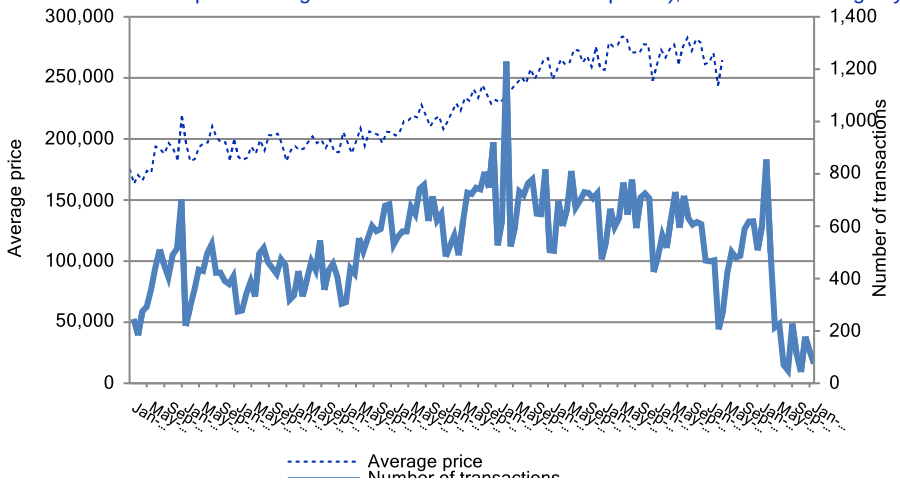


Figure: 10-year average house price change (inflation adjusted)
Source: Land registry Oct06-Oct07 to Oct16-Sep17

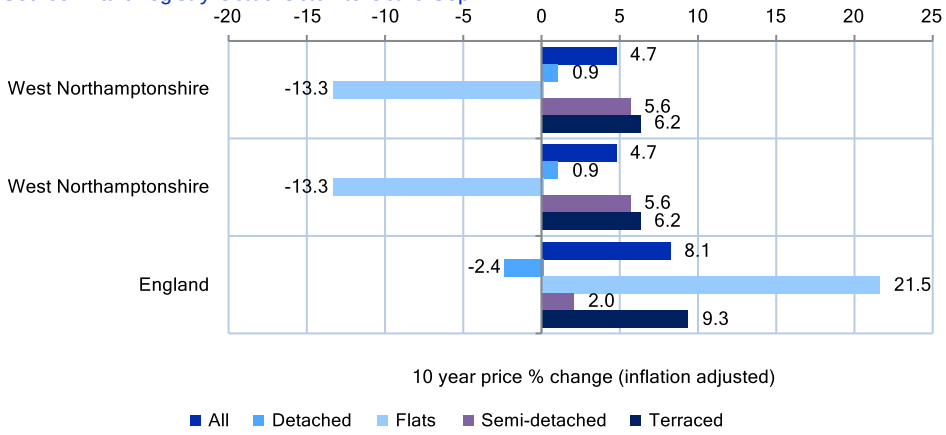
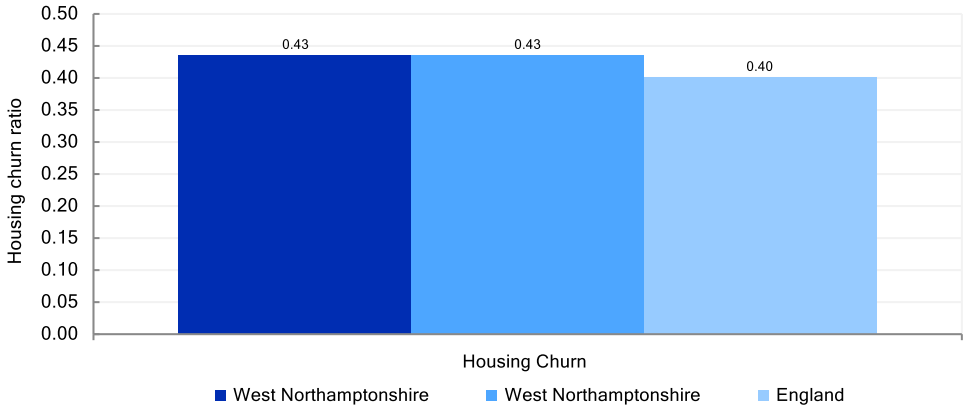


Figure: Ratio of residential property transactions to the total number of private dwellings
Source: Land Registry Mar-21 to Feb-22, Census 2011



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Housing: How affordable is local housing? (3)

What information is shown here?

The information in this section combines measures of local house prices and local earnings to provide a more balanced picture of housing affordability.

There are three indicators displayed here: **housing affordability gap**, **savings ratio** and **total affordability ratio**. Each of these indicators is given for two measures of house price: the average (median) house price and the lower quartile house price. The lower quartile house price is set such that the cheapest 25% of houses fall within this price and is a measure of the cost of cheaper, more affordable housing in the area.

Housing affordability gap: An estimate of the gap between the cost of local houses and the amount residents can borrow. This is defined as the difference between the local house price (either median or lower quartile) and 4.5 times local annual earnings (mortgage lenders are typically willing to lend 4-5 times annual salaries). Higher figures represent more unaffordable houses.

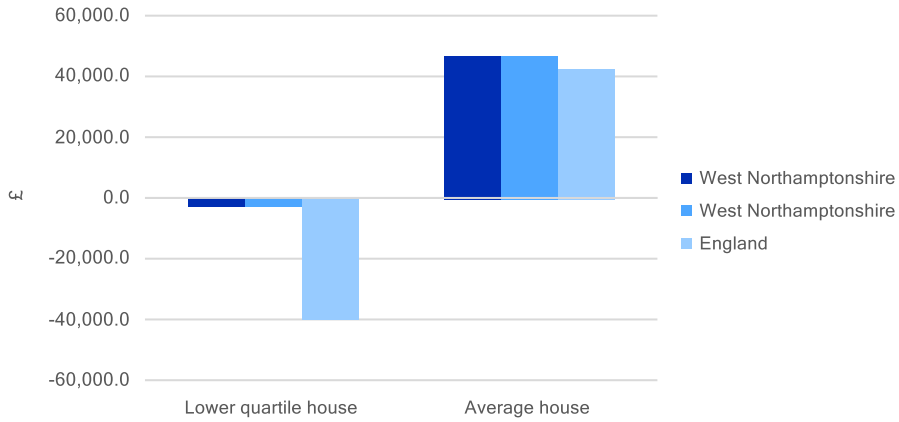
Savings ratio: The ratio between 15% of the house price (an estimate of the savings required for a deposit) and monthly earnings. It can be interpreted as the number of months' worth of earnings required for a deposit (not accounting for inflation or changes in earnings or house prices).

Total affordability ratio: This is the ratio between the total house price and annual earnings. It can be interpreted as the number of years' worth of earnings required for a deposit (not accounting for inflation or changes in earnings or house prices).

The data for these measures come from the ONS House Price Statistics for Small Areas (HPSSA) and ONS Income Estimates. Earnings data is published at MSOA level and house price data is published at LSOA level and above) Where necessary, we have modelled data to LSOA and OA geographies. The methodology used to produce these statistics is based ONS's housing affordability analysis.

Lower quartile house price ('affordable housing')	Average house price
Affordability gap	Affordability gap
-£2,120	£46,589
England average = -£39,328	England average = £42,272
Savings ratio (months of earnings for a deposit)	Savings ratio (months of earnings for a deposit)
8.21	10.63
England average = 6.54	England average = 10.41
Total ratio (years of earnings for a house)	Total ratio (years of earnings for a house)
4.41	5.57
England average = 3.57	England average = 5.5

Figure: Housing affordability gap for lower quartile house prices and average house prices.
Source: ONS House Price Statistics for Small Areas Oct16-Sep17; ONS earnings data 2015/2016



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Housing: Central heating, household overcrowding and dwelling size

What information is shown here?

The information on this page details indicators of the built environment: overcrowded housing, vacant housing, population density, the size of housing units and the proportion of households lacking central heating.

A household's accommodation is described as 'without central heating' if it had no central heating in any of the rooms (whether used or not). The data also shows breakdowns by tenure. This enables users to compare differences in the proportion of households with inadequate heating supply in the owner occupied, social rented and private rented sectors.

Households are classified as overcrowded if there is at least one room fewer than needed for household requirements using standard definitions. The standard used to measure overcrowding is called the 'occupancy rating' which relates to the actual number of rooms in a dwelling in relation to the number of rooms required by the household, taking account of their ages and relationships. The room requirement states that every household needs a minimum of two common rooms, excluding bathrooms, with bedroom requirements that reflect the composition of the household. The occupancy rating of a dwelling is expressed as a positive or negative figure, reflecting the number of rooms in a dwelling that exceed the household's requirements, or by which the home falls short of its occupants' needs.

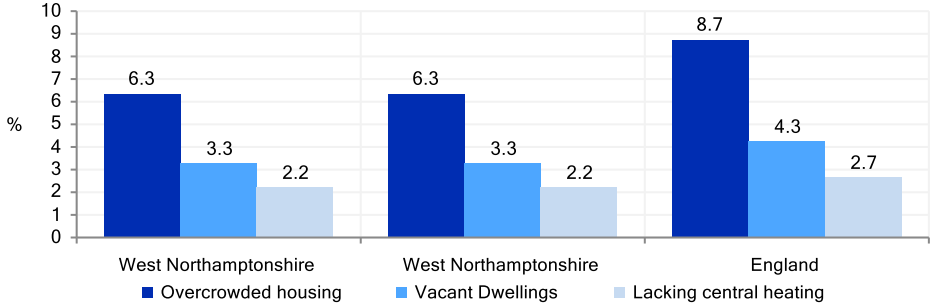
Vacant dwellings are households that do not have any usual residents. This includes households that may still be used by short-term residents, visitors who were present on census night, or a combination of short-term residents and visitors. It also includes vacant household spaces and household spaces that are used as second addresses.

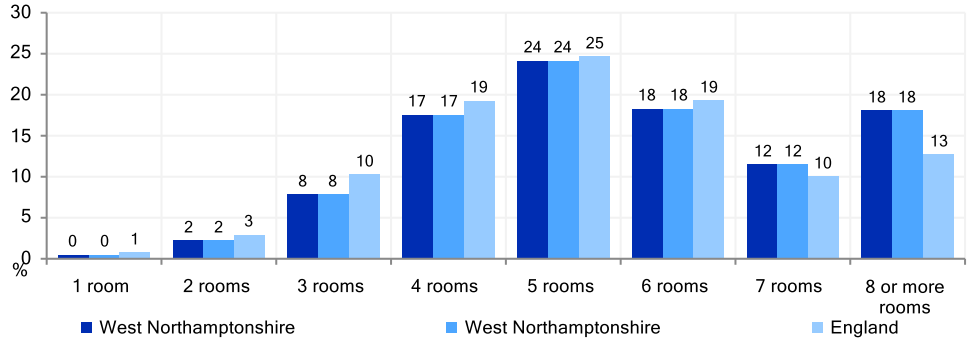
Population density (persons / hectare)	Houses lacking central heating	Overcrowded Housing	Vacant Dwellings
2.9	3,478	9,830	5,278
England average = 4.3	2.2% (England average = 2.7%)	6.3% (England average = 8.7%)	3.3% (England average = 4.3%)

Dwellings with 2 rooms or fewer	Dwellings with 8 or more rooms	Average dwelling size (persons)
4,212	28,055	2.38
2.7% (England average = 3.7%)	18.1% (England average = 12.7%)	England average = 2.36 people)

Source: Census 2011. Population density data – Office for National Statistics (ONS) 2016

Figure: Top - Housing Environment; Bottom - Dwelling size (number of rooms per household)
Source: Census 2011





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Housing: Domestic gas and electricity consumption

What information is shown here?

The Department for Business, Energy and Industrial Strategy publishes small area estimates of domestic gas and electricity consumption in megawatt hours (Kwh). Gas consumption data are weather corrected annual estimates of consumption for all domestic meters. A similar methodology is used for collecting domestic electricity consumption data; however, these values are not weather corrected. The methodologies are sufficiently similar that summing the electricity consumption and gas consumption gives an estimate of total annual energy consumption.

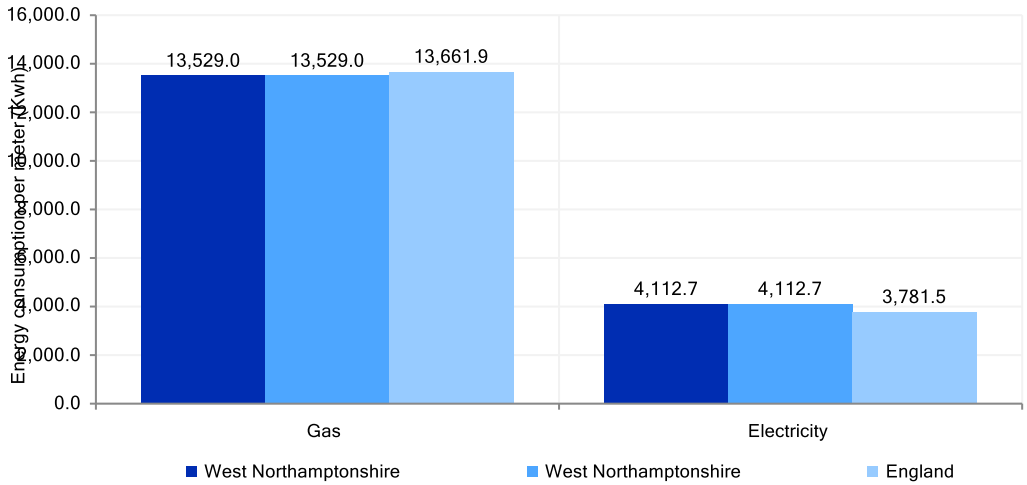
The data on this page were originally published by BEIS at postcode level and have been designated as experimental statistics. Experimental statistics are statistics that are new and subject to possible changes to meet user needs or that do not meet the rigorous quality standards of National Statistics. To avoid disclosure, postcodes are excluded if they contain less than 6 meters or that have average consumption figures of 0 or 1.

The estimated number households not connected to the gas network is based on the difference between the number of households and the number of domestic gas meters.

To read more about the data and methodology here please visit https://www.gov.uk/government/collections/sub-national-electricity-consumption-data

Electricity consumption (Kwh)	Gas consumption (Kwh)	Households not connected to the gas network
591,001,010	1,984,666,162	20,335
(4112.74 Kwh per meter) England average = 3781.46 Kwh per meter	(13529.02 Kwh per meter) England average = 13661.89 Kwh per meter	(11.53% of households) England average = 12.43%

Source: Department for Business, Energy and Industrial Strategy, 2020 (consumption), Not connected to gas network, 2020
Figure: Domestic gas and electricity consumption, 2020



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Housing: Energy efficiency of domestic buildings

What information is shown here?

This page details the energy efficiency ratings of domestic buildings within West Northamptonshire.

The data are taken from Energy Performance Certificates (EPC) for domestic buildings published by MHCLG at postcode level and have been aggregated to Output Areas. These include those recorded between January 2017 and December 2021.The definitions of the measures on the right are given below.

The energy efficiency rating, expressed in Standard Assessment Procedure (SAP) points, is a score between 1-100 with 1 being poor energy efficiency and 100 being excellent energy efficiency. The current average rating of buildings is given alongside the potential rating (if improvements to the buildings were made) and the difference between the two - the 'energy efficiency gap'.

The number and proportion of buildings have been split into three bands of energy efficiency rating; A-C, D-E and F-G, where band 'A' EPC rating is the most efficient. Please be aware that these figures do not account for all domestic buildings in an area.

Only homes that have been built, bought, sold or retrofitted since 2008 have an EPC, which represents about 50 to 60 per cent of homes within a local authority area. Additionally, data has not been published where the holder of the energy certificate has opted-out of disclosure, energy certificates are excluded on grounds of national security or energy certificates are marked as "cancelled" or "not for issue". Only postcodes that match the ONS postcode file directory have been included.

Energy efficiency rating, current (SAP points)	Energy efficiency rating, potential (SAP points)	Energy efficiency gap (SAP points)
65.01	83.03	18.01
England average = 64.15	England average = 81.65	England average = 17.51

Band A-C buildings	Band D-E buildings	Band F-G buildings
43892	40348	2412
(50.65%) England average = 47.19%	(46.56%) England average = 49.47%	(2.78%) England average = 3.34%

Source: MHCLG. Data collected between Jan 2017- Dec 2021.

Figure: Energy efficiency rating (SAP points)

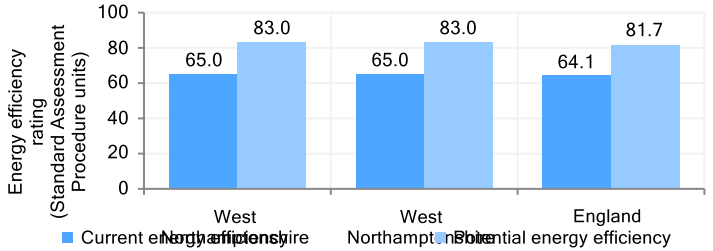
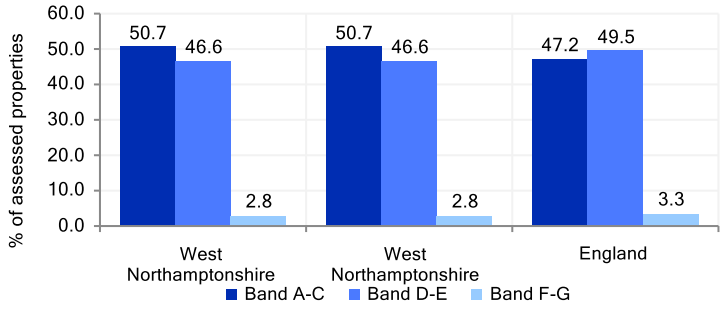


Figure: Energy efficiency rated buildings by band



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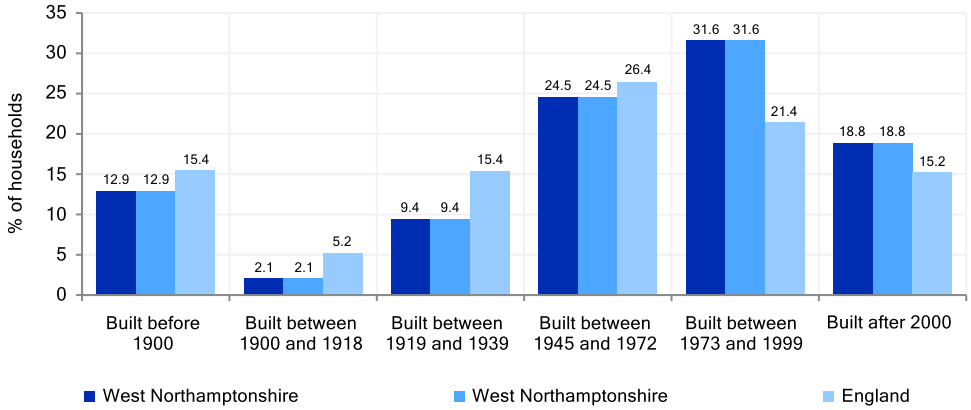
Housing: Dwellings by age of dwelling

What information is shown here?

The information on this page shows the number of domestic properties (the 'dwelling stock') broken down by age of property (when the property was constructed). The rate figures refer to the proportion of all properties whose build age is known.

Built before 1900	Built between 1900 and 1939	Built between 1945 and 1999	Built after 2000
22,870	20,420	99,830	33,490
12.9% (England average = 15.4%)	11.5% (England average = 20.6%)	56.1% (England average = 47.8%)	18.8% (England average = 15.2%)

Figure: Dwellings by age of dwelling (year property was constructed)
Source: Valuation Office Agency (VOA) 2021



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Housing: Communal establishment residents

What information is shown here?

The information on this page shows the number of people living in communal establishments, with breakdowns by the main types.

A communal establishment is defined as an establishment providing managed (full-time or part-time supervised) residential accommodation.

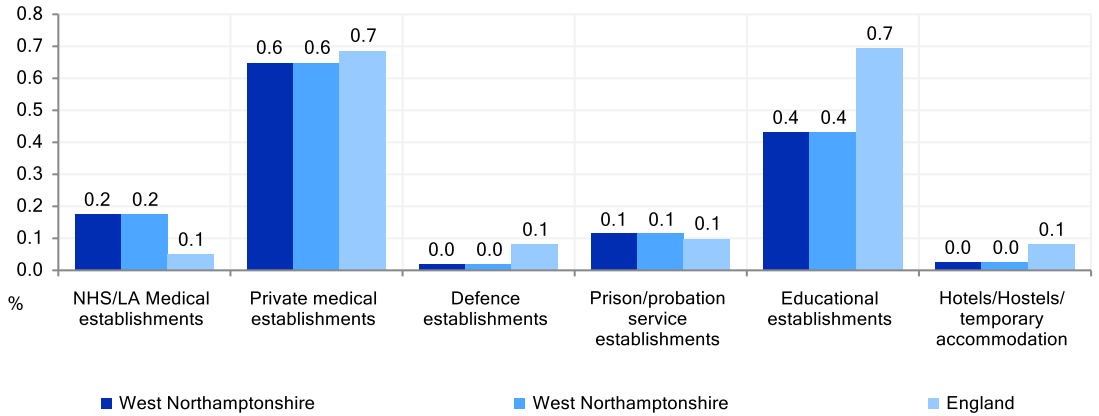
The information boxes on the right show the number and proportion of people in communal establishments by main type of establishment. Medical and care establishments include psychiatric hospital / homes, other hospital homes children's homes, residential care homes, nursing homes managed by the NHS, Local Authority or private organisation; Educational establishments include primarily University halls of residence; Defence establishments include barracks, air bases and naval ships; Other establishments include prison service establishments, bail hostels, hotels, boarding houses or guest houses, hostels and civilian ships.

The chart on the top right provides the same information with associated comparator areas.

All in communal establishments	Medical and care establishments	Education establishments	Defence establishments	Other establishments
6,255	3,089	1,622	76	265
1.7% (England average = 1.8%)	0.8% (England average = 0.7%)	0.4% (England average = 0.7%)	0.0% (England average = 0.1%)	0.1% (England average = 0.1%)

Source: Census 2011

Figure: Communal establishments by type
Source: Census 2011



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What information is shown here?

The information on this page and the following shows the level of recorded crime in West Northamptonshire and comparator areas. This is based on data for individual crime incidents published via the www.police.uk open data portal, which has been linked by Local Insight to selected neighbourhoods. Further information on how these crimes and incidents have been categorised, as well as which crimes and incidents have been mapped and why, is available at: www.police.uk/about-this-site/faqs/#why-are-some-crimes-not-displayed-on-the-map

The information boxes show counts and rates for the main crime types and anti-social behaviour incidents. The overall crime rate is presented for monthly, quarterly and annual snapshots, with the underlying crime types shown as annual totals.

The line charts to the right and on the following page track monthly change in recorded crime across five key offences (violent crime, anti-social behaviour, burglaries, criminal damage and vehicle crime) across West Northamptonshire and comparator areas.

Note: Police.uk crime counts were not recorded for Greater Manchester Police due to a change in IT systems no crime, outcome or stop and search data is available from July 2019 onwards. West Midlands: Due to recent major system changes Crime and Stop & Search data is unavailable from April 2021 onwards. Please see https://data.police.uk/changelog/ for more details.

All crimes February 2022 monthly total	All crimes Dec-21 to Feb-22	All crimes Mar-21 to Feb-22
3,144	9,807	41,669
8.2 per 1,000 population (England average = 7.2)	25.8 per 1,000 population (England average = 22.6)	102.4 per 1,000 population (England average = 93.3)
Violent crimes Mar-21 to Feb-22	**Criminal damage incidents Mar-21 to Feb-22**	**Anti-social behaviour incidents Mar-21 to Feb-22**
16,442	3,351	7,644
40.4 per 1,000 population (England average = 31.6)	8.2 per 1,000 population (England average = 7.5)	18.8 per 1,000 population (England average = 19.4)
Burglaries Mar-21 to Feb-22	**Robberies Mar-21 to Feb-22**	**Vehicle crimes Mar-21 to Feb-22**
1,626	363	2,311
10.2 per 1,000 households (England average = 9.0)	0.9 per 1,000 population (England average = 0.9)	5.7 per 1,000 population (England average = 5.0)

Source: Recorded crime offences – https://data.police.uk/ (2021/2022)

Figure: Violent crime offences
Source: https://data.police.uk/

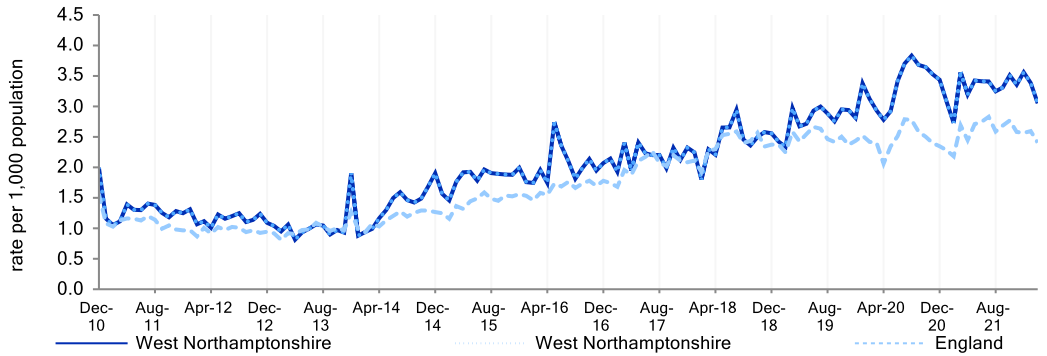

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Figure: Anti-social behaviour offences
Source: https://data.police.uk/

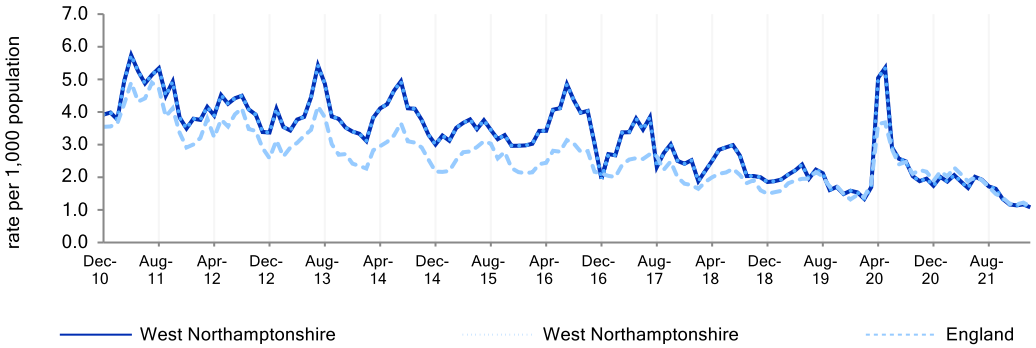


Figure: Burglary offences
Source: https://data.police.uk/

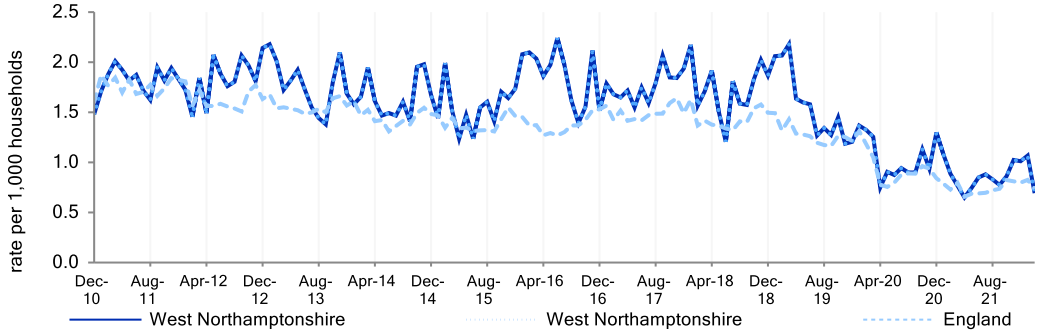


Figure: Criminal damage offences
Source: https://data.police.uk/

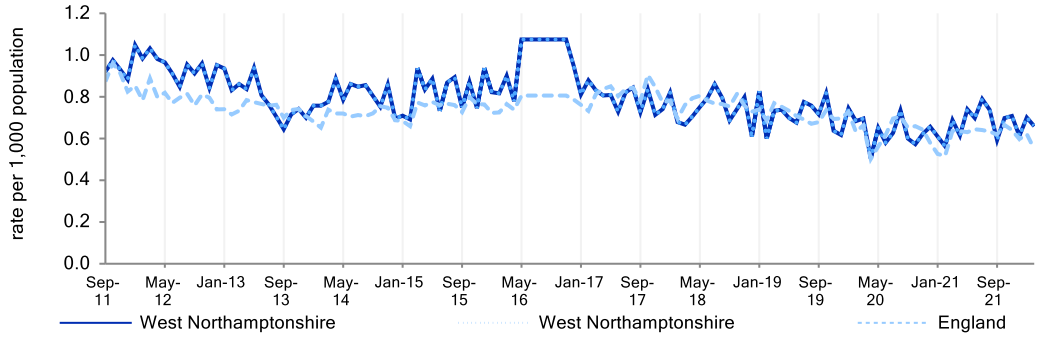
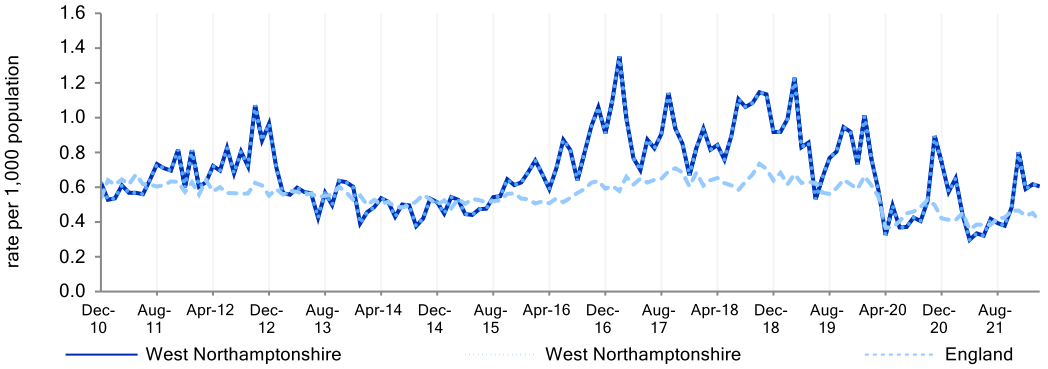


Figure: Vehicle crime offences
Source: https://data.police.uk/



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What information is shown here?

The information in this section explores variations in life expectancy and premature mortality. Life expectancy is a measure of the age a person born today can expect to live until, if they experience current mortality rates throughout their life. The chart on the right shows life expectancy at birth for females and males in West Northamptonshire and comparator areas.

The first chart on the following page shows the standardised mortality ratio for all causes and all ages for West Northamptonshire. This indicator highlights the ratio of observed to expected deaths (given the age profile of the population). A mortality ratio of 100 indicates an area has a mortality rate consistent with the age profile of the area, less than 100 indicates that the mortality rate is lower than expected and higher than 100 indicates that the mortality rate is higher than expected.

The second chart on the following page show incidence of cancer (with breakdowns for the most common forms of cancer). The data is presented as an incidence ratio (ratio of observed incidence vs expected incidence given the age profile of the population).

Figure: Life expectancy
Source: Office for National Statistics (2015-2019)

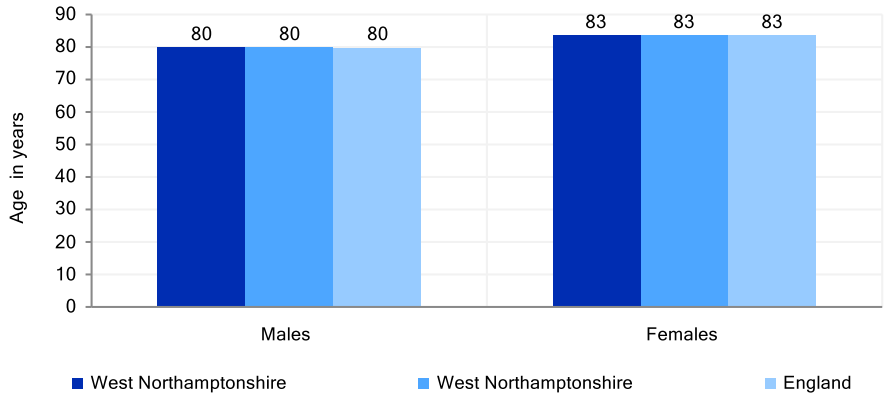

Figure: Healthy Life Expectancy
Source: Office for National Statistics (2009-2013)

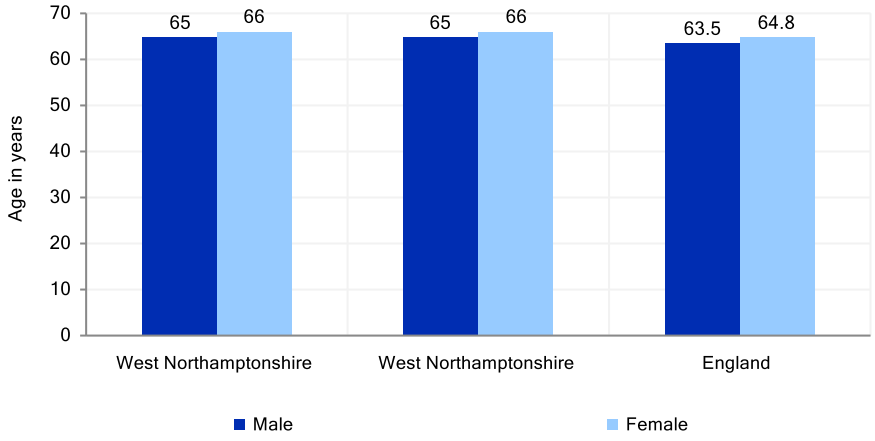

Figure: Disability-free Life Expectancy
Source: Office for National Statistics (2009-2013)

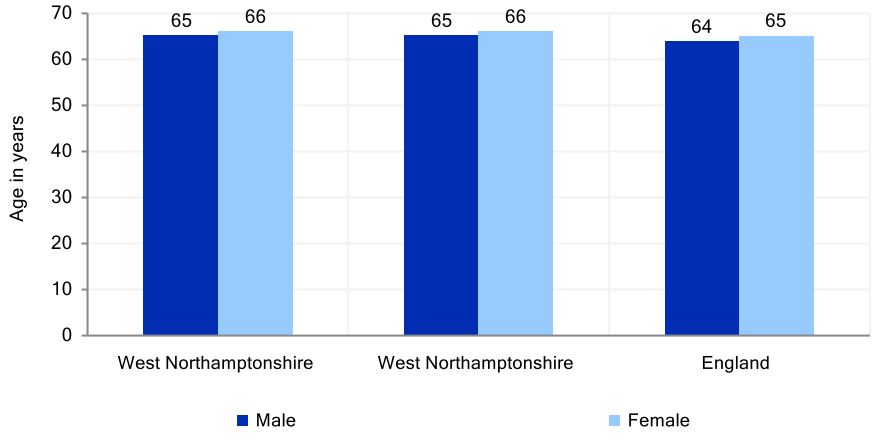

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Figure: Incidence of cancer: Standardised incidence ratio (select causes)
Source: Office for National Statistics (2012-2016)

If an area is above 100, there is a higher incidence of cancer than had been expected. If it is below 100, there is a lower incidence of cancer than expected.

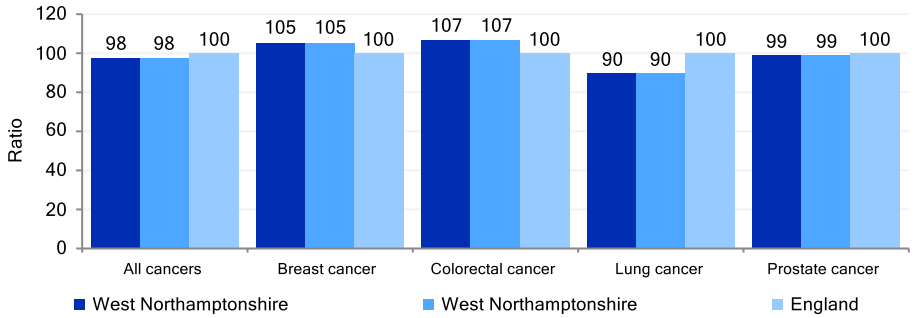
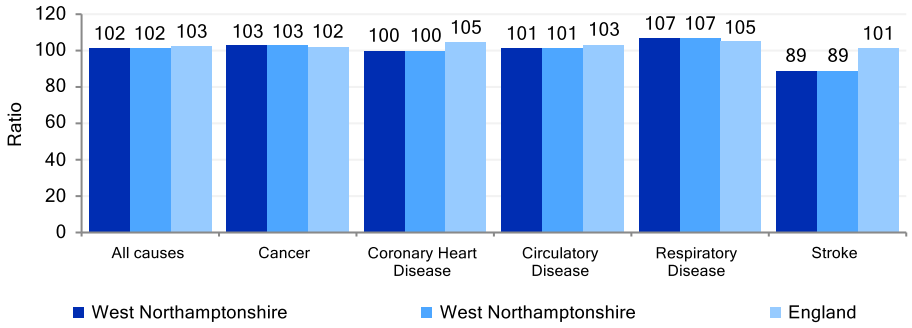


Figure: Standardised mortality ratio (select causes)
Source: Office for National Statistics (2015-2019)

If an area is above 100, there is a higher proportion of deaths than had been expected. If it is below 100, there is a lower proportion of deaths than expected.



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What information is shown here?

The information in this section looks at general levels of health, focusing on the number of people living in neighbourhoods with poor levels of overall health (health deprivation hotspots) and the number of people with a limiting long-term illness.

Limiting long-term illness is defined as any long-term illness, health problem or disability which limits someone's daily activities or the work they can do. Health deprivation 'hotspots' are neighbourhoods ranked among the most deprived 20% of neighbourhoods in England on the Indices of Deprivation 2015 Health domain. The domain measures morbidity, disability and premature mortality. All neighbourhoods in England are grouped into ten equal sized groups "deciles"; the 10% of neighbourhoods with the highest level of health deprivation are grouped in decile 10, and so on with the 10% of neighbourhoods with the lowest levels of health deprivation grouped in decile 1.

The chart on the right shows the number of people in West Northamptonshire living in each health decile. The charts below shows the proportion of residents in West Northamptonshire with a limiting long-term illness by age.

Number of people living in health deprivation 'hotspots' (Indices of Deprivation 2015)	People with a limiting long-term illness (Census 2011)	People aged 16-64 with a limiting long-term illness (Census 2011)	Babies born with a low birth weight (ONS 2011-2015)
67,201	57,577	26,967	517
16.6% (England average = 19.6%)	15.3% (England= 17.6%)	11.0% (England= 12.7%)	2.3% (England= 2.8%)

Figure: Number of people in each deprivation decile, Health domain
Source: Indices of Deprivation 2015

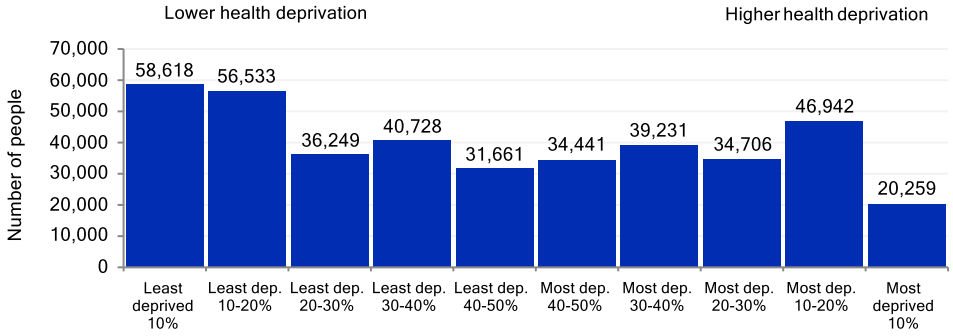
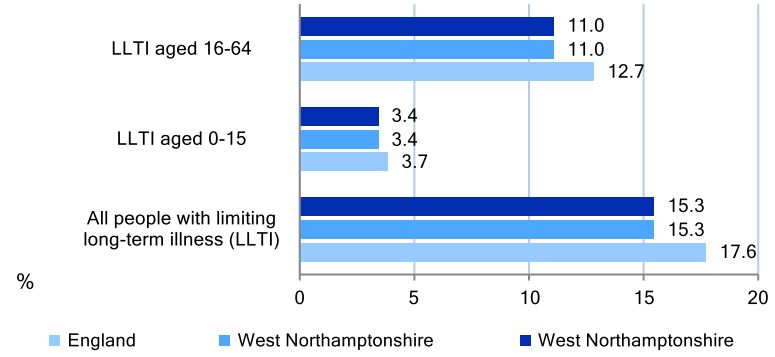


Figure: People with a limiting long-term illness
Source: Census 2011



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What information is shown here?

The information in this section looks at admissions to hospital by main health condition and hospital admissions and A&E attendance rates for children (aged under 5 years). The chart on the top right shows emergency admissions to hospital across West Northamptonshire and comparators. The chart on the bottom right shows elective in-patient hospital admissions (admissions that have been arranged in advance).

The data are presented as standardised ratios; a ratio of 100 indicates an area has an admission rate consistent with the national average, less than 100 indicates that the admission rate is lower than expected and higher than 100 indicates that the admission rate is higher than expected.

The information boxes at the bottom show the rate of emergency hospital admissions and A&E attendances for children (aged under 5 years) per 1,000 resident population in West Northamptonshire. Approximately 35% of all admissions in the NHS in England are classified as emergency admissions, costing approximately £11 billion a year. Over one quarter of emergency hospital admissions in children aged under 5 years in 2014/15 was for respiratory infections. A&E attendances in children aged under five years are often preventable, and commonly caused by accidental injury or by minor illnesses which could have been treated in primary care.

Emergency hospital admissions for children under 5 (per 1,000 population)	A&E attendance for children under 5 (per 1,000 population)
189	434
(England = 162)	(England = 630)

Source: Hospital Episode Statistics, Information Centre for Health and Social Care, Office for National Statistics (2017/2018 - 2019/2020)

Figure: Emergency hospital admissions: Standardised ratio (select causes)
Source: Hospital Episode Statistics, Information Centre for Health and Social Care, Office for National Statistics (2015/2016 - 2019/2020)

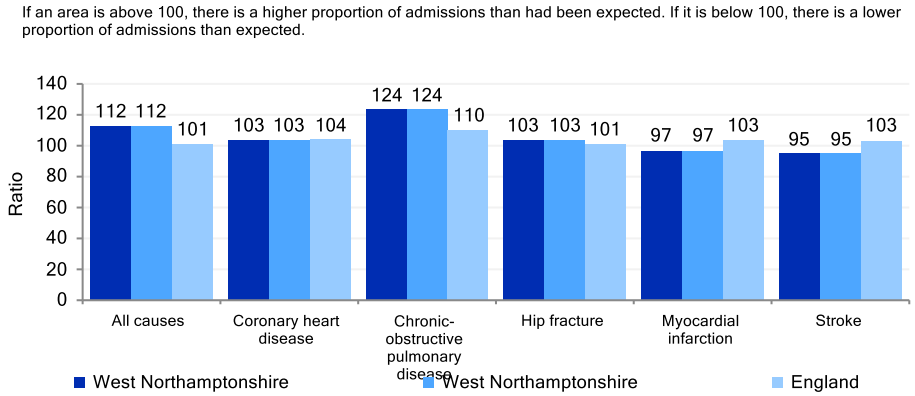
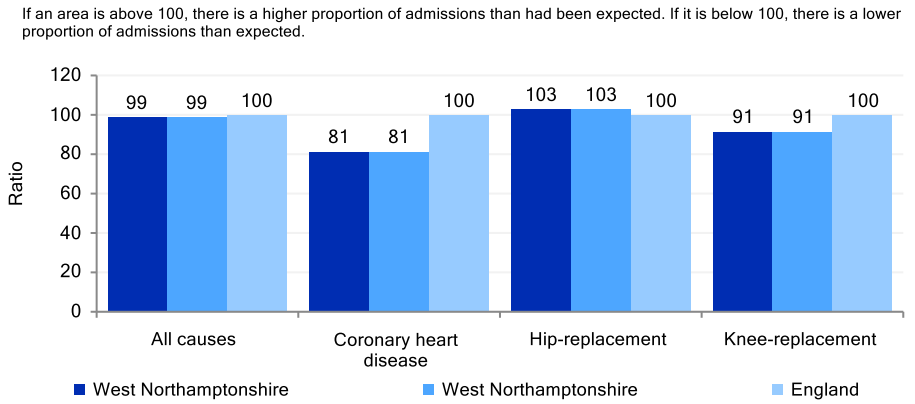


Figure: Elective hospital admissions: Standardised ratio (select causes)
Source: Hospital Episode Statistics, Information Centre for Health and Social Care, Office for National Statistics (2011/12-2014/15)



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What information is shown here?

Arthritis UK have partnered with Imperial College London to produce modelled estimates of the prevalence of musculoskeletal conditions for MSOAs in England. The estimates were calculated by identifying risk factors, sourcing suitable data sources and using statistical techniques to produce synthetic estimates of the numbers of people with hip osteoarthritis, knee osteoarthritis and back pain.

We have defined percentages consistently with Arthritis UK's methodology. **Knee and hip osteoarthritis figures are expressed as a percentage of the population aged 45 and over. Back pain figures are express as a percentage of the total population.**

People are deemed to have severe pain if they have pain most of the time or they are unable to walk a quarter of a mile unaided or they have previously undergone hip or knee replacement due to arthritis.

For more information visit https://www.arthritisresearchuk.org/arthritis-information/data-and-statistics/musculoskeletal-calculator.aspx

© Arthritis Research UK

Number of people with knee osteoarthritis (Arthritis UK 2011)	Number of people with hip osteoarthritis (Arthritis UK 2011)	Number of people with back pain (Arthritis UK 2011)
29024	17344	63871
18.2% (England= 18.2%)	10.9% (England= 10.9%)	16.9% (England= 16.9%)
Number of people with severe knee osteoarthritis (Arthritis UK 2011)	Number of people with severe hip osteoarthritis (Arthritis UK 2011)	Number of people with severe back pain (Arthritis UK 2011)
9263	4869	38400
5.8% (England= 6.1%)	3.1% (England= 3.2%)	10.1% (England= 10.3%)

Figure: Prevalence of hip and knee arthritis in people aged 45 and over
Source: Arthritis UK (2011)

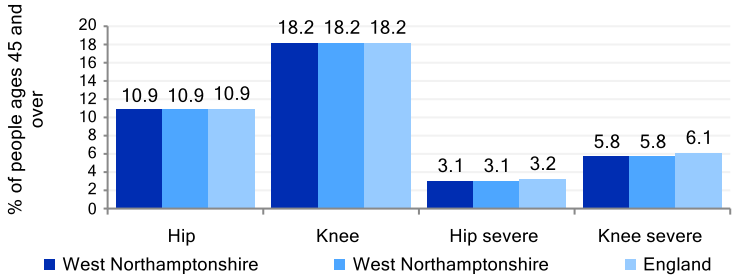
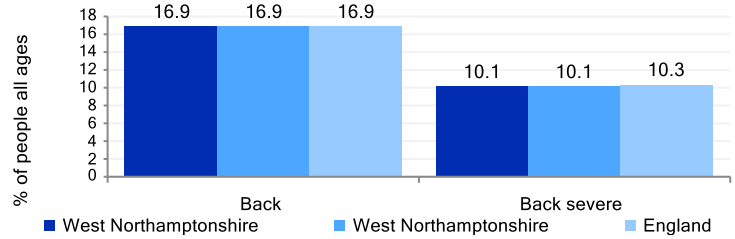


Figure: Prevalence of back pain in people of all ages
Source: Arthritis UK (2011)



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What information is shown here?

The information on this page looks at lifestyle behaviours of people living in West Northamptonshire. Lifestyle behaviours are risk factors which play a major part in an individual's health outcomes and will have varying physical and psychological consequences.

The chart on the top right shows the healthy eating levels (consumption of five or more portions of fruit and vegetables a day among adults) in West Northamptonshire. It also shows smoking prevalence and levels of binge drinking in these areas. Binge drinking is defined as the consumption of at least twice the daily recommended amount of alcohol in a single drinking session (8 or more units for men and 6 or more units for women).

The chart on the bottom right shows the percentage of people children (in reception year and year 6) and adults classified as obese in West Northamptonshire. People are considered obese when their body mass index (BMI) a measurement obtained by dividing a person's weight by the square of the person's height, exceeds 30 kg/m2.

Data for adult health are modelled estimates created from Health Survey for England 2006-2008. This is due to a lack of alternative small-area data for these indicators.

Figure: "Healthy eating" (consumptions of 5+ fruit and veg a day), binge drinking and smoking
Source: Health Survey for England 2006-2008

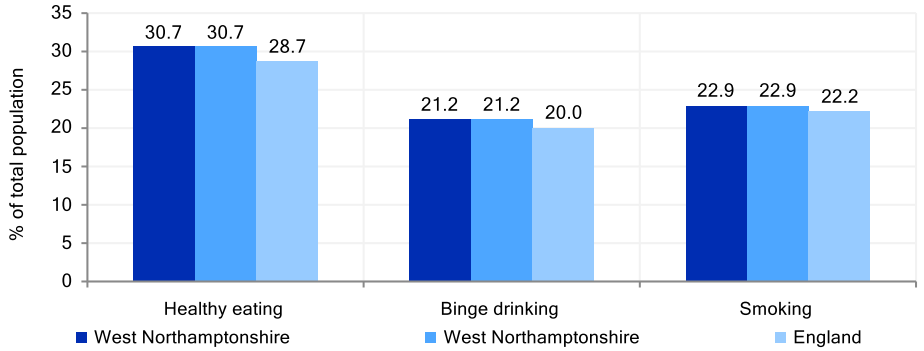
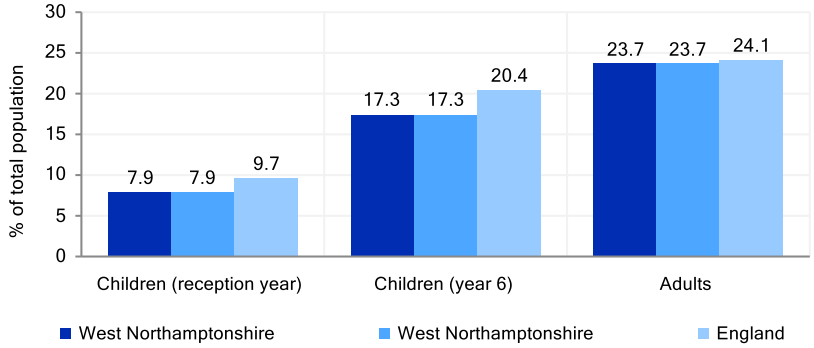


Figure: Children and adults classified as obese
Source: National Child Measurement Programme (NCMP) (2017/18-2019/20), Health Survey for England 2006-2008



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What information is shown here?

The information on this page looks at further lifestyle behaviours of people living in West Northamptonshire.

The chart on the top right shows the percentage of children (in reception year and year 6) classified as overweight or obese in West Northamptonshire. This indicator shows the number of children classified as overweight (including obese) where their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex. The indicator can be used to estimate and monitor excess weight and obesity in children in order to reduce prevalence, inform planning and delivery of services for children, and ensure the proper targeting of resources to tackle obesity.

The chart on the bottom right shows the modelled prevalence of smoking status for people aged 15 in West Northamptonshire. It shows the percentage of those aged 15 who are regular smokers or regular or occasional smokers. There is a large body of evidence showing that smoking behaviour in early adulthood affects health behaviours later in life. The Government's Tobacco Control Plan (2017) sets out their aim to reduce the number of 15 year olds who regularly smoke from 8% to 3% or less. This indicator will ensure that as well as focusing on reducing the prevalence of smoking among adults (primarily through quitting) local authorities will also address the issue of reducing the uptake of smoking among children.

Figure: Children classified as overweight or obese
Source: National Child Measurement Programme, NHS Digital (http://www.localhealth.org.uk/) (2017/18-2019/20)

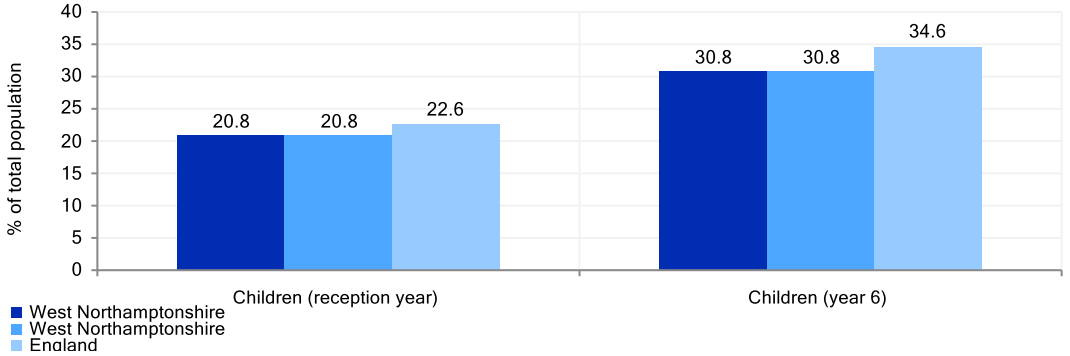
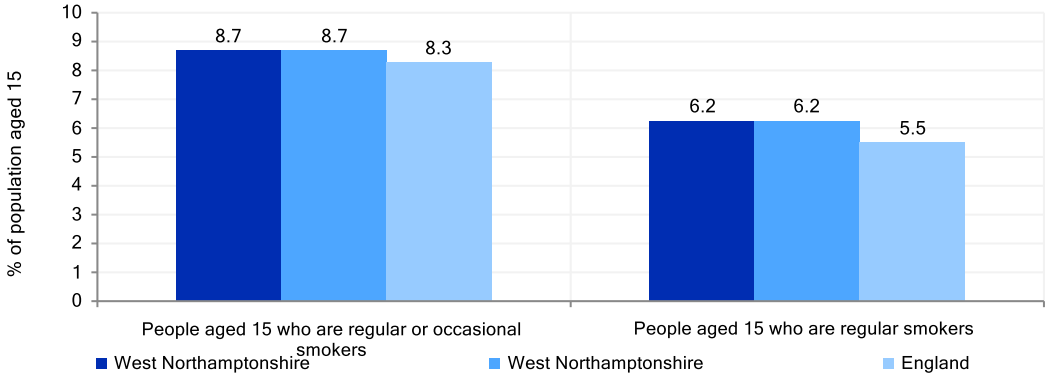


Figure: Prevalence of people aged 15 smoking status
Source: Department of Geography, University of Portsmouth and Geography and Environment, University of Southampton (http://www.localhealth.org.uk/) (2014)



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What information is shown here?

This chart shows estimates of the levels of physical activity among adults. The data have been produced by Sport England using a Small Area Estimation technique - modelling down from a National Survey (the Active Lives Survey 2020) to Middle Layer Super Output Area (MSOA) based on the local demographic characteristics of the local population. For more information on the modelling method see https://www.sportengland.org/know-your-audience/data/active-lives/active-lives-data-tables

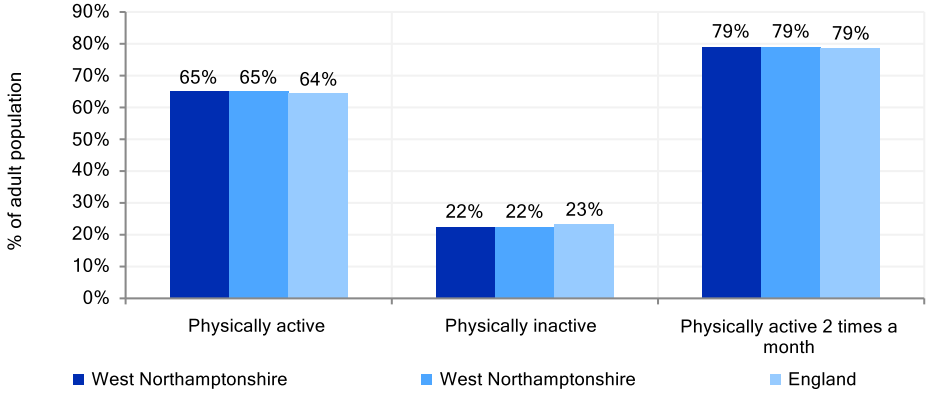
The categories of physical activity follow the guidelines set by the Chief Medical Officer and are defined below:

Physically active: undertaking at least 150 minutes per week in the past month excluding gardening

Physically inactive: undertaking less than 30 minutes in the past month excluding gardening

Physical activity at least twice a month: undertaking physical activity on at least two occasions in the past month

Figure: Physical activity among adults
Source: Sport England (Active Lives Survey 2020) – small area data 2018/2019



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What information is shown here?

The information on this page looks at the estimated prevalence of a different health conditions in West Northamptonshire.

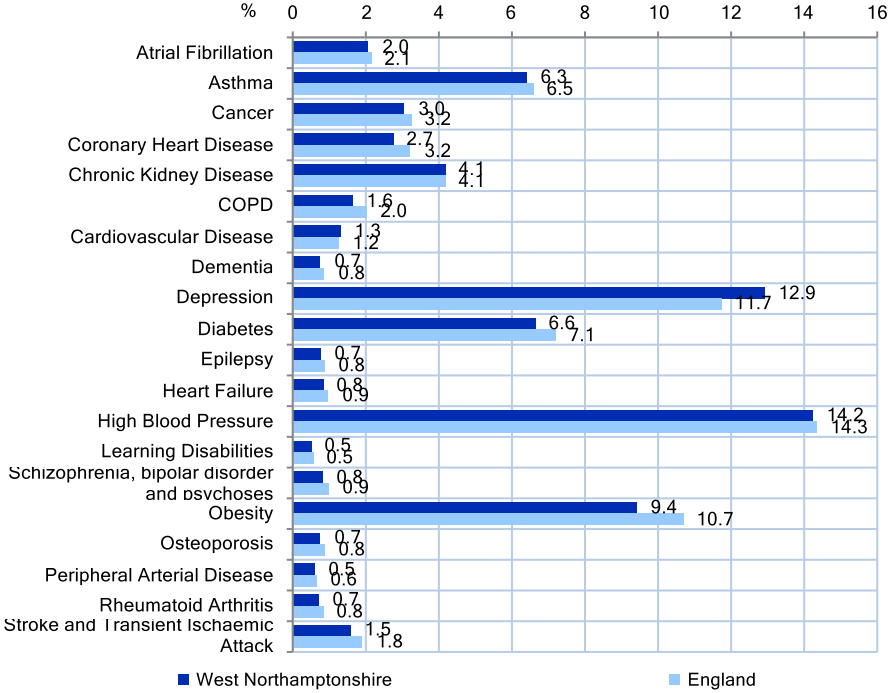
The estimates calculated are based on the number of people listed on GP registers in 2019/20, and the number of people recorded as having the relevant health conditions. The data from England's GP practices was published by NHS digital. As the data is for 2019/20, it may be affected by the beginning of the COVID-19 pandemic.

It should be noted that these are only estimates and that they are sensitive to the accuracy of GP data reporting. For some conditions (e.g. obesity and dementia), GP-recorded prevalence is lower than the proportion of people living with the condition.

For full notes, methodology, and limitations, please see https://commonslibrary.parliament.uk/social-policy/health/diseases/constituency-data-how-healthy-is-your-area for more details.

The bar chart on the right shows a detailed breakdown of the estimated percentage of prevalence by category of health condition.

Figure: % of estimated disease prevalence
Source: House of Commons Library (2019/20)



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What information is shown here?

The information on this page looks at the index of 'Access to Health Assets and Hazards' (AHAH) Version 2, a multidimensional index produced by the CDRC that measures how 'healthy' neighbourhoods are by looking at accessibility and geographical determinants of health. It combines indicators under four different domains of accessibility:

- Retail environment: access to fast food outlets, pubs, off-licences, tobacconists, gambling outlets,
- Health services: access to GPs, hospitals, pharmacies, dentists, leisure services, and
- Physical environment: access to Blue Spaces, Green Spaces - Active, Green Spaces – Passive (total green space areas available to each postcode in a range of a 900-metre buffer prior to creating LSOA averages),
- Air Quality: three air pollutants (Nitrogen Dioxide, Particulate Matter 10 and Sulphur Dioxide).

The information boxes on the top right show the score on each of the four domains of accessibility and the overall AHAH index score for West Northamptonshire. A higher score indicates a poorer health-related environment.

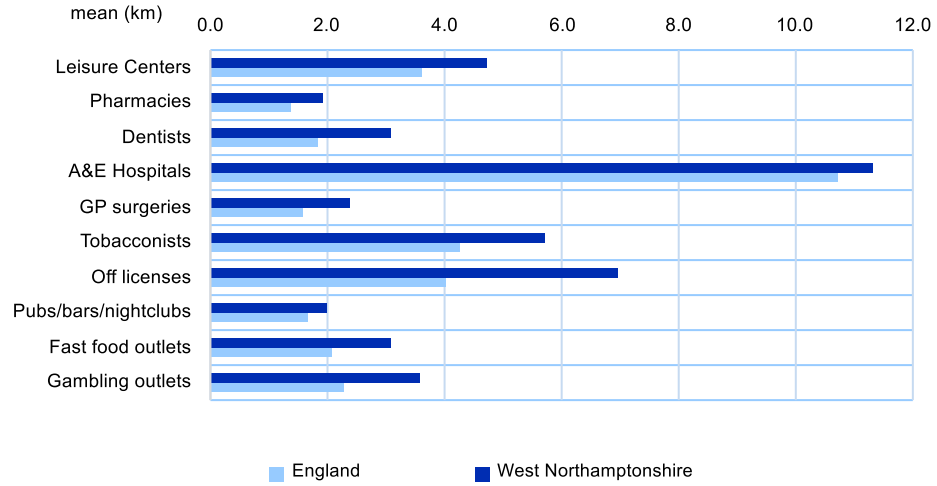
The bar chart on the right shows a detailed breakdown of the inputs for the retail environment and health services domains all of which show the mean distance in kilometres to each of these outlets and services.

For full notes, methodology, and limitations please see https://data.cdrc.ac.uk/dataset/ahah2 for more details.

AHAH Retail Environment domain (CDRC 2017)	AHAH Health Services domain (CDRC 2017)	AHAH Physical Environment domain (CDRC 2017)
14.3	29.7	22.2
(England = 23.4)	(England = 20.1)	(England = 21.3)

AHAH Air quality domain (CDRC 2017)	AHAH Index (CRDC 2017)
15.6	20.5
(England = 26.8)	(England = 22.9)

Figure: Inputs for retail environment and health services domain
Source: CDRC (2017)



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What information is shown here?

The information boxes and chart on the right show the education levels of residents in West Northamptonshire, showing the number and proportion of adults (aged 16+) by highest level of qualification. *Note, figures in the table and charts may not add up to 100% because they do not include figures for those for who with other qualifications or unknown qualifications.*

The Chart on the bottom left shows the proportion of people turning 18 between 2010-11 and 2014-15 who went on to enter higher education.

People with no qualifications	People with highest qualification level 1	People with highest qualification level 2	People with highest qualification level 3
61,986	44,189	48,957	36,880
20.6% of working age people (England= 22.5%)	14.7% of working age people (England= 13.3%)	16.3% of working age people (England= 15.2%)	12.3% of working age people (England= 12.4%)

People with highest qualification level 4+ (degree)	
79,487	'Level 1' qualifications are equivalent to a single O-level, GCSE or NVQ. 'Level 2' qualifications are equivalent to five O-levels or GCSEs. 'Level 3' qualifications are equivalent to two A levels. 'Level 4' qualifications are equivalent to degree level or higher.
26.4% of working age people (England= 27.4%)	

Source: Census 2011

Figure: Participation in higher education (Proportion of a young cohort that has entered higher education by age 19)
Source: Office for Students (OFS)

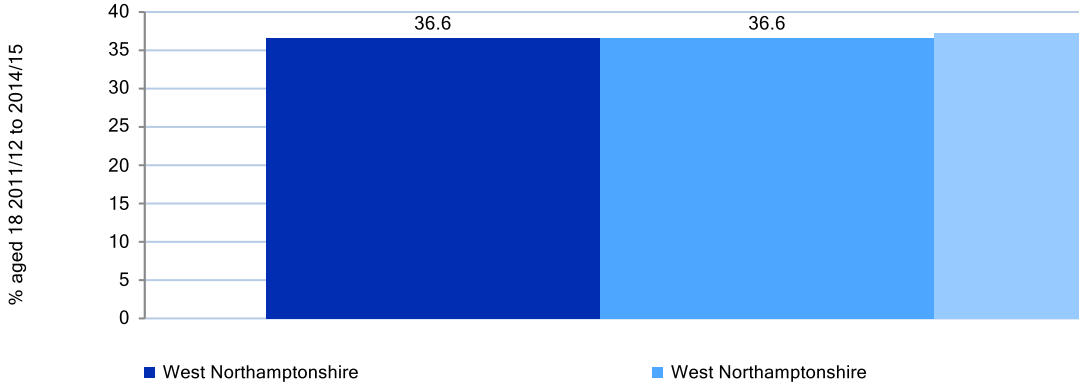
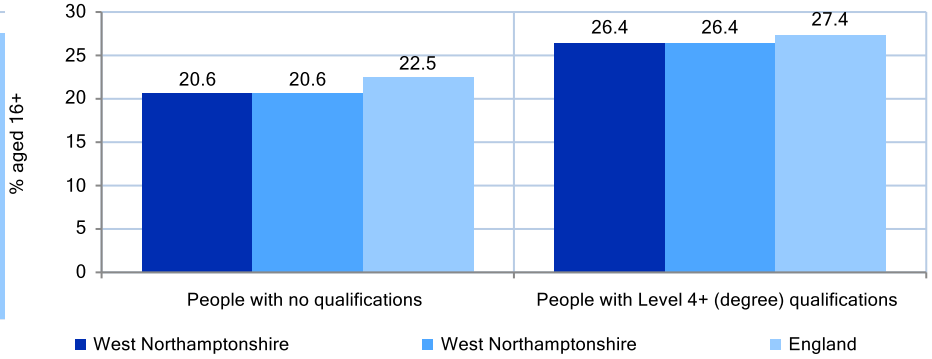


Figure: People with no qualifications and degree level qualifications
Source: Census 2011



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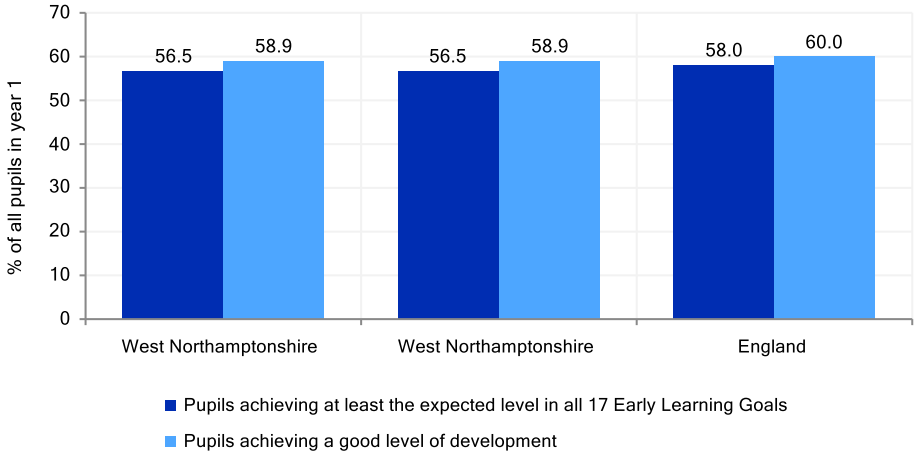
What information is shown here?

The information on this page shows the outcomes of children in the Early Years Foundation Stage (EYFS), a series of tests measuring children's progress in terms of Personal, Social and Emotional Development (PSED) and Communication, Language and Literacy (CLL). These are typically 5-year-old pupils; however, a minority of slightly older and younger pupils may have been assessed.

The new Early Years Foundation Stage Profile requires practitioners to make a best fit assessment of whether children are emerging, expected or exceeding against each of the new 17 Early Learning Goals (ELGs). Children have been deemed to have reached a Good Level of Development (GLD) in the new profile if they achieve at least the expected level in the ELGs in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and in the specific areas of mathematics and literacy. These are 12 of the 17 ELGs. The Department for Education has also introduced a supporting measure which measures the total number of points achieved across all 17 ELGs and reports the average of every child's total point score.

The chart on the right shows the percentage of pupils achieving 17 ELG and the percentage of pupils achieving a good level of development.

Figure: Early years foundation stage profile
Source: Department for Education (2013-2014)



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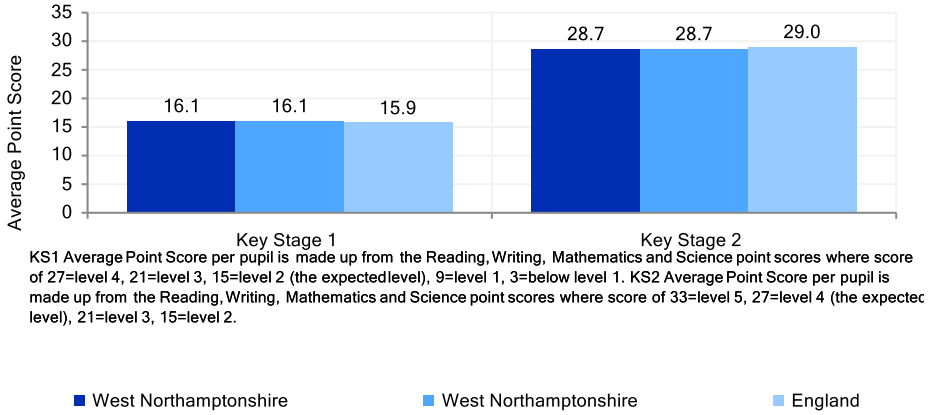
What information is shown here?

The chart on the top right show the education levels of pupils in West Northamptonshire, showing the examination results at Key Stage 1 (tests set at aged 7) Key Stage 2 (tests set at aged 11) and Key Stage 4 (GCSEs).

The figures show the Average Point Score of pupils from each of the Key Stage examinations. This adjusts for high achieving pupils as well as pupils achieving expected levels.

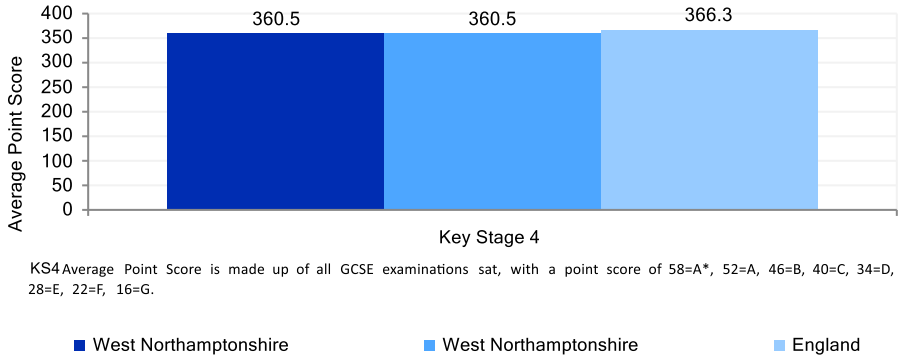
The chart on the top right shows Average Point Score (across all examinations) per pupil at Key Stage 1 and Key Stage 2. The chart on the bottom right compares the gap in Average Point Score at Key Stage 4 (GCSE) per pupil between West Northamptonshire and the national average over time. The gap is measured as the point difference against the England average. Areas with a score of greater than 1 are performing better than the national average, while areas with a score of less than 1 are performing below.

Figure: Pupil attainment at Key Stage 1 and Key Stage 2
Source: Department for Education (2013-2014)



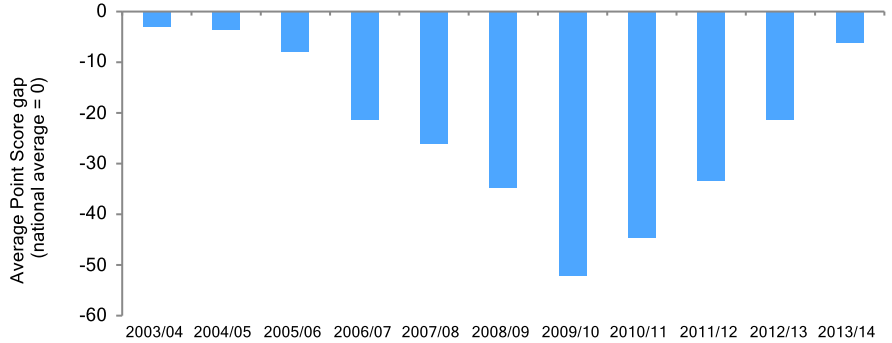
KS1 Average Point Score per pupil is made up from the Reading, Writing, Mathematics and Science point scores where score of 27=level 4, 21=level 3, 15=level 2 (the expected level), 9=level 1, 3=below level 1. KS2 Average Point Score per pupil is made up from the Reading, Writing, Mathematics and Science point scores where score of 33=level 5, 27=level 4 (the expected level), 21=level 3, 15=level 2.

Figure: Pupil attainment at Key Stage 4
Source: Department for Education (2013-2014)



KS4 Average Point Score is made up of all GCSE examinations sat, with a point score of 58=A*, 52=A, 46=B, 40=C, 34=D, 28=E, 22=F, 16=G.

Figure: Gap in pupil attainment at Key Stage 4 (difference from the national average)
Source: Department for Education



Scores above 0 show an improvement on the National average. Average Point Score is made up of all GCSE examinations sat, with a point score of 58=A*, 52=A, 46=B, 40=C, 34=D, 28=E, 22=F, 16=G.

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What information is shown here?

The information on this page looks at four types of income category: average household income; average equivalised household income after housing costs; households living in fuel poverty and median net equivalised household PAYE and benefits income. Fuel poverty is said to occur when in order to heat its home to an adequate standard of warmth a household needs to spend more than 10% of its income on total fuel use.

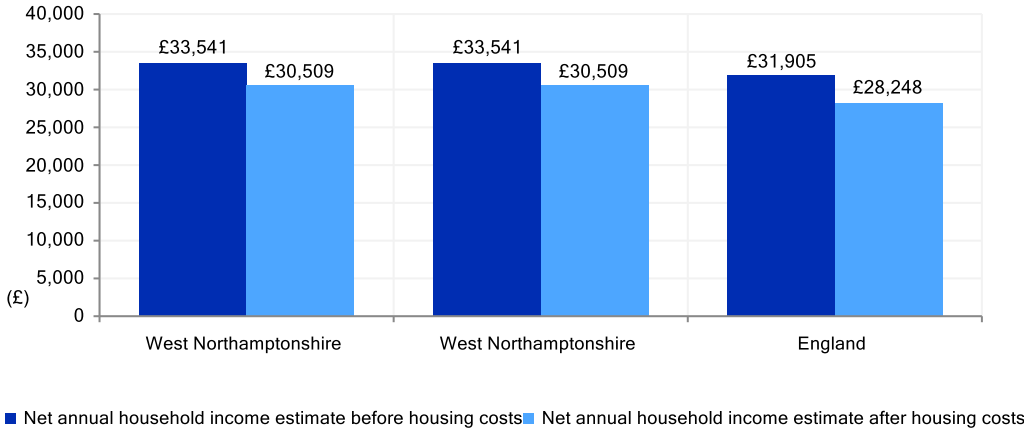
The information boxes on the top right provide an estimate of the number of households in West Northamptonshire below the poverty line and an estimate for the number of households in fuel poverty.

The chart on the right shows the average annual household income estimate (equivalised to take into account variations in household size) across West Northamptonshire and comparator areas before and after housing costs.

Annual household income (Office for National Statistics 2017/18)	Annual household income, after housing costs (Office for National Statistics 2017/18)	Households living in 'Fuel Poverty' Department for Business, Energy and Industrial Strategy (2020)
£44,968	£30,509	19,855
England Average = £43,966	England Average = £28,248	11.9% of households (England = 13.2%)

Median net equivalised household PAYE and benefits income (Office for National Statistics 2015/16)
£25,143
England Average = £24,577

Figure: Annual household earnings (£)
Source: Office for National Statistics (2017/18)



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What information is shown here?

The levels of private debt, in the form of unsecured loans and mortgage debt per head, for West Northamptonshire are displayed here.

These figures, available at postcode sector level, are published by UK Finance and account for around 60% of borrowing in the UK. OCSI have modelled this data to Output Areas using an address-based lookup from postcode sector to Output Area in combination with the number of local households and the local population.

The personal debt figure is the total amount of borrowing outstanding on customer accounts divided by the population aged 18+. Personal debt includes all unsecured loans such as credit cards, credit for new cars (eg when buying on finance) and other personal loans. Student debt is not included.

The mortgage debt figure is the total borrowing outstanding on customer accounts for residential mortgages divided by the total number of households.

The SME debt figure is the total amount of borrowing outstanding on customer accounts for Small and Medium-sized enterprises divided by the population aged 18+.

Personal debt per head	Residential mortgage debt per head	SME lending debt per head
£767.0	£49735.0	£2565.0
England Average = £575.8	England Average = £44001.7	England Average = £2101.0

Source: UK Finance (Sep-21)

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What information is shown here?

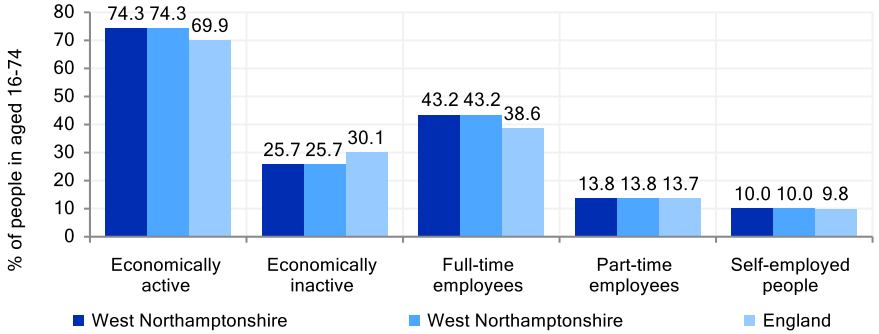
The information on this page shows economic activity breakdowns for adults aged 16-74 in West Northamptonshire.

The data in the information boxes shows the number and proportion of residents who are economically active, with breakdowns for those working part time, full time or are self-employed (*note, these figures do not add up to all those economically active as it excludes those economically active who are unemployed or full-time students*).

Economically active	Full-time employees	Part-time employees	Self-employed people	Economically inactive
204,474	119,019	37,934	27,547	70,908
74.3% (England average = 69.9%)	43.2% (England average = 38.6%)	13.8% (England average = 13.7%)	10.0% (England average = 9.8%)	25.7% (England average = 30.1%)

Source: Census 2011

Figure: Economic Activity
Source: Census 2011



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What information is shown here?

The information on this page shows breakdowns of the main industry sectors people in West Northamptonshire are working in, and their occupational status.

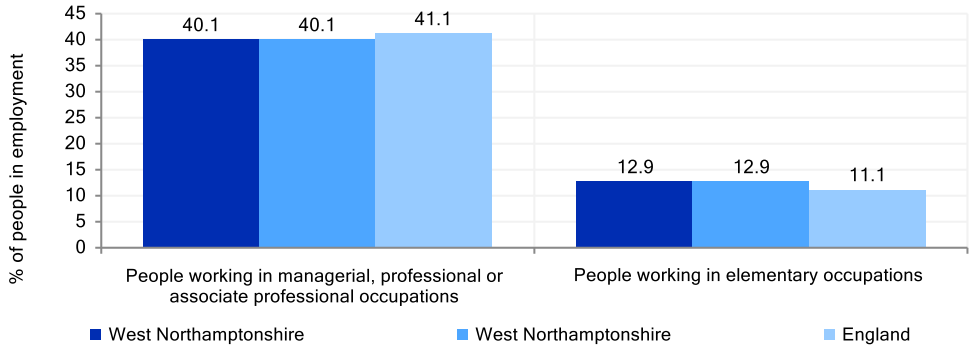
The data in the top information boxes shows the three largest employment sectors for residents in the local area, also the number and percentage of employed people working in each of these sectors. The lower information boxes and the chart on the right show the numbers of residents in West Northamptonshire by type of occupation (e.g., managers, professional, administrative).

Largest employment sector	Second largest employment sector	Third largest employment sector
Retail	Health & social work	Manufacturing
34,991 employees (18% of 192,068 of people in employment)	21,951 employees (11% of 192,068 of people in employment)	20,051 employees (10% of 192,068 of people in employment)

Managerial occupations	Professional (or associate) occupations	Administrative or secretarial occupations	Skilled trades occupations	Elementary occupations
22,933	54,138	23,601	21,238	24,722
11.9% of 192,068 people in employment (England = 10.9%)	28.2% of 192,068 people in employment (England = 30.3%)	12.3% of 192,068 people in employment (England = 11.5%)	11.1% of 192,068 people in employment (England = 11.4%)	12.9% of 192,068 people in employment (England = 11.1%)

Source: Census 2011

Figure: People in professional and elementary occupations
Source: Census 2011



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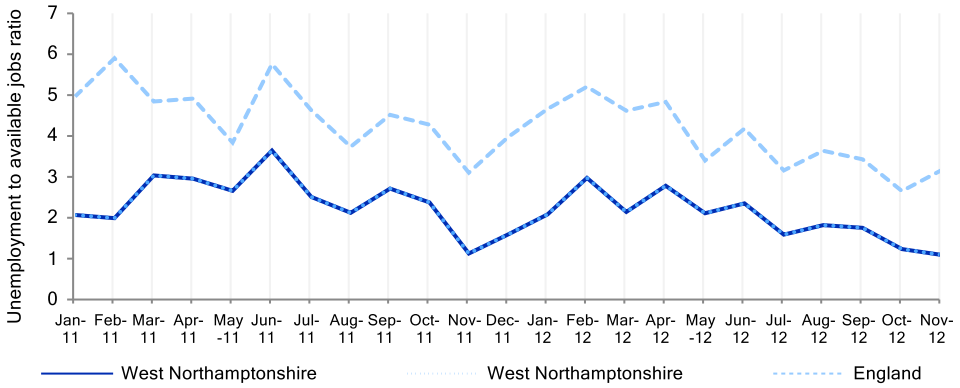
What information is shown here?

The information on this page shows the number of vacant jobs in West Northamptonshire compared against the overall unemployment levels in the area.

The 'Unemployment to 'Available Jobs' ratio, shown in the information box on the right and the line chart below is the total number of people claiming unemployment benefit (Jobseekers Allowance) divided by the total number of job vacancies notified to Jobcentre Plus expressed as a ratio.

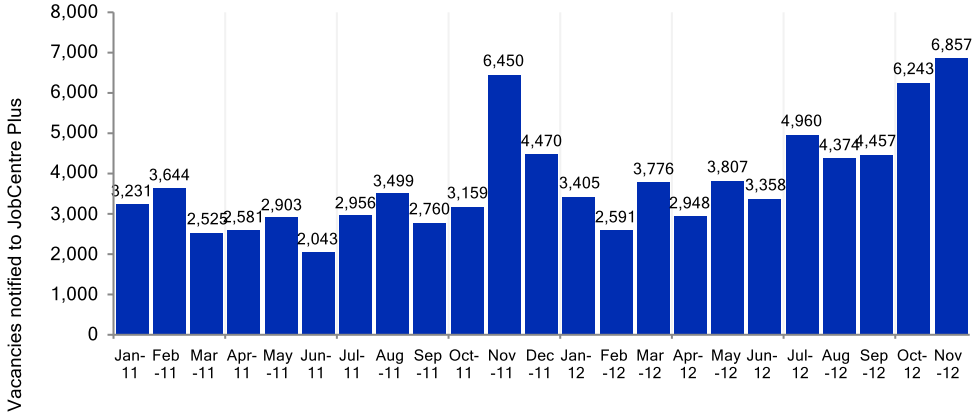
The bar chart on the bottom right shows month-on-month changes in the number of job vacancies notified to Jobcentre Plus, that are located in the area covering West Northamptonshire (based on postcode location of the job). *Note, this data was last updated by Jobcentre Plus for November 2012.*

Figure: Ratio of unemployment (JSA claimants) to jobs (vacancies notified to Jobcentre Plus
Source: Office for National Statistics/Job Centre Plus, Department for Work and Pensions



Unemployment to 'Available Jobs' ratio	Source: Job Centre Vacancies - Office for National Statistics/Jobcentre Plus (Nov-12), Jobseekers Allowance claimant count – Department for Work and Pensions (Nov-12)
1.35 claimants per job	
England average = 3.43	

Figure: Total number of vacancies notified to Job Centre
Source: Office for National Statistics/Job Centre Plus



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What information is shown here?

The information in this section shows the concentration of workforce jobs in West Northamptonshire. Workforce jobs are taken from the Business Register and Employment Survey (BRES) which publishes employee and employment estimates based on a survey of approximately 80,000 businesses and weighted to represent all sectors of the UK economy.

The information boxes show the three largest industry groups for workforce jobs based in West Northamptonshire. The bar chart on the top right shows the change in 'Jobs Density' (the number of jobs as a % of working age population) across West Northamptonshire over time. The bar chart on the bottom right shows the share of jobs broken down by public and private sector.

Largest industry sector	Second largest industry sector	Third largest industry sector
Transport	Health	Business administration & support services
12.4% of all people in employment	11.5% of all people in employment	8.7% of all people in employment

Source: Business Register and Employment Survey (BRES) (2020)

Figure: Jobs Density (jobs as a % of working age population) (2020)
Source: Business Register and Employment Survey (BRES)

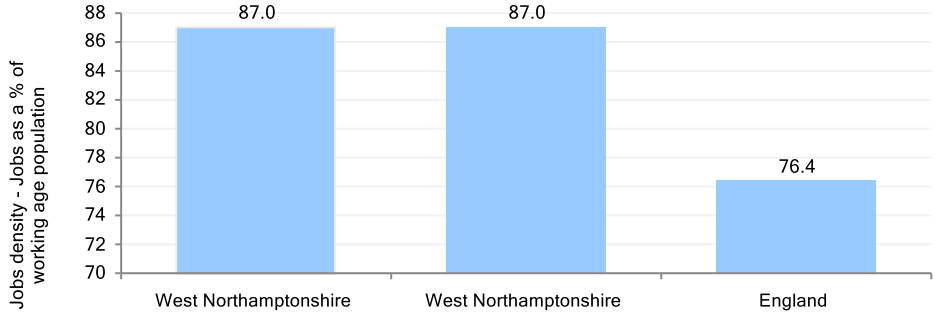
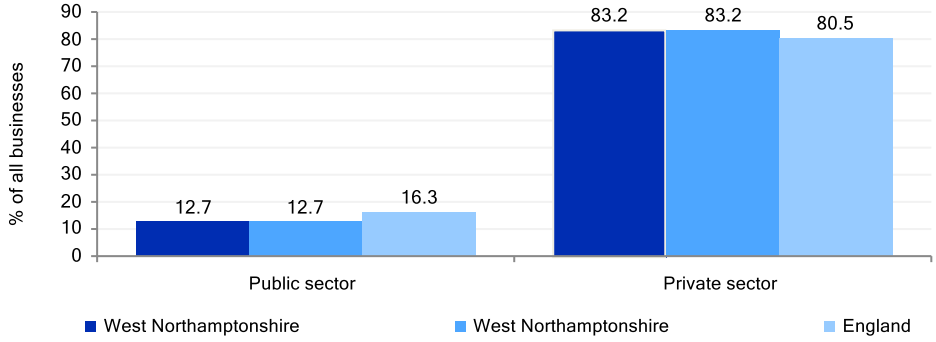


Figure: Jobs by public sector/private sector (2020)
Source: Business Register and Employment Survey (BRES)



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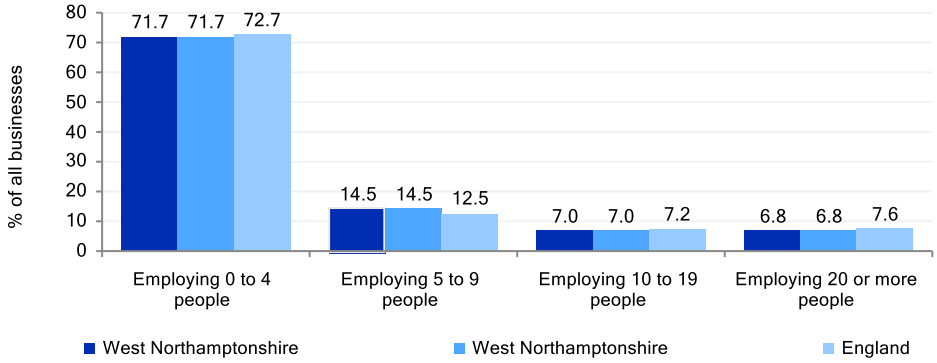
What information is shown here?

The information in this section shows the concentration of 'local business units' in West Northamptonshire. 'Local business units' are counts of businesses based on the location of an operational unit. Though larger businesses such as supermarket chains may have their head office in a large city, these figures measure all subsidiaries of that larger enterprise based on where subsidiaries are located. The figures cover all business eligible for VAT (1.7 million businesses in the UK are registered for VAT). These businesses are categorised into 16 broad industry groups derived from the Standard Industrial Classification (UKSIC (2003)).

The information boxes show the three largest industry groups for businesses based in West Northamptonshire. The line chart shows the change in the number of businesses per head of the population across West Northamptonshire over time. The bar chart shows the count of local business broken down by size of business. Businesses are broken down into four employment size bands based on the number of paid employees (0-4, 5-9, 10-19 and 20+ paid employees).

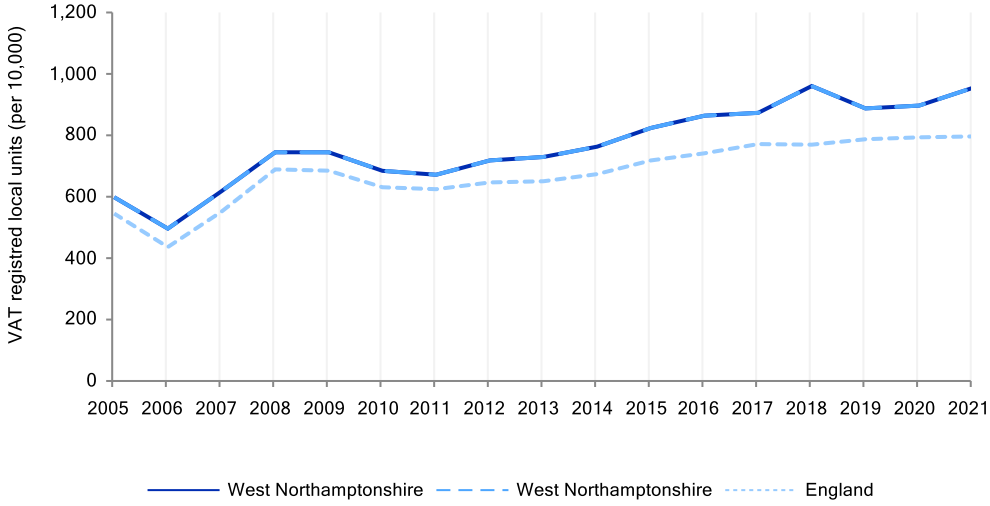
Figure: Businesses (VAT based local units) by employment size band (2021)
Source: Office for National Statistics



Largest business sector	Second largest business sector	Third largest business sector
Transport	Professional, scientific & technical services	Construction
13.4% of all local businesses	13.3% of all local businesses	12.5% of all local businesses

Source: Office for National Statistics (2021)

Figure: Businesses (VAT based local units) per 10,000 working age population
Source: Office for National Statistics



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What information is shown here?

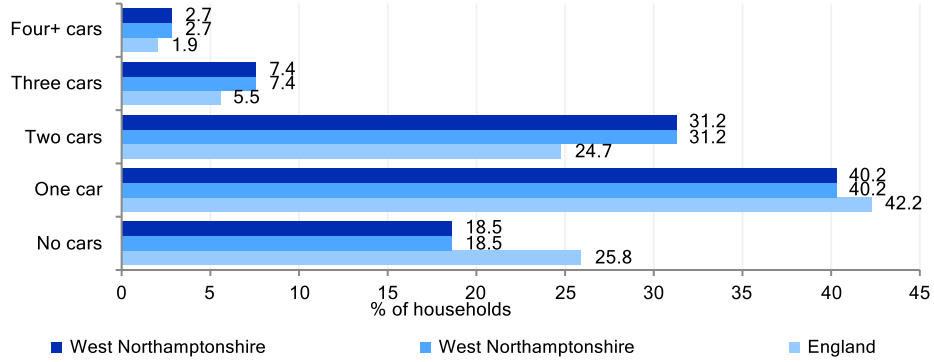
The information on the right shows details of the number of cars and vans in each household in West Northamptonshire. The count of cars or vans in an area is based on details for private households only. Cars or vans used by residents of communal establishments are not counted.

The information boxes show the number of households by number of cars owned across West Northamptonshire, while the charts show the same information (expressed as a percentage) against comparator areas.

No cars	One car	Two cars	Three cars	Four + cars
28,655	62,325	48,345	11,530	4,240
18.5% of 155,095 households (England = 25.8%)	40.2% of 155,095 households (England = 42.2%)	31.2% of 155,095 households (England = 24.7%)	7.4% of 155,095 households (England = 5.5%)	2.7% of 155,095 households (England = 1.9%)

Source: Census 2011

Figure: Car ownership
Source: Census 2011



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What information is shown here?

The information on this page shows the accessibility of key services and amenities to people living in West Northamptonshire. Accessibility is measured both in terms of distance and travel times to key services.

The information boxes on the right show average distances (in kilometres) to five key services. The chart on the right shows average travel times in minutes to key services when walking or taking public transport.

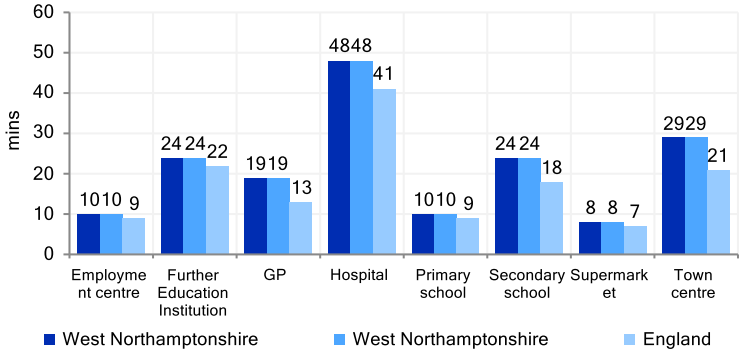
The final information box on the right shows the overall Job access score. This measure of connectivity developed by UK Onward includes the number of jobs accessible by car and public transport from every local area (LSOA) in the country across different time horizons. The metric provides the reachable number of jobs and distance with 15 minutes, 30 minutes, 60 minutes and 90 minutes by both driving and public transport for each LSOA.The data incorporates a “door-to-workplace” measure, including every journey stage from time spent walking to the car, driving, to parking and walking to an office - as well as average delays, timetabling and actual journey time on public transport. These measures have been combined into an overall Jobs access score, the weighted average job count, combining driving and public transport. A higher score indicates greater levels of job accessibility. For more information and a link to the research paper please see here: https://www.ukonward.com/reports/network-effects/

Average road distance from Job Centre	Average road distance from Secondary School	Average road distance from GP	Average road distance from Pub	Average road distance from Post Office
6.7km	2.9km	1.6km	0.9km	1.1km
England average = 4.6km	England average = 2.1km	England average = 1.2km	England average = 0.7km	England average = 1.0km

Job Access Score (2021)
658407.5
698519.5 average = 698519.5

Source: Road distances - Commission for Rural Communities: Distance to Service dataset (2010); UK Onward (2021)

Figure: Average travel time (mins) by walking or public transport to the nearest key service
Source: Department for Transport: Core Accessibility Indicators (2019)



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What information is shown here?

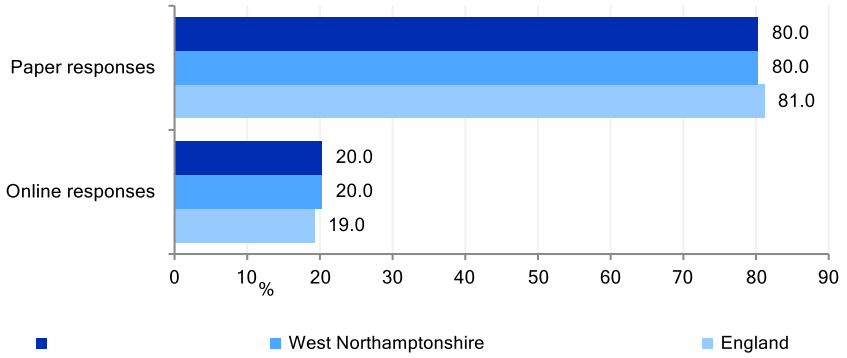
The information on this page shows two measures of access to the internet. The first measure shows information on broadband take-up, speeds and availability. It has been produced by Ofcom and contains data provided by communications providers. The data shows the average broadband line speed in West Northamptonshire and the proportion of premises in West Northamptonshire with broadband speeds below the Universal Service Obligation (USO) (download speeds at or above 10Mbit/s and upload speeds at or above 1Mbit/s including non-matched records and zero predicted speeds).

The chart on the right shows the proportion of people who responded to the 2011 Census online, compared with the proportion that filled in the Census form on paper in West Northamptonshire. This is a proxy measure of digital engagement as areas with a high proportion of online Census responses are more likely to be digitally engaged than those in areas with low levels of online responses.

Premises with broadband speeds below the USO (2019)	Average broadband download speed (Mbit/s) (2020)	Average broadband upload speed (Mbit/s) (2020)
3,750	73.78	15.46
2.1% (England average = 1.8%)	England average = 73.40	England average = 12.74

Source: Ofcom 2019 & 2020

Figure: Census online and paper responses
Source: Census 2011



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What information is shown here?

The information on this page looks at the characteristics of neighbourhoods across West Northamptonshire as defined using the Output Area Classification (OAC). OAC classifies every area in the country based on a set of socio-demographic characteristics, to provide a profile of areas to identify similarities between neighbourhoods. The information boxes on the right show the number and proportion of neighbourhoods in West Northamptonshire that fall within the eight supergroup categories, detailed below. The chart on the right shows the proportion of areas falling within supergroup categories across West Northamptonshire and comparators.

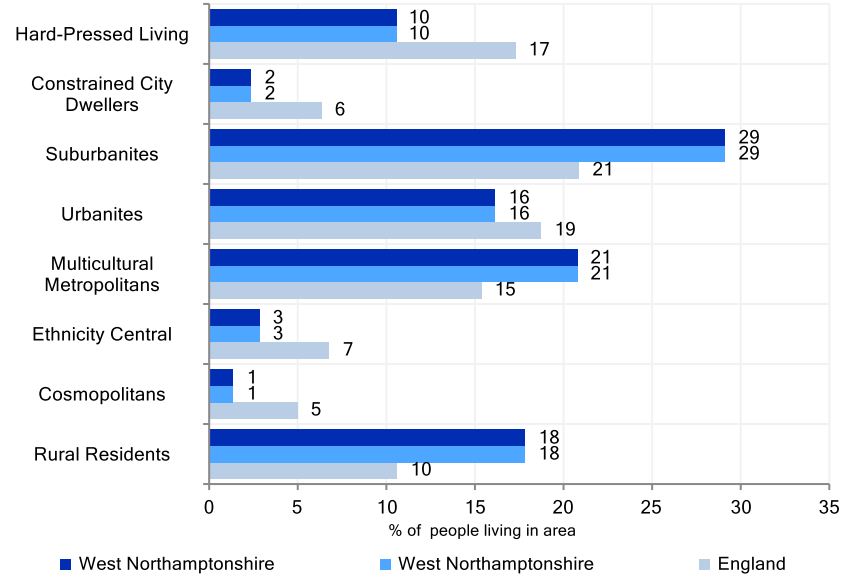
Rural residents	Rural areas, sparsely populated, above average employment in agriculture, higher number owning multiple cars, an older married population, a high provision of unpaid care and an above average number of people living in communal establishments.
Cosmopolitans	Residing in densely populated urban areas, high ethnic integration, high numbers of single young adults without children including students, high public transport use, above average qualification levels
Ethnicity central	Concentrated in Inner London and other large cities, high ethnic diversity, high proportion of rented accommodation, high proportion of people living in flats, low car ownership.
Multicultural metropolitans	Concentrated in larger urban conurbations in the transitional areas between urban centres and suburbia, high proportion of BME groups, high proportion of families.
Urbanites	Predominantly in urban areas with high concentrations in southern England. More likely to live in either flats or terraces that are privately rented.
Suburbanites	Located on the outskirts, in areas with high owner occupation, high numbers of detached houses, low unemployment, high qualifications and high car ownership.
Constrained city dwellers	Higher proportion of older people, households are more likely to live in flats and to rent their accommodation, and there is a higher prevalence of overcrowding, higher proportion of people in poor health, lower qualification levels and high unemployment
Hard-pressed living	Mostly on the fringe of the UK's urban areas, particularly in Wales and the North of England. High levels of people in terraced accommodation, high unemployment, low ethnic diversity, high levels of people employed in manufacturing

Rural residents	Cosmopolitans	Ethnicity central	Multicultural metropolitans
66,387	4,478	10,276	77,657
17.7% (England average = 10.5%)	1.2% (England average = 4.9%)	2.7% (England average = 6.6%)	20.7% (England average = 15.3%)

Urbanites	Suburbanites	Constrained city dwellers	Hard-pressed living
59,982	108,764	8,384	39,173
16.0% (England average = 18.6%)	29.0% (England average = 20.8%)	2.2% (England average = 6.2%)	10.4% (England average = 17.2%)

Source: Office for National Statistics Output Area Classification 2011

Figure: Area Classification 2011: Proportion of people living in different types of neighbourhood (by classification type)
Source: Output Area Classification (2011)



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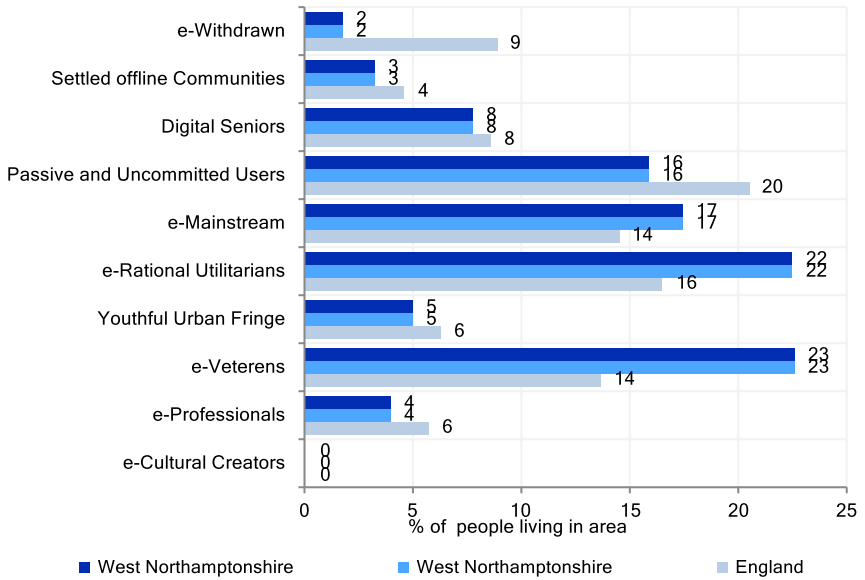
What information is shown here?

The information on this page looks at the classification of neighbourhoods across West Northamptonshire in terms of how they interact with the Internet. The Consumer Data Research Centre (CDRC) have developed an Internet User Classification using data from the British Population Survey (BPS), which provides info on the behavioural characteristics of the population regarding various aspects of internet use, which could be linked with demographic data from the census and supplemented with data from online retailers, on online transactions and infrastructure data from OfCom on download speed. Every LSOA in England has been classified into 10 groups (summarised in the table below). The chart on the right shows the proportion of areas falling within each group across West Northamptonshire and comparators.

Source: *Alexiou, A. and Singleton, A. (2018). ESRC Consumer Data Research Centre; Contains National Statistics data Crown copyright and database right (2017); Ofcom data (2016). CDRC data from Data Partners (2017)*

Figure: Internet User Classification 2018: Proportion of people living in different types of neighbourhood (by classification type)



e-Cultural Creators	High levels of Internet engagement, particularly regarding social networks, communication, streaming and gaming, but relatively low levels of online shopping, besides groceries.
e-Professionals	High levels of Internet engagement, and comprises fairly young populations of urban professionals, typically aged between 25 and 34. They are experienced users and engage with the Internet daily and in a variety of settings.
e-Veterans	Affluent families, usually located within low-density suburbs, with populations of mainly middle-aged and highly qualified professionals. Higher levels of engagement for information seeking, online services and shopping, less for social networks or gaming.
Youthful Urban Fringe	Reside at the edge of city centres and deprived inner city areas, ethnically diverse, young, large student and informal household populations, access via mobile devices. High levels of Internet engagement are average over-all, with high levels of social media usage
e-Rational Utilitarians	Comprising mainly rural/semi-rural areas with higher than average retired populations, constrained by poor infrastructure. Users undertake online shopping, the Internet is used as a utility rather than a conduit for entertainment.

e-Mainstream	Exhibit typical Internet user characteristics in heterogeneous neighbourhoods at the periphery of urban areas or in transitional neighbourhoods.
Passive and Uncommitted Users	Limited or no interaction with the Internet. They tend to reside outside city centres and close to the suburbs or semi-rural areas. Higher levels of employment in semi-skilled and blue-collar occupations.
Digital Seniors	Typically White British, retired and relatively affluent. Average use of the Internet, typically using a personal computer at home. Despite being infrequent users, they are adept enough to use the Internet for information seeking, financial services and online shopping.
Settled offline Communities	Elderly, White British, in semi-rural areas. They undertake only limited engagement with the Internet, they may have only rare access or indeed no access to it at all.
e-Withdrawn	Least engaged with the Internet. Deprived neighbourhoods of urban regions. Highest rate of unemployment and social housing among all Lowest rates of engagement in terms of information seeking and financial services, as well as the lowest rate in terms of online access via a mobile device.

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Communities and environment: Neighbourhood satisfaction & local participation (1) 61

What information is shown here?

The information on this page shows different measures of people's satisfaction with their neighbourhood and their sense of community cohesion in the neighbourhood. It also shows different measures of people's participation in volunteering and political decision making in the local area. In addition, the information box on the far bottom right shows the number of registered charities per 1,000 population. This is based on location of charities rather than areas where they operate, some of which will have a global focus.

Figures are self-reported and taken from the Place Survey. *The Place survey is collected at Local Authority level so does not include neighbourhood information, and ceased nationally in 2008 so is increasingly out of date.*

"People from different backgrounds get on well together in the local area"	People who feel that they belong to their neighbourhood	People who are satisfied with local area as a place to live	Aged 65+ "satisfied with both home and neighbourhood"
76%	56%	79%	82%
(England = 76%)	(England = 58%)	(England = 79%)	(England = 83%)

People involved in decisions that affect the local area in the past 12 months	People who believe they can influence decisions in their local area	People who have given unpaid help at least once per month over the last 12 months	Total registered charities (2021)
13%	25%	24%	3.1 per 1,000 population
(England = 14%)	(England = 29%)	(England = 23%)	(England = 2.8 per 1,000)

Source: Place Survey / Charity Commission

Figure: Indicators of civic engagement
Source: Place Survey (2008)

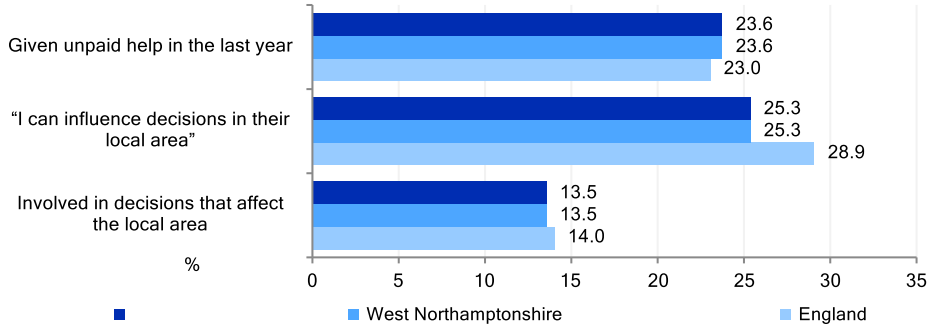
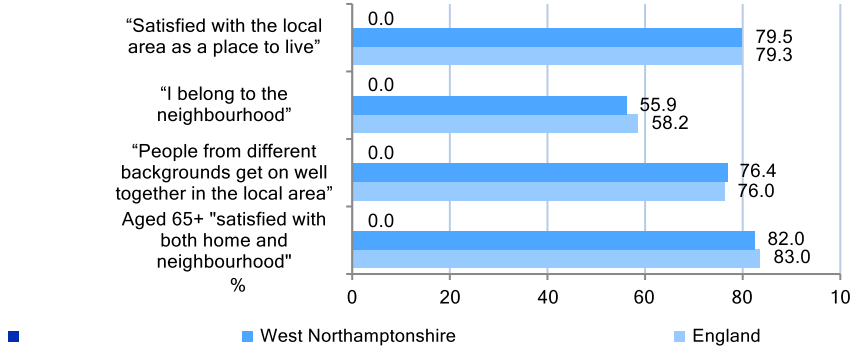


Figure: Indicators of community strength
Source: Place Survey (2008)



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Communities and environment: Neighbourhood satisfaction & local participation (2) 62

What information is shown here?

The page shows the Community Dynamics indicators for West Northamptonshire. The Community Dynamics data set (https://www.communitydynamics.social-life.co/) has been developed by Social Life with the aim of quantifying how people feel about the area they live in.

By modelling responses from the annual Community Life Survey and Understanding Society Survey to Output Areas, Social Life have created small area measures of: **strength of local social relationships**, **strength of belonging to a local area** and **satisfaction with a local area as a place to live**. Positive values represent greater belonging/relationship strength/satisfaction than the national average. Negative figures represent less belonging/relationship strength/satisfaction than the national average.

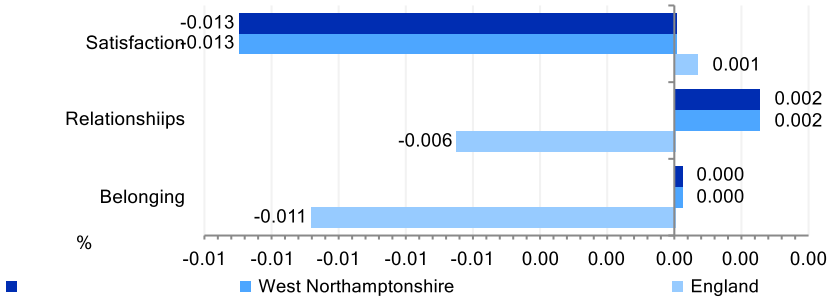
Please note that these indicators have been created by combining the survey responses of samples of the population and modelling these to Output Areas by linking survey sample demographics to the demographics of Output Areas. As a result, many implicit assumptions are built into the data which will not hold for all areas. The values presented here offer an indication of community belonging, strength and satisfaction rather than an absolute measure.

The fourth information box shows the valid voter turnout (%) at the most recent Local Council Elections. Because the electoral cycle varies in different parts of the country (with associated impacts on turnout) the turnout figures from previous years have been adjusted either upwards or downwards from the 2019 average. This is in order to reflect variation in turnout across different years. For example if turnout was 30% in 2018 and 35% in 2019 than each area in 2018 would be revised upwards using the following calculation 35/30 = 1.166*2018 turnout.

Local social relationships	Belonging	Satisfaction with local area as a place to live	Voter Turnout at Local Elections (%)
0.002	0	-0.013	29.2
(England = -0.006)	(England = -0.011)	(England = 0.001)	(England = 33%)

Figure: Community Dynamic scores for belonging, relationships and satisfaction
Source: Social Life (modelled from the annual Community Life Survey), 2015/2016

Electoral Commission (2019)



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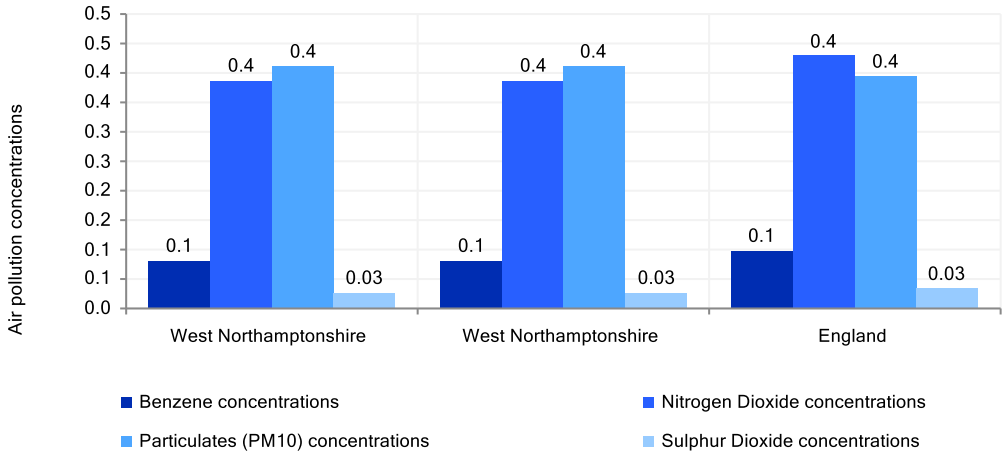
What information is shown here?

The information on this page shows background concentrations from four air pollutants: nitrogen dioxide, benzene, sulphur dioxide and particulates. The air quality data was collected for 2016 on a 1km grid and obtained from the UK National Air Quality Archive for use in the Indices of Deprivation 2019. A higher score indicates a higher concentration of the pollution with a score of greater than 1 indicating that the levels of pollution exceed national standards of clean air.

The fifth information box shows the total carbon footprint per person in units of kilogrammes of carbon dioxide equivalent. This data is sourced from the place-based carbon calculator. For more information please visit: https://www.carbon.place/.

Figure: Air pollution concentrations for four pollutants

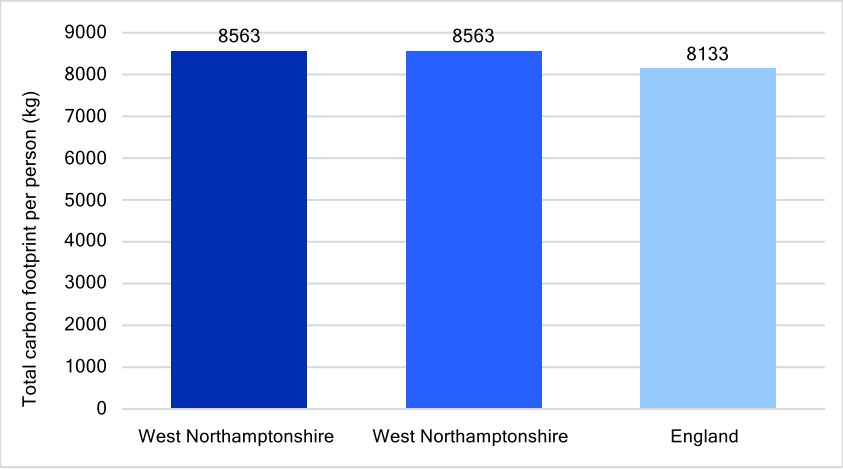


Source: Communities and Local Government (Indices of Deprivation 2019 – from National Air Quality Archive 2016)

Benzene concentrations	Nitrogen Dioxide concentrations	Particulates (PM10) concentrations	Sulphur Dioxide concentrations	Total carbon footprint per person (kg)
0.08	0.4	0.4	0.03	8563
(England average = 0.10)	(England average = 0.4)	(England average = 0.4)	(England average = 0.03)	(England average = 8133)

Source: Communities and Local Government (Indices of Deprivation 2019 - from National Air Quality Archive 2016), PBCC 2021, Morgan, Malcolm, Anable, Jillian, & Lucas, Karen. (2021). A place-based carbon calculator for England (https://www.carbon.place/about/)

Figure: Total carbon footprint per person (kg), Source: PBCC 2021



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What information is shown here?

Ordnance Survey (OS) publish the locations and extent of green spaces that are likely to be accessible to the public. The data include the following types of green spaces: allotments or community growing spaces, bowling greens, cemeteries, religious grounds, golf courses, other sports facilities, play spaces, playing fields, public parks or gardens and tennis courts.

OCSI have intersected OS Open Greenspaces data with Output Area boundaries to produce data for the greenspace per standard geographical area (eg OA, LSOA, LA).

Two green space measures are shown here. The **total green space** (which includes all types of green space) and the **public parks and gardens green space** (only public parks and gardens).

Large rural areas such as National Parks are not included in the OS Greenspace dataset. Religious grounds are included where there is seen to be a significant amount (>500m2) of accessible greenspace. Sports stadiums and grounds which are primarily for spectating rather than participating in sports are not included. Playing fields should only be included in OS Greenspace dataset where they are used by the public at least some of the time. Playing fields such as school fields which are entirely enclosed and only for use of the school, would not be expected to be included.

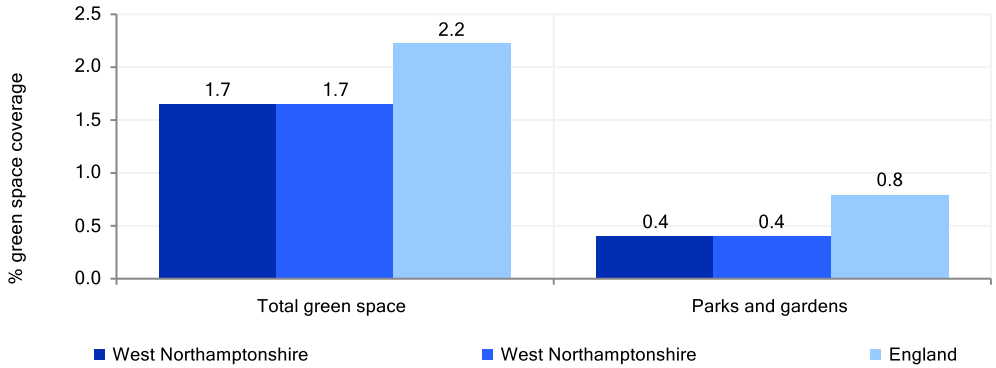
Wooded areas that function as public parks (i.e. are freely accessible to the public in their entirety and are managed for recreation) should be included, however, the constraints of the capture method employed to create the data mean that in many cases these may not yet be included.

OS data © Crown copyright and database right 2017

Total green space	Public parks and gardens greenspace
1.7%	0.40%
2280.8 hectares (England average = 2.2%)	553.4 hectares (England average = 0.8%)

Source: OS data © Crown copyright and database right 2017

Figure: Percentage of green space coverage
Source: OS data © Crown copyright and database right 2017



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What information is shown here?

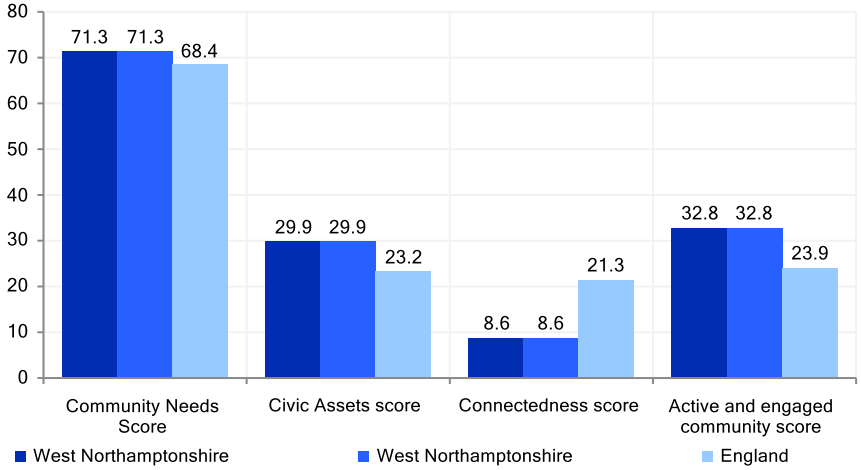
The Community Needs Index that was developed to identify areas experiencing poor community and civic infrastructure, relative isolation and low levels of participation in community life. The index was created by combining a series of 19 indicators, conceptualised under three domains: Civic Assets, Connectedness and Active and Engaged Community. A high score indicates that the area has high levels of need.

- Civic Assets: measures the presence of key community, civic, educational and cultural assets in a close proximity of the area. These include pubs, libraries, green space, community centres, swimming pools – facilities that provide things to do often, at no or little cost, which are important to how positive a community feels about its area.
- Connectedness: measures the connectivity to key services, digital infrastructure, isolation and strength of the local jobs market. It looks at whether residents have access to key services, such as health services, within a reasonable travel distance. It considers how good public transport and digital infrastructure are and how strong the local job market is.
- Active and Engaged Community: measures the levels of third sector civic and community activity and barriers to participation and engagement. It shows whether charities are active in the area, and whether people appear to be engaged in the broader civic life of their community.

Community Needs Score	Civic Assets score	Connectedness score	Active and engaged community score
71.3	29.9	8.6	32.8
(England average = 68.4)	(England average = 23.2)	(England average = 21.3)	(England average = 23.9)

Source: Oxford Consultants for Social Inclusion (OCSI) and Local Trust (https://localtrust.org.uk/insights/research/left-behind-understanding-communities-on-the-edge/)

Figure: Community Needs Index
Source: Oxford Consultants for Social Inclusion (OCSI) and Local Trust (2019)



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What information is shown here?

This page looks at funding and includes data on the National Lottery Fund and grant funding from national grant giving organisations.

National Lottery Community Fund figures on this page are taken from data on grants made to projects and organisations in local areas in the UK by the National Lottery Fund, modelled down to standard statistical geographies from ward grants data published by Big Lottery in conjunction with the 360Giving initiative. National Lottery used the 360Giving standard to produce a dataset of all the grants made from 2004-2021. Please note this excludes grants greater than 1 million in order to focus on community grants.

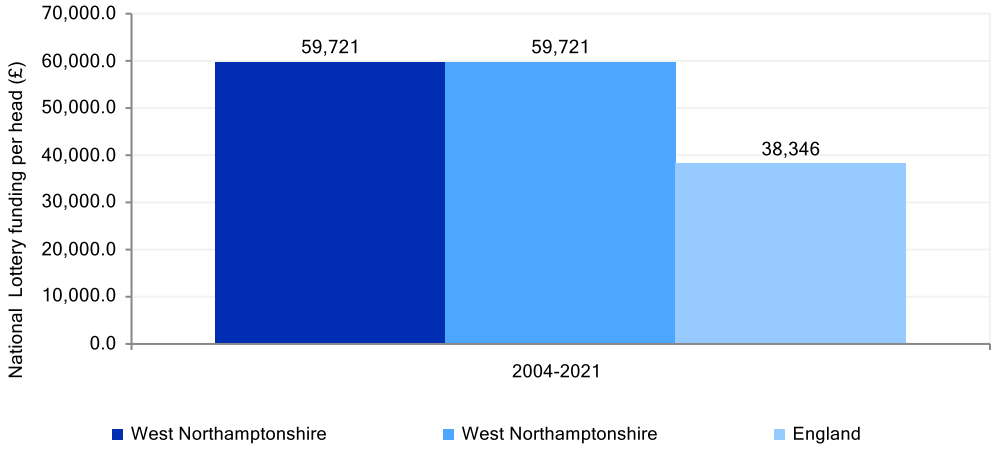
The fourth information box shows the total combined grant funding from the largest national grant giving organisations whose data has been subject to the 360giving standard. The data is based on the location of grant recipients rather than the location of beneficiaries. Organisations included: Sport England, The Henry Smith Charity, The Tudor Trust, Lloyds Bank Foundation for England and Wales, Barrow Cadbury Trust, Department for Transport, Esmée Fairbairn Foundation, Masonic Charitable Foundation, Nationwide Foundation, Co-operative Group, Paul Hamlyn Foundation, Woodward Charitable Trust, Power to Change, The Dulverton Trust, Virgin Money Foundation, The Clothworkers Foundation, A B Charitable Trust, Seafarers UK, Three Guineas Trust, Nesta, The Joseph Rank Trust, National Churches Trust, LandAid Charitable Trust, True Colours Trust, Pears Foundation, Wates Family Enterprise Trust, The Blagrave Trust, Tuixen Foundation, Samworth Foundation, Tedworth Charitable Trust, Road Safety Trust, Wates Foundation, Staples Trust, The David & Elaine Potter Foundation, Gatsby Charitable Foundation and ZING.

For more information on the 360Giving data format and initiative please visit www.threesixtygiving.org/

National Lottery Community funding per 1,000 population (2004-2021)	National Lottery Community Fund (Individual grants issued per 10,000 population) (2004-2021)	Total grants awarded from major funders (in £1000s) (2019)
£24,290,570	1,006	£05,830,288
(£59721 per 1,000) England average = £38346 per 1,000	(25 per 10,000) England average = 30 per 10,000	(£14 per head) England average = £34 per head

Source: National Lottery, 360Giving

Figure: National Lottery grant funding per 1,000 population, 2004-2021
Source: National Lottery, 360Giving, 2021



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Appendix A: About the data and geographies used in this report

How we have identified the "West Northamptonshire" area

This report is based on the definition of the "West Northamptonshire" area (this area can be viewed on the Local Insight map, through finding the area on the 'show services' dropdown in the top left hand corner of the map. We have aggregated data for all the neighbourhoods in "West Northamptonshire" to create the data used in this report.

Alongside data for the "West Northamptonshire" neighbourhood we also show data for selected comparator areas.

Data in this report is based on regularly updated open data published by government sources

All the data in this report is based on open data published by more than 50 government agencies, collected and updated by OCSI on weekly basis. Data is updated on regular basis, with the reports and mapped data on the website reflecting the latest available data.

Details of the individual datasets are provided on the pages where the data is presented, with information on dates and sources presented alongside the charts and tables. On the website, information about each source is available on the popup "About the indicator" link at the top-right of the map.

Standard geographies used in this report

Super Output Areas (SOAs): SOAs are a statistical geography created for the purpose of presenting data such as the Census, Indices of Deprivation, and other neighbourhood statistics. There are two layers to the SOA geography: 'lower layer' (LSOA) and 'middle layer' (MSOA). SOAs are designed to produce areas of roughly equal population size - 1,500 people for LSOAs and 7,200 for MSOAs. The majority of data used in this report is based on LSOA boundaries; of which there are 32,844 in England (there were changes to around 4% of LSOA definitions in Census 2011).

Output Areas (OAs): OAs are a more detailed statistical geography than SOAs, with each covering around 300 people, or 120 households. There are 171,372 OAs in England (there were changes to around 5% of OA definitions in Census 2011).

Wards: A small number of datasets are published at ward level. These are on average four times larger than LSOAs. Data is less detailed than LSOA level datasets and wards vary greatly in size, from less than 200 residents (Isles of Scilly), to more than 36,000 residents (in Sheffield).

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Appendix B: Data source details by theme

Theme	Data	Data source/ time period	Date published	Date next update
Population	Total population and by age	Mid-Year Estimates (ONS) 2020	Annually (published September 2021)	Sep-22
	Population by ethnicity	Census 2011	10 yearly (published August 2013)	2023
	Population by country of birth	Census 2011	10 yearly (published August 2013)	2023
	Population by household language	Census 2011	10 yearly (published August 2013)	2023
	People who have moved address within the last 12 months	Census 2011	10 yearly (published August 2013)	2023
	National Insurance no. registrations of overseas nationals	DWP 2020/21	Annually (published May 2021)	June-22
	Level of inward and outward migration (by age)	ONS 2010	Irregular (published 2011)	No publication date confirmed
	Population by household composition	Census 2011	10 yearly (published August 2013)	2023
	Population by religion	Census 2011	10 yearly (published August 2013)	2023
Vulnerable groups	Unemployment benefit (JSA and Universal Credit)	DWP Apr-22	Monthly (published May 2022)	Jun-22
	Jobseekers Allowance claimants, claiming for over 12 months	DWP Apr-22	Monthly (published May 2022)	Jun-22
	Youth unemployment (18-24 receiving JSA or Universal Credit)	DWP Apr-22	Monthly (published May 2022)	Jun-22
	Older person unemployment (50+ receiving JSA or Universal Credit)	DWP Apr-22	Monthly (published May 2022)	Jun-22
	Unemployment benefit (JSA and Universal Credit), male	DWP Apr-22	Monthly (published May 2022)	Jun-22
	Unemployment benefit (JSA and Universal Credit), female	DWP Apr-22	Monthly (published May 2022)	Jun-22
	Universal Credit claimants: Employment indicator	DWP Mar-22	Monthly (published May 2022)	Jun-22
	Working age workless benefit claimants	DWP Nov-21	Quarterly (published May 2022)	Aug-22
	Incapacity Benefit claimants	DWP Nov-21	Quarterly (published May 2022)	Aug-22
	Disability Living Allowance claimants	DWP Nov-21	Quarterly (published May 2022)	Aug-22
	Attendance Allowance claimants	DWP Nov-21	Quarterly (published May 2022)	Aug-22
	Personal Independence Payments (PIP)	DWP Jan-22	Quarterly (published December 2021)	Apr-22
	Universal Credit household breakdowns	DWP Feb-22	Quarterly (published May 2022)	Aug-22
	Universal Credit by Conditionality	DWP Apr-22	Monthly (published May 2022)	Jun-22
	Income Support (IS) claimants	DWP Nov-21	Quarterly (published May 2022)	Aug-22
	Housing Benefit claimants	DWP Nov-21	Quarterly (published May 2022)	Aug-22
	Universal Credit claimants	DWP Apr-22	Monthly (published May 2022)	Jun-22
	Indices of Deprivation (ID) 2019 by domain	MHCLG (Indices of Deprivation 2019)	Irregular (September 2019)	
	Children in low income families	DWP 2020	Annual (published March 2022)	Apr-23
	Children in lone parent households	DWP 2012	Irregular	No publication date confirmed
	Children in poverty	DWP 2016	Annually (published December 2018)	Delay in publication
	Child Wellbeing Index	CLG (Child Wellbeing Index 2009)	Irregular (published 2009)	No publication date confirmed
	Private pensioner households with no car or van	Census 2011	10 yearly (published August 2013)	2023

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	Households of one pensioner	Census 2011	10 yearly (published August 2013)	2023
	Pension credit claimants	DWP Nov-21	Quarterly (published May 2022)	Aug-22
	State Pension total claimants	DWP Nov-21	Quarterly (published May 2022)	Aug-22
	Loneliness index	Age UK 2011	Irregular (published January 2016)	No publication date confirmed
	Mental health related benefits	DWP Nov-21	Quarterly (published May 2022)	Aug-22
	Households suffering multiple deprivation	Census 2011	10 yearly (published August 2013)	2023
	Household is not deprived in any dimension	Census 2011	10 yearly (published July 2014)	No publication date confirmed
	Household is deprived in 1 dimension	Census 2011	10 yearly (published July 2014)	No publication date confirmed
	Household is deprived in 2 dimensions	Census 2011	10 yearly (published July 2014)	No publication date confirmed
	Household is deprived in 3 dimensions	Census 2011	10 yearly (published July 2014)	No publication date confirmed
	People providing unpaid care	Census 2011	10 yearly (published August 2013)	2023
	Unpaid care (50+ hours per week)	Census 2011	10 yearly (published August 2013)	2023
Housing	Dwelling type breakdowns	Census 2011	10 yearly (published August 2013)	2023
	Housing tenure breakdowns	Census 2011	10 yearly (published August 2013)	2023
	Average house prices by housing type	Land registry Mar-21 to Feb-22	Quarterly (published April 2022)	Jul-22
	Households by Council Tax Band	Valuation Office Agency (VOA) 2021	Annually (published September 2021)	Sep-22
	Housing affordability gap, average house prices and savings ratio	ONS House Price Statistics for Small Areas; ONS earnings data 2015/2016	Irregular (published April 2018)	Earnings data April-19
	Population density (persons / hectare)	ONS 2016	Annually (published November 2018)	
	Housing Environment	Census 2011	10 yearly (published August 2013)	2023
	Dwelling size	Census 2011	10 yearly (published August 2013)	2023
	Electricity and Gas consumption	Department for Business, Energy and Industrial Strategy, 2020	Annually (published January 2022)	Jan-23
	Households not connected to the gas network	Department for Energy and Climate Change (DECC) 2019	Annually (published January 2021)	January 2022
	Energy efficiency ratings	MHCLG. Data collected between 2017-2021	Irregular (published Apr-22)	
	Communal establishments by type	Census 2011	10 yearly (published August 2013)	2023
Crime and safety	Recorded crime offences	Police UK Mar-21 to Feb-22	Quarterly (published April 2022)	Jul-22
Health and wellbeing	Life expectancy	ONS 2015-2019	Irregular (published 2021)	No publication date confirmed
	Healthy Life Expectancy	ONS 2009-2013	Annually (published 2016)	No longer updated
	Disability-free Life Expectancy	ONS 2009-2013	Annually (published 2016)	No longer updated
	Incidence of cancer by cause	ONS 2012-2016	Annually (published 2019)	No publication date confirmed
	Cancer mortality by cause	ONS 2013-2017	Annually (published 2019)	No publication date confirmed
	Number of people living in health deprivation ‘hotspots’	CLG (Indices of Deprivation 2015)	Irregular (September 2015)	2019
	People with a limiting long-term illness	Census 2011	10 yearly (published August 2013)	2023
	Babies born with a low birth weight	ONS 2011-2015	Annually (published 2017)	No publication date confirmed

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	Hospital admissions	ONS 2015/2016 - 2019/2020	Irregular (published 2021)	No publication date confirmed
	Musculoskeletal conditions by type	Arthritis UK (2011)	Irregular (published 2017)	No publication date confirmed
	"Healthy eating" (consumptions of 5+ fruit and veg a day), binge drinking and smoking	Health Survey for England 2006-2008	Irregular (published 2014)	No publication date confirmed
	Children classified as obese	National Child Measurement Programme (NCMP) (2017/18 - 19/20)	Irregular (published 2020)	No publication date confirmed
	Adults classified as obese	Health Survey for England 2006-2008	Irregular (published 2014)	No publication date confirmed
	Physical activity among adults	Sport England (Active Lives Survey) 2020	Irregular (published April 2020)	No publication date confirmed
	Index of Access to Health Assets and Hazards (AHAH)	2016	No update planned (published 2017)	No plans to update
Education and skills	Qualifications by level	Census 2011	10 yearly (published August 2013)	2023
	Participation in Higher Education	Office for Students (OFS)	Irregular	No publication date confirmed
	Early years foundation stage profile	DfE 2013-2014	Annually (published June 2015)	Delay in publication
	Pupil attainment at Key Stage 1, Key Stage 2 and Key Stage 4	DfE 2013-2014	Annually (published June 2015)	Delay in publication
Economy	Annual household income	ONS 2017/18	Irregular (published March 2020)	March-21
	Annual household income, after housing costs	ONS 2017/18	Irregular (published March 2020)	March-21
	Households living in 'Fuel Poverty'	Department for Business, Energy and Industrial Strategy (2019)	Annually (published April 2021)	April-22
	Debt	UK Finance (Sep-21)	Biannually (published Mar 2022)	Oct-22
	Economic activity by type	Census 2011	10 yearly (published August 2013)	2023
	Employment type by sector	Census 2011	10 yearly (published August 2013)	2023
	Job centre vacancies	ONS/Jobcentre Plus (Nov-12)	Irregular (published December 2012)	No publication date confirmed
	Jobs by sector	Business Register and Employment Survey (BRES) (2020)	Annually (published November 2020)	Nov-22
	Business VAT based local units by sector and size	ONS 2021	Annually (published September 2021)	Sep-22
Access and transport	Car ownership by number	Census 2011	10 yearly (published August 2013)	2023
	Road distances to key services by type	Commission for Rural Communities: Distance to Service dataset (2010)	Irregular (published 2011)	No publication date confirmed
	Average travel time (mins) by walking or public transport to the nearest key service	DfT 2017	Annually (published July 2018)	Nov-22
	Broadband speed	Ofcom 2020	Annually (published June-2020)	Irregular
	Census online and paper responses	Census 2011	10 yearly (published August 2013)	2023
Communities and environment	Area classifications by type	ONS Output Area Classification 2011	10 yearly (published July 2014)	No publication date confirmed
	Internet User Classification	Consumer Data Research Centre	Annually (published 2018)	2019
	Indicators of community strength and civic engagement	Place Survey (2008)	Irregular (published June 2009)	No publication date confirmed
	Total registered charities	Charity Commission 2020	Irregular	No publication date confirmed
	Community Dynamic scores for belonging, relationships and satisfaction	Social Life (modelled from the annual Community Life Survey), 2015/2016	Irregular	No plans to update
	Air pollution concentrations for four pollutants	CLG, Indices of Deprivation 2015 - from National Air Quality Archive 2012	Irregular (September 2015)	2019

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	Greenspaces and parks	OS data © Crown copyright and database right 2017	Irregular (published May 2017)	No publication date confirmed
	Big Lottery funding	Big Lottery, 360Giving, 2004-2021	Irregular	No publication date confirmed
	Community Needs Index	OCSI, Local Trust 2019	Irregular (published September 2019)	No publication date confirmed

Local Insight gives you the data and analysis you need to ensure your services are underpinned by the best possible knowledge of local communities, levering the power of information right across your organisation, from high-level visualisations for Board level to detailed reports on local neighbourhoods. Saving you time and money, Local Insight gives you the most relevant and up-to-date data on the communities where you work, with no need to invest in specialist mapping and data staff, consultancy or software. See http://local.communityinsight.org/ for more information.

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WEST NORTHANTS Health and Wellbeing Board
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Item no: 11

WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

8th September 2022

Report Title	**West Northamptonshire Anti Poverty Strategy Action Plan Update**
Report Author	**Phil Veasey, Consultant in Public Health, West Northants Council** **Vicki Rockall, Interim Head of Community Safety and Engagement, West Northants Council**

Contributors/Checkers/Approvers		
Other Director/SME	Sally Burns, Director of Public Health, West Northants Council	5th September 2022
	Jane Carr, Director Communities and Opportunities, West Northants Council	6th September 2022

List of Appendices

Appendix A – West Northamptonshire Anti Poverty Strategy Action Plan

1. Purpose of Report

1.1 This report will update members on the development of the West Northamptonshire Anti Poverty Strategy action plan and its immediate priorities.

2. Executive Summary

2.1 In our Corporate Plan for West Northamptonshire we committed to focus on the things that will significantly improve the quality of life and well-being for all our residents. The West Northamptonshire Anti Poverty Strategy is a major step in ensuring that our residents are offered opportunities, support, advice and information that will address the causes of poverty.

2.2 'Our vision is for a fairer and more inclusive West Northamptonshire, where everyone is able to live their best life, prosperous and fulfilling, free from poverty and inequality'

2.3 Living in poverty has negative impacts in other aspects of people's lives and is not just about money – it impacts educational attainment, access to good paying work, increases the risk of developing poor health conditions and reduces life expectancy. It also means that many people are not able to take part in the normal life of a place as experienced by other residents. The pandemic has particularly exacerbated the impacts of poverty on our most vulnerable residents and communities.

3. Recommendations

3.1 The Board is asked to note the Anti Poverty Strategy action plan.

4. Report Background

4.1 Background

The West Northamptonshire Anti-Poverty Strategy (APS) was published in April 2022. Since then, the Public Health Team and the Housing and Communities Team have been working with the APS Oversight Board and other partners to turn the Strategy into a series of measurable actions.

The APS project team wishes to ensure members are aware of the planned actions and can make connections with other partners to make this work as aligned and joined up as possible.
Members are reminded that the APS focuses on 3 priorities: Supporting people who are struggling in poverty now; Preventing people from falling into poverty in the first place; Continue to influence the Government and other national organisations to get a better deal for the communities in West Northants.

These in turn are supported by 8 strategic objectives and 32 commitments, high level ambition statements that collectively support the shared vision and are aligned to the 3 priorities.
The strategy has been coproduced through the Anti-Poverty Oversight Group, a West Northants partnership of cross party elected members, service providers, public health, housing, and voluntary and community representatives, including the VCSE Assembly and the Poverty Truth Commission.
Its aim is to add value to work already being undertaken and seeks to add value to this through further collaborative work. The strategy will be regularly reviewed to ensure continued alignment with other policies and strategies and reflect the voices and involvement of people with a lived experience of poverty.

The strategy will be kept under regular review as new evidence and learning emerges from the impact of the pandemic and we continue to be informed by the findings of the West Northants Poverty Truth Commission.

The Poverty Truth Commission has provided the opportunity to listen and learn from the lived experiences of people in poverty. A website has been set up for the Poverty Truth Commission in West Northants poverty-truth.org.uk which is encouraging real life stories, from those with lived experienced of poverty. These case studies are coming from seldom heard groups within our communities, those that are vulnerable and those most in need.

Through continued engagement and consultation, a comprehensive action plan was produced in May/June, and it contains over 100 actions.

However, due to the wide range of actions emanating from the strategic objectives and commitments the APS Oversight Board met on 16 June to discuss and agree a set of 'must do' set of actions. The 'must do' actions are attached as Appendix A and are intended to ensure a focus on absolute priorities for year 1.

Members will be highly aware that the cost of living crisis has continued to worsen since the publication of the APS. The APS project team has therefore identified the 'must do' actions that should ideally commence immediately. These are highlighted in yellow in Appendix A and work is already beginning on their implementation.

4.2 **Progress to date**

Progress is already being made in the following areas and key partners across our statutory, community and voluntary and faith sector are working collaboratively to deliver the year 1 'must dos':

- Establishing a West Northants Social Welfare Alliance – learning gathered from other areas such as Newham to build a model of training and support across our front-line services for West Northants.
- The distribution of the Household Support Fund, ensuring that those most in need are supported with global inflationary challenges and the significant rise in the cost of living
- Fuel poverty working group established, exploration of immediate actions such as 'warm spaces',
- Immediate food poverty/ long term food aid – working with Food Aid Alliance West Northamptonshire
- Communication and Engagement strategy being drafted, building on the initial work that has been done to pull together all the services that are currently in place to support those in need.
- Money and debt consortium, inclusive of both internal West Northants Council services and external Community and Voluntary Organisations, to look at information and advice services across West Northants, as we know that a large number of benefits remain unclaimed.
- Immigration support and advice – work underway with key partners to establish the current need and potential future modelling for a service that provides specialist immigration advice.
- Mental health support and referral pathways
- Poverty Hotspots/Hubs

4.3 **Next steps**

The APS project team is also developing a performance framework with indicators to measure the impact of the agreed actions.

We plan to update members at the Health and Wellbeing Board meeting on 10 January 2023.

5. Implications (including financial implications)

5.1 **Resources and Financial**

5.1.1 The projects outlined in the action plan support improved health and wellbeing outcomes and will help make a system shift to investment in prevention. Applications will be made to use Public Health reserve funding where appropriate.

5.2 **Legal**

5.2.1 There are no legal implications arising from the proposals

5.3 **Risk**

5.3.1 The Strategy focuses on ensuring that the most vulnerable people in our communities receive the support they need, those most at risk and in need of accessing our services.

5.4 **Climate Impact**

5.4.1 There is no specific climate and environmental impact that may arise from implementing the strategy. However, there is potential for positive impact in developing initiatives to reduce fuel poverty.

5.5 **Community Impact**

5.5.1 The Strategy provides a framework to prevent people from falling into poverty as well as supporting those who are already struggling. Therefore, this Strategy will have an overall positive effect across all equality strands.

5.5.2 Delivery of the ambitions of the Strategy will make a significant difference to the health and wellbeing of our local communities and tackle health inequalities Equality and diversity considerations are an integral part of our approach to addressing poverty in West Northants. The 'effects' and 'causes' sections of the strategy provide a useful summary of the inequalities that we are tackling.

5.5.3 An Equalities Screening Assessment has been completed.

6. Background Papers

None

Appendix A – 'Must Do' actions

The West Northamptonshire Anti- Poverty Strategy (APS) was published in April 2022. Since then, the Public Health Team and the Housing and Communities Team have been working with the APS Oversight Board and other partners to turn the Strategy into a series of measurable actions.

Due to the wide range of strategic objectives and commitments the APS Oversight Board met on 16 June to discuss and agree a set of 'must do' set of actions. This paper is what was discussed and broadly agreed upon.

Members will be highly aware that the cost of living crisis has continued to worsen since the publication of the APS and the 16 June meeting. The APS project team has therefore identified the 'must do' actions that should ideally commence immediately and these are outlined in section 5. They are also highlighted in yellow below.

The 'must do' actions fall into 3 key areas:

1. Large scale/ longer term transformational change projects - major things being delivered by other WNC teams that are critical to the Strategy
2. Immediate quick wins - things we can get on with the minimum of formal approval from Boards etc.
3. Year 1 must do actions - the things we must do in year one across the 3 priorities

Must do priority	Actions area
Large scale/ longer term transformational change projects	**Housing and Homelessness:** • Develop a new West Northants Housing Strategy
	Economic development • The Skills and Social Enterprise Development Fund project • West Northants Economic Growth Strategy • Free Employment Support Service (may move to quick wins)
Immediate quick wins	**Priority 1: Establish a West Northants Social Welfare Alliance** • Create a Social Welfare Alliance of all partners to provide an ongoing training development pathway for all frontline workers and volunteers (FLWVs) in the borough who are regularly having conversations with residents who are presenting with a range of social welfare issues

	Priority 1: Household Support Fund (HSF) • Household Support Fund (HSF) – ensure all partners know how to refer those in severe hardship into the agency that distributes this funding • HSF - review the current method of allocating funding to ensure it is reaching those in severe hardship (In anticipation of regular HSF announcements for the foreseeable future we become agile and always prepared - as the distribution of this type of hardship fund may be the norm for some time to come)
	Priority 1: Safe Surgeries • Work in partnership with GPs to create a West Northants approach to safe Surgeries – with a focus on Northampton Town – to ensure all vulnerable residents have access to primary care
Priority 1: To support those that are struggling/living in poverty now - Year 1 must do actions	**Poverty hotspots** • Identify and prioritise the poverty hotspots and incidences in West Northants Council (WNC) - our geography - and ensure there are sufficient services to match demand in these areas - taking in to account urban and rural settings • Make ongoing assessments of the funding required to achieve the delivery of the Strategy and ensure we are aware of funding opportunities and levering in external funding – consider requesting the C&O Directorate to appoint an officer post that will scan for funding opportunities and can work on developing bids for us to secure funding opportunities • Find solutions to accessing good public/community transport to provide good connectivity to services and support that residents will require
	Fuel poverty • Establish as a matter of urgency a cross sector fuel poverty working group identifying all possible interventions ahead of the 22/23 winter period
	Hardship funds • Identify all sources of hardship funding and other support funds/ provisions to enable partners to target those in severe hardship

	Innovation fund • Create a Community Health and Wellbeing Innovation Fund that the community and voluntary sector can access, aligned to the outcomes of the strategy
	Immediate food poverty/ long term food aid • Work in partnership with The Food Aid Alliance for WN (FAAWN) - an alliance of foodbanks - and other food aid providers to enable partners to develop long term food aid to support those in severe hardship
	Communications • Create a range of approaches to communicate the availability of all support and services, plus public health and primary care provision to all partners working with residents • Form a task and finish group to drive a communication and engagement with partners and residents
	Money and debt • Review and expand the financial wellbeing service offer within West Northants to form a Challenging Debt Consortium (working title) with VCS organisations including Citizens Advice, Community Law Service and other leading partners
	Immigration support and advice • Create a sustainable approach to address the shortfall in immigration support/advice to ensure all eligible residents achieve settled status • Establish a task and finish group to move this work forwards urgently • Communicate the support services in this action plan that are applicable for those with NRPF
Priority 2: Preventing People from falling into poverty in the first place - Year 1 must do actions	**Social mobility, employment and skills** • Initiate and establish an emphasis on the development of a holistic approach to learning and employment for residents - forming a learning and skills consortium that delivers in local and trusted settings

	• The consortium will work creatively to approach the issue of highly skilled migrants with NRPF or language skills that may need developing and/or qualifications that need to be interpreted positively in the UK - to enter the job market in a way that matches their potential and skills
	Staying relevant and on point/agile • Keep reflecting and maintain a 'real time' list of evolving key actions that we must continue to implement in priorities 1 and 2
	Local provision of services • Use the framework of the neighbourhood areas/ the creation of the Integrated Care System in Local Area Partnerships to develop the local/ hyper local provision of services to support residents to address key social welfare issues
	Healthy lives and physical activity • Work with partners across the system to ensure the delivery of wellbeing and targeted physical activity programmes to reach vulnerable residents in local communities at a neighbourhood level
	Healthy eating and access to sustainable food • Explore the potential of the local food industry to be part of progressive solutions to address food poverty
	Housing • Draft a new housing strategy ready for adoption in Autumn 2022 • Work with partners and stakeholders to develop an action plan to deliver on the priorities within the housing strategy • Undertake an independent assessment of the needs of people sleeping rough, at risk of rough sleeping for the first time and those who are at risk of returning to rough sleeping • Review accommodation and support provision, identify gaps to inform revised and / or service provision

	Mental health support and referral pathways • Create a Mental Health task and finish group and/or work with the Mental Health Collaboration/ colleagues in the Public Health Team to implement services and support to be delivered in local community settings • Develop a modular training programme – as part of the Social Welfare Alliance - for all front line workers who are regularly having conversations with residents who are presenting with a risk of poor mental health. Training will provide a context and how to recognise the presenting issues, and provide a referral pathway for expert support. This will include suicide prevention action
Priority 3: Influencing the Government and other national organisations to get a better deal for the communities in West Northants – Year 1 must do actions	**Additional funding** • Identify funding opportunities that will add value to the delivery of the actions in the Anti – Poverty Strategy

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WEST NORTHANTS Health and Wellbeing Board
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Item no: 12

WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

8th September 2023

Report Title	**Community Engagement Framework and Engagement and Project One: ICP Strategy**
Report Author	**Dionne Mayhew, Director of Communications NHFT, Communications and Engagement Lead, ICB** **Simon Deacon, Assistant Director of Communications, NHFT/ICB**

Contributors/Checkers/Approvers		
Other Director/SME	Sally Burns, Director of Public Health, West Northants Council	26th August 2022

List of Appendices

Appendix A – Integrated Care Northamptonshire Community Engagement Framework

1. Purpose of Report

1.1 To offer assurance regarding the development and delivery of the Integrated Care Board's (ICB) Draft Community Engagement Framework. This underlines the health and care's system's commitment to working with people and communities and how the approaches within it will assist in the creation of the Integrated Care Partnership (ICP) Strategy and ICB Forward Plan.

2. Executive Summary

2.1 Every Integrated Care System (ICS) is required to produce a strategy and approach for how it will work with people and communities.

2.2 In Northamptonshire it was agreed that this 'framework' of approach should be co-designed with key colleagues, practitioners, VSCFE and community representatives. This co-design process took place earlier this year.

2.3 The Community Engagement Framework in Appendix 1 is the result of this work, articulating the ICB's ambition, vision and values for working with people and communities, our shares themes

for working together and which priority projects will take place in Y1 and 2. Critically the approaches co-designed for Project One – Listening and working together to inform our strategic plans – is being used in the creation of the ICP Strategy and ICB Forward Plan.

3. Recommendations

3.1 Note the Integrated Care Board's Draft Community Engagement Framework (Appendix 1).

3.2 Be assured that through having this shared Framework for working it, will more robustly enable the voice of people and communities to help form and shape our work together across Integrated Care Northamptonshire (ICN) and inform both the ICP Strategy and ICB Forward Plan.

3.3 Support the ongoing development of the Framework and its priority programmes to ensure they embed across health and care.

4. Report Background

4.1 As part of the ICB's obligations and its Readiness to Operate statement, each ICS needed to produce a **strategy/approach for working with people and communities.**

4.2 This approach had to take into consideration the NHS guidelines/10 principles for working with people and communities. These were published in July 2022.

4.3 These 10 principles were subject to recent additional public consultation and formed the starting point for the creation of the Framework at Appendix 1. While we are assured they align with our co-produced Draft, the outcomes of the consultation will be considered in our finalisation of the draft Framework

4.4 The draft framework, themes and projects within it were approved by the ICB in June 2022. Now in Phase 2, we are taking the draft through a 'Routes to Action' process to embed and align with emerging Collaborative and Place based ways of working. The final version of the document will be taken to ICB Board for assurance.

5. Issues and Choices

5.1 As stated in 2.2 in Northamptonshire it was agreed to co-produce the required Community Engagement Framework.

5.2 This activity was undertaken through Spring and early Summer with an independent partner – Traverse, a provider endorsed by NHSE Patient and Public Involvement Team (NHSE PPI)

5.3 Traverse is also additionally engaged by NHSE PPI to undertake a quality review of the engagement strategies for all 42 health systems in the county.

5.4 Following this process of co-production – which is outlined in the framework – the draft strategy was developed with a number of aims:

5.4.1 Set a specific ambition, vision and values for working together with people and communities as co-produced through the process.

5.4.2 Define our early priority projects to support the delivery of the national four priorities of ICSs.

5.4.3 Develop framework themes and an action plan for embedding the priorities and principles for working together.

5.4.4 Outline how we understand our impact, continue to listen and learn.

5.5 The first priority project is 'listening and working together to inform our strategy plans.' The creation of the ICP Strategy and ICB Forward Plan represent the ideal opportunities to bring the framework to life.

5.6 Key ICB colleagues and the chair have been sighted on this approach which has now commenced to ensure community engagement is embedded into the creation of our strategic plans.

5.7 Through a phased programme of collective work we are taking a three-pronged approach to bring the voice of people and communities into our strategic plans as above and we ask;

- What does the data say?
- What do people say?
- Can anything be done?

5.8 The approach recognises that communities are complex as is the scope and pace for creating our plans. It aims to acknowledge that different segments of our population may have very diverse 'wants' and 'needs' and that those who need the most may be the least likely to articulate their view on the 'hows'.

5.9 Therefore our approach takes into account what we already know and have heard, will delve deeper where we see gaps and align our focus with identified priority areas.

5.10 This work involves:

- **Phase One: Research** Developing thematic and gap analysis insights report(s) to understand what it is our patients and communities want from their health and care.
- **Phase Two: Inform** Using our research, bring together key colleagues to sight, inform further and incorporate findings into their planning e.g. LAPs, Strategic groups, key ICB Boards
- **Phase Three: Involve** Collaborate to support ICN wide 'public conversations' to inform the ICP strategy and feed into ICB plan development
- **Phase Four: Engage** On the ICB Joint Plan with H&WBBs, wider stakeholders and interested members of the public

- **Phase Five: Embed and review** Use Community Engagement Framework to work towards a longer-term goal of embedded co-production across all our activity.

6. Implications (including financial implications)

6.1 **Resources and Financial**

Work is underway to scope out any resource and financial implications for the delivery of this work. Where possible existing resource will be utilised to enable delivery.

6.2 **Legal**

N/A

6.3 **Risk**

N/A

6.4 **Consultation**

N/A

6.5 **Consideration by Overview and Scrutiny**

N/A

6.6 **Climate Impact**

N/A

6.7 **Community Impact**

6.7.1 A focus on community Impact is inherent in the Framework, particularly the vision, values and ambitions

Integrated Care Northamptonshire

[DRAFT] Community Engagement Framework

Our strategic approach for working together with people and communities (WORKING DRAFT)

July 2022-25

Version control

Document Information	
Title	Community Engagement Framework
Subtitle	Our strategic approach (DRAFT)
Dates	27/05/2022
Status	Working draft; Phase 2
Assurance and finalisation process (in planning)	**Phase 1:** • Co-design and co-production - involving participants, stakeholders and experts by experience, March – May 2022 • Noted and agreed for progression - ICB Shadow Board, Jun 2022, • Document undergoing ongoing accessibility checks, June 2022 **Phase 2:** • To be shared for implementation discussion with Integrated Care Partnership and Place working group, June 2022 • To be shared with those involved in co-production process for ongoing information, July 2022 • To be shared for implementation discussion at ICN collaborative/programme meetings; iCAN, Children & Young People, Elective Care, Mental Health, Learning Disability and Autism, July / August 2022 • Agenda items requested for North / West Health and Wellbeing Boards, Sept 2022 • Final approval at ICB Board (timing as appropriate)
Classification	Restricted – working draft
Authors	Dionne Mayhew, Skye McCool, Grace Evans, Morgan Fraser
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This document was developed in partnership by Traverse and the Northamptonshire Integrated Care System, their partners, and local people through a co-production process.

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Foreword

Our county is home to over 750,000 people, who all lead different lives, have different views of the world and have different health and care needs. It is important to recognise that as our population ages and changes, we need to listen and change together.

Of course, through the pandemic we needed to focus our efforts in a different way to help us get through it as safely as possible, concentrating on providing the best care and community support. This meant that our working together with people and communities, across all of our services didn't happen as much as we would have wanted it to. While conversations did and do still happen, we know it wasn't ideal that we couldn't continue our ongoing engagement and conversations about our wider health and care services.

We have always acknowledged that we all need to work together if we are to deliver the lasting, positive changes we would hope to see **and now we have an exciting opportunity…**

In April 2021, Northamptonshire was designated by the NHS as an Integrated Care System (ICS). **And from July 2022, as our Integrated Care Board (ICB) formally launches, together our ICS will be called Integrated Care Northamptonshire (ICN)**.

In a fundamental change to how health and care is organised, we are now one of 42 ICS areas created across England. National expectations have outlined that each area must organise their local organisational structures in a particular way so that they effectively share the powers and responsibilities to support their populations to live healthy lives and get the care and support they need when they need it.

This structure offers a great opportunity for us to work together more effectively. So building on this we have developed a **Community Engagement Framework.** Central to the new structure of the ICN and endorsed by our ICB, this framework sets out our expected ways of working, our shared vision and our highest priority projects to help us to work together with people and communities, not just in pockets or on an ad hoc basis, but across all we do in better and more authentic ways.

We have shaped this approach together through co-production, and in the true essence of co-production we will continue to shape and evolve our approach. It is ambitious, but together so are we.

So please read on to find out more about our plans, and we hope you all join us in striving for our shared vision and making a positive difference together.

Dionne Mayhew
Communications and engagement lead

Toby Sanders
ICB Chief Executive

On behalf of Integrated Care Northamptonshire

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Introduction

Our Community Engagement Framework: a strategic approach for working together with people and communities

This framework and our approach was developed by and for members of Integrated Care Northamptonshire (ICN), in partnership with Traverse – an independent social purpose consultancy – and with a wide range of local partners and people through a co-production process, in support of the ICN formation in July 2022. Progress against its delivery will be monitored and owned by Northamptonshire's Integrated Care Board (ICB).

Working in partnership with people and communities forms the foundations of our strategic approach to developing integrated care for all Northamptonshire's citizens. The **objective** of our **Community Engagement Framework** is to enable ICN partners to work more effectively together, as it provides a clear expectations for working with people and communities in the design, delivery and improvement of health and care systems.

This framework also supports ICN (monitored via the ICB) to meet its obligations as set out in the NHS 'Working in Partnership with People and Communities Statutory Guidance'.

Key definitions

A key finding from our conversations with local people and organisations was the need for a shared understanding of terms used to describe different types of approaches to working with people and communities, particularly co-production.

In this document, we are using the following definitions from the NHS Working in Partnership with People and Communities Statutory Guidance for Integrated Care Boards, NHS Trusts, NHS Foundation Trusts and NHS England (Draft).[1]

Inform: Sharing accessible information so people understand changes and can have their say.

Consult: Asking for people's opinions on one or more ideas or options.

Engage: Listening to people to understand issues and discussing ideas for change.

Co-design: Designing with people and incorporating their ideas into the final approach.

Co-produce: Working together in an equal partnership with people with lived and learnt experience from start to finish.

Additionally, we refer to '**involvement**', whilst not defined in the NHS Working in Partnership with People and Communities Statutory Guidance, it is a commonly used term. We take it to mean any approach to people or community participation and as such it covers the spectrum of the above terms.

[1] https://www.engage.england.nhs.uk/consultation/working-in-partnership-with-people-and-communities/user_uploads/b1133_i---guidance-on-working-in-partnership-with-people-and-communities---consultation-draft-may-2022.pdf

Why working with people and communities is integral to our Integrated Care System

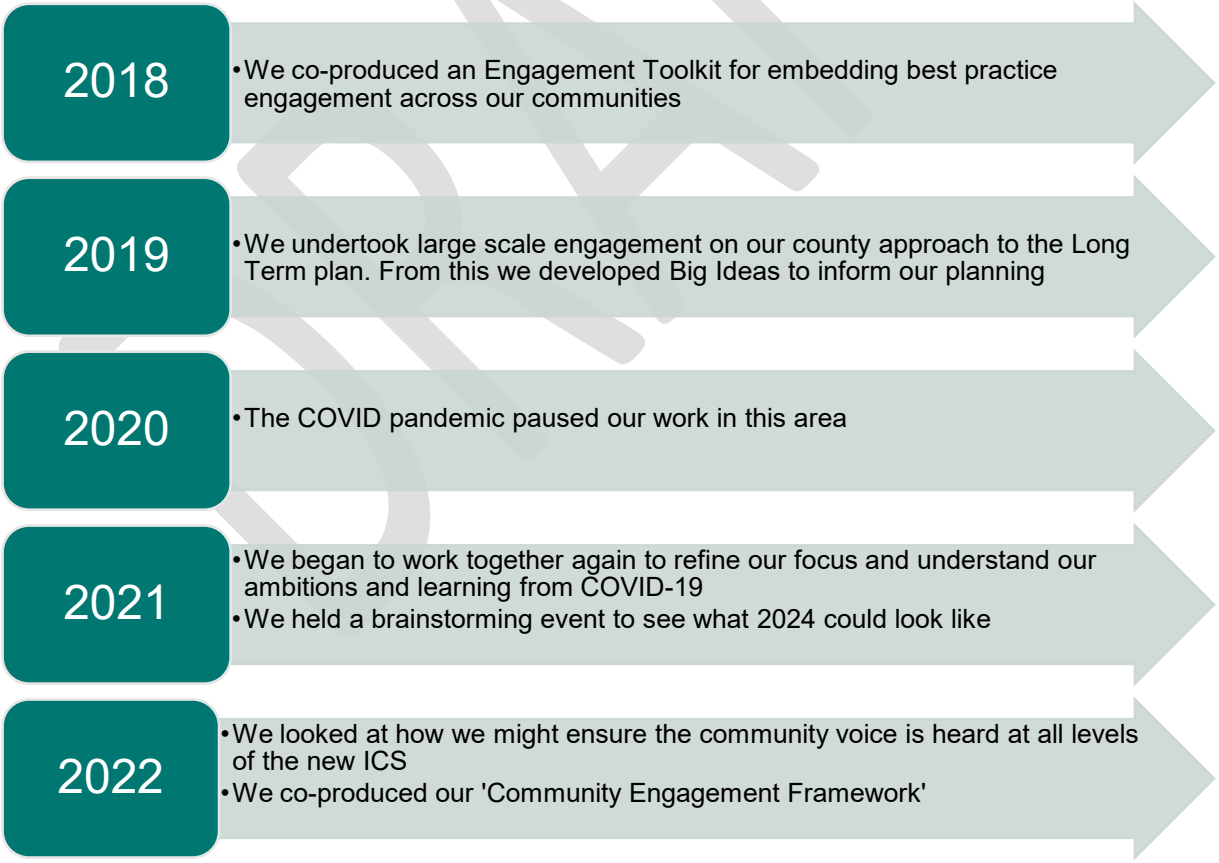
A strong and effective ICS has a deep understanding of all the people and communities it serves. Unlocking diverse experiences, insights, assets, and solutions from local people and communities will enable us as ICN to work together to improve outcomes, tackle health inequalities and the other challenges faced by our health and care systems more effectively.

Becoming ICN creates a fresh opportunity to strengthen work with local people and communities. This means building on all our of good practice, trusted relationships, effective networks, and positive activities where people and communities are involved, to ensure that at a system level this all adds up to more than the sum of its parts, for all communities in Northamptonshire.

Northamptonshire Health and Care Partnership - A history of working together with people and communities in Northamptonshire

We heard and learned more about the many, varied and extensive involvement activities across providers and in the Voluntary, Community, Faith and Social Enterprise Sector (VCSFE) organisations, which have been in place for many years, and which have supported the delivery and development of many of our services and pathways of care. From the outset across NHCP we have worked together with involvement practitioners to bring the learnings and insights from this work into our system level activity. As NHCP our history is outlined below:

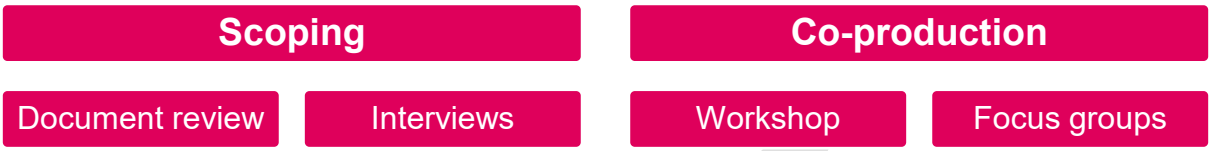
Figure 1: Summarised timeline of prior work done



How we went about co-producing our framework

We co-produced this system-wide strategic framework – with the commitment and buy-in from local people, senior leaders, and key partners – to build on the best of our local practice and existing relationships. Co-producing in this way means that people, communities, and partners helped define our shared vision, ambitions, and priority actions. This will ensure they are embedded in our approach and can be involved in developing key strands of work that emerge.

Figure 2: Overview of process for developing the strategic approach



The co-production process (Figure 2) began in March 2022, concluding in early June 2022. It involved 51 people from 29 organisations or community groups.

We invited a wide breadth of representatives to our conversations. We acknowledge that we could have involved more people and organisations who were missing from these conversations, but we are focused on building our capacity and capability to widen our involvement for future iterations. If you want to know more about the co-production process, see Appendix B: Co-production process.

Using the NHS England ten principles for 'Working together with people and communities' as a guide, we explored the following key questions to create our framework:

- What is the shared **vision** for working together with people and communities?
- What are our **ambitions** for working together with people and communities?
- What should be our core **values** for working together with people and communities?
- What are the **opportunities, challenges, and tensions** for implementing the approach?
- What **actions** are needed to deliver the co-produced approach?

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Figure 3: Ten principles for working with people and communities[2]

Ensure people and communities have an active role in decision-making and governance	Provide clear and accessible public information
Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions	Use community-centred approaches that empower people and communities, making connections to what works already
Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working	Use co-production, insight and engagement methods so that people and communities can actively participate in health and care services
Build relationships based on trust, especially with marginalised groups and those affected by inequalities	Tackle system priorities and service reconfiguration in partnership with people and communities
Work with Healthwatch and the voluntary, community and social enterprise sector as key partners	Learn from what works and build on the assets of all health and care partners – networks, relationships and activity in local places

Our community engagement framework

Our **community engagement framework** outlines our aspirations for working together with people and communities – co-produced by local people and organisations. It sets out what we want this to be like, what it should feel like for those involved, the values that will guide us and our actions – and provides themes for how we will achieve these things.

We also know that through working together as ICN **our shared priorities are to improve outcomes, tackle health inequalities, make best use of resources and enable broader socio-economic development**. So, we have considered this and developed some priority strategic projects to focus our efforts on.

Why have a framework and who is it for?

Our framework is for everyone, this document is our call to action for staff, practitioners, and people across ICN to work together to deliver the changes we have all said we want to see. Through having a strategic framework, we have clarity on our direction of travel, accountability for our actions and agreement on our priorities.

[2] Working in Partnership with People and Communities: Statutory Guidance for Integrated Care Boards, NHS Trusts, NHS Foundation Trusts and NHS England

Our shared vision for the Community Engagement Framework

Our vision, ambitions and values were developed via the interviews, refined via the workshop, finalised in the focus groups. They are developed to support us to work together and via our Integrated Care Board to deliver the ambitions of the Framework, over the next five years. In 2027, we want the vision we have co-designed together to be our reality.

"We work in partnership with people and communities in Northamptonshire, especially those affected by inequalities, on issues that are important to them. Everyone will know how their contribution has made a difference."

Our ambitions

These statements, co-produced within our activity as set out above will set the framework and basis for all our work together as we move forwards.

- We build trusting relationships and effective partnerships, by embedding a consistent approach to co-production
- We are all committed to genuinely hearing what people say, and feeding back the influence on our decisions and actions
- We have genuine diversity and inclusion at all levels in the system, involving people according to their needs and preferences
- We prioritise the needs and issues that are important to people and communities
- We evaluate what we do, share learning, and celebrate our successes

Our values

These values, directly selected from the feedback within our conversations, will be our motivation and guide for how we work together as ICN and with people and communities. They will help us prioritise **what** we do and very importantly, provide the framework for **how** we do it.

- Trusted
- Transparent
- Authentic
- Accountable
- Accessible

How we will work with people and communities

This section is about making things happen, it outlines what we need to do, and our plans to achieve the vision, ambitions, and values outlined in the previous section.

What does an Integrated Care System need to do?

In our co-production workshop, Toby Sanders, our ICB Chief Executive Designate talked about what an ICS should do and shared their four key priorities;

An ICS should:

- Build on NHS Long Term Plan priorities
- Build on COVID system response
- Focus on collaboration, not competition
- Build closer NHS and local government working

ICS priorities are to:

1. Improve outcomes
2. Tackle health inequalities
3. Make best use of resources
4. Enable broader socio-economic development

You said: Opportunities and challenges in working together in new ways

Opportunity: Learning from Covid-19

People described substantial opportunities to build on the success of working with people and communities realised over recent years, especially those that arose during the pandemic. There was increased partnership working; and much more effective information sharing with communities across Northamptonshire about COVID-19 and vaccination programme. In addition to this, work is already taking place within Northamptonshire to promote wellbeing, living healthy and happy lives and empowering people to support their own outcomes. We need to make best use of these successes and opportunities to further build and sustain relationships, particularly with seldom heard communities.

Challenge: Embedding involvement

We have heard that people, communities, and partners are unsettled by the current changes to health and care, and those working with the system feel fatigued by those that have taken place in public services over many years. Whilst we hear and appreciate this, we will still endeavour to take this opportunity to shift culture and behaviour around co-production, so it is no longer seen as a ‘nice-to-do’ but is fundamental to how we develop integrated health and care services.

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Opportunity: Defining what the different types of approaches to working with people and communities mean to all of us

Those we spoke to want to create a consistent understanding of true co-production and all levels of working with people and communities. We discussed that this could be 'an equal partnership where power is shared with people and communities'. So we will examine what this could mean to us, both in our statutory responsibilities and in our business as usual practice. Our aim will be to establish a consistency in usage and understanding from Board leadership through to those who design, deliver, and improve services.

Challenge: Building capacity and maximising resources

Finally, effective partnership working is the key to delivering our ambitions. We must keep our focus on developing trusted relationships and enabling skills, capacity, and resources to be shared across partners. We recognise that we may need to review how existing resources are deployed and identify additional funding to meet the requirements set out in this document.

Opportunity: Building on existing excellence in practice across our county

We heard about many examples of well-established involvement activities happening across provider and VCSFE organisations. Many of our staff, volunteers and community members have worked tirelessly to ensure the voice of people and communities is heard in their work, and in the co-design and co-production of services. We are seeing this work truly influence and have a positive impact. Activity happening through our NHS providers, local authorities and our developing Collaboratives programmes is already informing their case for change approaches and priorities.

We are truly thankful to each and every one of the staff, community members, involvees and volunteers who have taken the time to make this difference and work with people and communities. We know this is something we should be proud of and we want to take the opportunity to say thank you…and use this shared Framework to realise on our ambition to work together more robustly and build on the excellence in practice that already exists.

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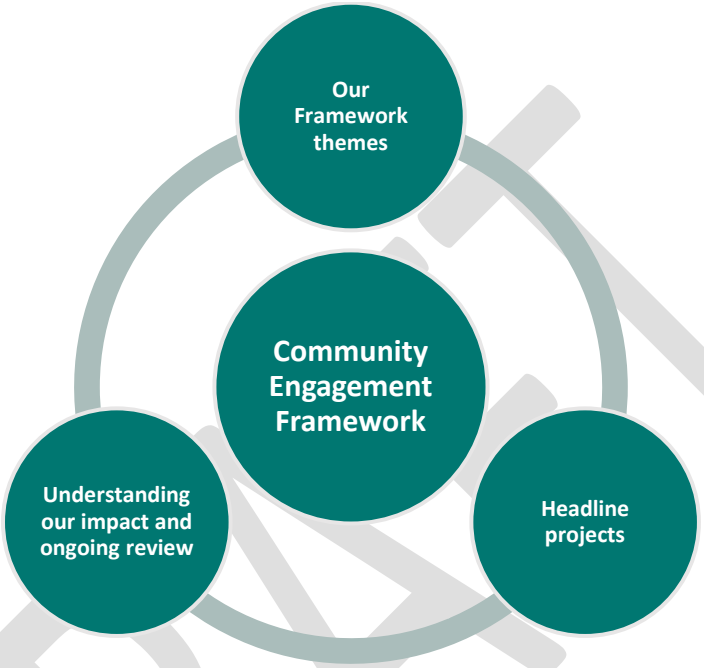
Making it happen

Together we agree we want to support the national ICS priorities, build a Framework around how we work, and deliver improvements together. We agree we want to build strong foundations to enable this, we agree we must understand our impacts and we agree we need to keep having conversations. So we will make this happen in the following ways.



Our Framework themes and how we will embed them

We have developed key themes to ensure we embed our framework as a **way of working** through 2022 to 2025:

1. **Embedding a consistent approach to co-production**
2. **Ensuring genuine diversity and inclusion is at the core of our approach**
3. **Making best use of our insight around the health and wellbeing of all our people and communities**
4. **Evaluating what we do, sharing the learning and celebrating our successes.**

Making progress against these themes will help us achieve against our ambitions.

We will set up working groups of key people who can work together to continue to shape and embed the themes effectively.

A detailed delivery plan is presented in Appendix A: Our Themes delivery plan. It outlines what we plan to do in year one, and years two to three, for each theme. These actions were identified through the co-production process.

Headline projects to support our priorities

The strategic projects below are developed to support a clear and aligned focus on the four national ICS priorities. The projects will be the **what**, the framework themes the **how** and we will need to create collaborative working groups and examine resources and capacity to ensure the delivery of these projects:

Project 1: Listening and working together to inform our strategic plans

Working with our NHS providers, local authorities, VCSFE organisations and colleagues across the Collaborative programmes we will make the best use of resources, by developing a **thematic and gap analysis insights report** to understand what it is our patients and communities want from their health and care. These insights should then be used in the shaping and development of our ongoing activity and in particular our five-year strategic plans.

Using this insight report as a key reference point, we will **bring together colleagues at all ICN levels**, in organisations, collaboratives, population health, including aligning with the health inequalities strategy, to **engage further** where needed on what improved outcomes might mean to the people and communities involved.

Using this insight as a guiding reference, we will then work towards a **longer-term goal of embedded co-production** across all our activity.

Supports:

- ✓ **Improve outcomes – priority aim**
- ✓ Tackle health inequalities
- ✓ Make best use of resources
- ✓ Enable broader socio-economic development

Project 2: Moving from hearing to doing

Our feedback is that historically, involvement initiatives in Northamptonshire have faced challenges in moving from ‘hearing’ to ‘doing’. Decision-making infrastructure needs to be defined such that people’s involvement has a **clear scope and route-to-influence** from the start of any process.

We will design and deliver a **programme and methodology** to embed the value of working with people and communities at board and senior meeting level, to ultimately ensure that our involvement of people is meaningful and leads to tangible actions and impact.

With our system leaders support we will embrace the philosophy that better outcomes happen through co-production, rather than through informing or consulting.

This initiative will seek to embed this approach and demonstrate the impact of community frameworks and feedback into Board level objectives. Similarly, **we will seek to embed accountability for involving people and communities into standard reporting requirements** (as is seen in requirements for financial accountability or Equality Impact Assessments).

Co-production as an approach expects decision-makers and those responsible for implementing services and initiatives to be ‘in the room’ alongside people and communities. We believe that building better ways for that to happen more will ultimately support our vision and ambitions.

Supports:

- ✓ Improve outcomes
- ✓ Tackle health inequalities
- ✓ **Make best use of resources – priority aim**
- ✓ Enable broader socio-economic development

Project 3: Work together to embed equality through emerging Health and Wellbeing forums at Integrated Care Partnership levels

Throughout the co-production process, equality, diversity, and inclusion was identified as a priority for working with people and communities. There are existing voluntary, community, social enterprise, and faith sector organisations who are already working effectively with diverse communities and groups. They know their communities well and have existing trusted relationships. Many of these relationships were strengthened during the pandemic.

Through the structures of ICN, in particular at 'Place' level, **we will collaborate with our Health and Well-being Boards and Voluntary Assembly and VCFSE organisations to consider equality forums or core representation for structural levels as relevant**. Our aim is to have wide representation from health inclusion groups who can support and work to facilitate co-production on health and care plans and services with those they support. Through the example set by the 'Hearing to doing' model', there will be an expectation that services will respond to the specific needs and insights of the groups and people involved.

Supports:

- ✓ Improve outcomes
- ✓ **Tackle health inequalities – priority aim**
- ✓ Make best use of resources
- ✓ **Enable broader socio-economic development – priority aim**

Understanding our impact and ongoing review

Building trusted relationships with people and communities is key to the success of our framework. An essential element of this will be to review and identify the impact of the work and publicly share it – successes, but also where there continues to be more to be done.

Our Integrated Care Board will review and update this document and progress made, at least annually. They will publish their report and invite feedback on it.

To support the understanding of our impact, we will be undertaking a benchmark analysis and co-producing an outcomes framework in June 2022. The benchmark analysis will review our current practice, highlighting key gaps in our current approach alongside existing good practice, to better understand strengths and areas for improvement. This will provide us with a baseline for future evaluations of our working with people and communities.

We will also co-produce an impacts framework for monitoring and measuring the impact of our strategic approach as it gets implemented.

The development of our approach is ongoing, and we invite feedback at any stage, via the contact details at the start of this document.

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Appendix A: Themes delivery plan

Theme	Year 1 actions (July 2022-23)	Years 2-3 actions (July 2023-2025)
Embedding a consistent approach to co-production	Develop a communications plan around our strategic approach to socialise and encourage cross system engagement with the vision, ambitions, and definitions of involvement with people, communities, at 'Place' levels and with and system partners	Develop an ongoing communications plan to support the activities and outcomes of our approach, with support from the Community Involvement Network
	Commission a co-production programme for the ICB to establish system leadership for our approach	Review the co-production programme approach in establishing system leadership
	Working withing the emerging structure of ICN and ICP level strategies, establish a framework for embedding a Community Involvement Network of key statutory and voluntary sector partners and local Healthwatch to take ownership of and drive forward our approach	Through the Community Involvement Network: ■ Identify and publicise examples of good practice ■ Identify priority areas for gathering additional insights (as a result of the insight gathering exercise below) ■ Identify the cultural change training and support needs for system partners to develop a collective understanding of genuine co-production ■ Clarify where co-production is not appropriate – and other forms of involvement are ■ Consider how to embed involvement as an accountability criteria in reporting
Ensuring genuine diversity and inclusion is at the core of our approach	Develop clear alignment and 'ways of working' with the Health Inequalities team, Population health board and colleagues in these areas. Establish a 'ways of working' agreement that aligns with the principles in the Health Inequalities strategy	Review our ways of working and, share insights and outcomes

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Theme	Year 1 actions (July 2022-23)	Years 2-3 actions (July 2023-2025)
	Commission voluntary and community sector partners working with diverse communities to establish equality forums with wide representation from health inclusion groups for each area to facilitate co-production with those they support	Review the equality forums approach, share insights and outcomes, and consider the need to widen representation
	Establish and communicate expectations around the use of plain English; interpreting and translation; and the Accessible Information Standards to facilitate equality of access to health and care services with system partners Communications leads	Explore signing up as a system to an aligned plain, clear language approach
		Monitor the use and feedback from people and communities about interpreting and translation services
		Evaluate the implementation of the Accessible Information Standard across system partners, share good practice and identify areas for improvement
Making best use of our insight around the health and wellbeing of all our people and communities	Create a 'community insights report' gathered from existing insights and involvement activity across Northamptonshire's NHS provider and VCSFE organisations, local authorities and community groups. This will be used to inform our five year plans and key ICN strategies	Identify gaps in our knowledge and key relationships from this process; and commission further insight gathering and involvement processes for co-production priorities, especially around health inequalities
	Use the insights gathering exercise above to map existing relationships and involvement networks	Explore the development of an insights and involvement hub to gather and provide easy access and analysis of insights. This hub will be a live resource to access latest feedback, activity and projects happening in our area.
	Discuss with Public Health how to make best use of the new Census data and population health management data, alongside people's health and wellbeing insights, to inform strategic and service decisions	Review and identify any tools and priorities for more insight gathering, e.g. citizen's panel / identify priority services/ areas / places
Evaluating what we do, sharing the learning and celebrating our successes	Undertake a benchmark analysis and review the outcomes to inform our approach	Create mechanisms for communicating and feeding back the outcomes of community involvement work to those who were involved, as well as to partners and organisations across the system.

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Theme	Year 1 actions (July 2022-23)	Years 2-3 actions (July 2023-2025)
	Develop an approach to evaluating progress against our vision and ambitions set out in this document. Examine the scope to build better, effective working relationships with our Research & Innovation, Business Intelligence and Patient Experience teams	Provide evidence that there is greater coordination of health and care through ongoing evaluations reporting
	Develop best practice guidance and share examples of successful community involvement across Northamptonshire	Hold 'People and Communities' networking and celebration events across different areas

Appendix B: Co-production process

For a full overview of participation refer to Appendix D: Co-production participants.

Scoping phase

The scoping phase was carried out by Traverse between March and April 2022, guided by the NHCP Communications team, to inform the design and delivery of the co-production phase.

Document review

Traverse reviewed key documentation related to existing patient, public and carer involvement from the NHCP and its key partners. This helped us understand the aims of previous and ongoing engagement, identify potential gaps and successes, understand the inclusiveness approaches, identify areas for further development, and highlight good practice and learning from elsewhere.

Interviews

Traverse ran 21 interviews alongside the document review. Overall, we hoped to:

- understand interviewees' ambitions for working with people and communities
- identify any opportunities or challenges, as well as potential tensions moving forward
- seek input into the co-production workshop
- identify any further documents for the document review.

Co-production phase

We explored several lines of inquiry through a series of co-production style events to develop the strategic approach.

- What is the shared **vision** for working together with people and communities?
- What are our **ambitions** for working together with people and communities?
- What should be our core **values** for working together with people and communities?

- What are the **opportunities, challenges, and tensions** for implementing the approach?
- What **actions** are needed to deliver the co-produced approach?

Co-production workshop

A half-day co-production workshop was delivered with 30 participants, including staff colleagues, patient and public representatives, and third sector organisations. The main aim of the workshop was to co-produce a shared vision and ambitions for working together with people and communities.

Focus groups

Four shorter focus groups were delivered following the main workshop:

- two 'test and challenge' sessions
- one session on equality, diversity, and inclusion
- one session on tools, approaches, and structures.

The aim of these sessions was to reflect on insights coming out of the workshop and start shaping and prioritising more specific approaches and next steps to support implementation and delivery.

Appendix C: Co-production insights

Scoping phase

Through the scoping, initial insights were identified around the system's approach to working with people and communities. Stakeholders described some pockets of good practice across the system, in particular the use of co-production within some collaboratives[3]. There is, however, a need for greater collaborative working across a wider range of system partners. Other ICSs, such as Dorset, Sussex, and Somerset, demonstrate more effective partnership working, with councils, local Healthwatch, and the voluntary and community sector.

Whilst there is a good understanding from individual stakeholders about their own involvement activities, there is a lack of clarity between different local players about what involvement is going more broadly. In turn, this leads to lack of understanding across the system about what local people think about their services. The NHCP documents tended to describe the engagement itself, rather than identify the impact or outcomes of working with people and communities.

NHCP articulate ambitions around empowering service-users to be involved in the decisions that affect them. Interviewees recognised that people and community involvement is challenging, particularly in acute healthcare settings, and said to do it in a meaningful way requires more funding, resourcing and support to make this ambition a reality. A lack of funding and capacity were seen as two of the primary barriers to people's involvement being prioritised at all levels of the system, and for progress on this agenda to be quick enough.

Other challenges include:

- Lack of clarity around roles and responsibilities relating to people and community involvement at all levels of the ICS.

[3] Stakeholder identified the mental health, learning disability and autism collaborative as an area which is leading the way in co-production.

- Implications of the COVID-19 pandemic.
- National issues, pressures and targets resulting in community involvement becoming a less urgent priority.
- Understanding and communicating the positive impact of community involvement between services and with the communities themselves.

Recommendations

Through the interviews, stakeholders described some initial recommendations for working with people and communities across the system:

- There needs to be a shared vision and collective commitment, from an ICB to local level, with clarity on language used, what the vision and priorities mean for each level and how this will translate into roles and responsibilities.
- There must be a shared understanding of genuine co-production to ensure that it is used effectively and consistently.
- There should be feedback mechanisms in place that allow the people involved in engagement or co-production to understand the impact that their involvement has had on health and care.
- More joined-up working is needed to make involvement more efficient and prevent 'engagement fatigue' across communities.
- There must be greater consideration of the wider determinants of health and a move towards a focus on wellbeing to address the social and economic factors which contribute to health inequalities.
- Community involvement must capture a wider range of voices and avoid the 'usual suspects' by engaging with those who might not access services and otherwise not be engaged.
    - Stakeholders were keen to understand what was meant by diversity and consider who might be missing – for example, working aged men or migrant communities.
- There should be sharing of training, skills, and resources across the system to help areas which find integrating people and community involvement more challenging – this might also include a network or repository for sharing best practice between partners.

The document review also highlighted areas that could enhance work with people and communities across the system:

- It is important to move beyond the sole involvement of only service users in future engagement, particularly when exploring health inequalities across the region.
- Most of the documents shared in relation to health inequalities were mostly focussed on addiction or disabled people. This should be expanded to investigate the breadth of people affected by health inequalities.
- The outputs generated could be co-produced with community partners before release. Some previous public documents have come across as 'cold', as if intended for an internal audience and affect how the community engage with them.
- The outputs produced should include solid conclusions, describing the outcomes of the community involvement and what that means for people and communities moving forward.

Co-production phase

Following the scoping, a workshop was held to explore ambitions and values, past successes and challenges, and potential tensions moving forward.

Draft ambitions

Workshop participants shared an extensive range of hopes and ambitions for ICN. The broadest and most significant of these were brought together into the vision in our strategic approach, a

range were clustered thematically to shape our ambitions, and the more specific action-based ones were collated into Appendix A: Our delivery framework.

Below we present a more comprehensive picture of participants' ambitions for ICN in working together with people and communities.

- Embed a consistent and fully integrated co-production approach and develop a shared understanding about the different levels and types of involvement.
- Ensure genuine diverse representation at all system levels, involving those who are traditionally excluded, as well as considering physical barriers, such as rurality.
- Prioritise the needs of people and communities ahead of the needs of the system, not making decisions about what is best for whom based on assumptions.
- Provide comprehensive and clear feedback on decisions and actions in an honest and transparent way. Outlining ambitions for involvement and what is achievable; communicating to those involved rather than in a non-targeted way to 'everyone'.
- Consider people's whole lives, going beyond health to things such as heating, food, and housing. Shift language and reframe the way that health and care is talked about by asking people what matters to them and their community.
- Share power, the same way that everyone shares in experiencing the challenges and barriers. Have difficult conversations and work together to make trade-offs. Engage people and communities in shaping priorities and co-designing bigger systems, approaches, and solutions.
- Commit to hearing what people say and doing something about it, having ownership of involvement across the whole system. Ensuring actions and decisions are informed by involvement, and that communities voices are heard across the whole system, not just those at the public-facing end.
- Provide different ways for people and communities to have a say; appreciating it is important to find a way of appropriately representing people that do not engage. Ask people how they want to receive information and designing different networks to communicate, rather than the traditional press releases.
- Move away from complicated jargon to communicating in plain and accessible language, understanding that the impact of this work is directly impacted by how it is communicated.
- Undertake ongoing evaluation of the outcomes and impact of this work. Celebrate contributions and successes, and communicate about involvement initiatives, particularly when using different approaches like co-production. Share insights and learning to build on what we know.
- Proactively go out to engage people and communities on their terms, in settings that suit them. Create more opportunities to hear people's experiences.
- Build trusting relationships and know each other. Build effective partnership approaches. Make connections, build and strengthen our networks

We refined these ambitions (Figure 4) to test through the focus groups, creating a final five.

DRAFT

Figure 4: First draft of ambitions for Integrated Care Northamptonshire

- We share power by embedding a consistent co-production approach
- We are all committed to hearing what people say and doing something about it
- We have genuine diversity and inclusion, at all levels in the system
- We engage and communicate in different ways, according to people's needs and preferences
- We comprehensively and clearly feedback our decisions and actions
- We put the needs of people and communities before the needs of the system
- We take a holistic approach, considering people's whole lives
- We evaluate what we do, share learning, and celebrate our successes
- We build trusting relationships and effective partnerships

Values

Workshop participants identified a range of values they felt are important for ICN when working with people and communities (Figure 5). These were refined through focus group discussions.

Figure 5: Values identified in the co-production workshop

Appendix D: Co-production participants

Organisation and role	Interview	Workshop	Focus group 1-2: Challenge	Focus group 3: EDI	Focus group 4: Tools
ICB – Chair	✓				
ICB – Chief Executive	✓	✓			
NHFT – Children and Young People Programme Lead	✓				
Northamptonshire Carers lead / NHFT Governor	✓	✓			
iCAN – Programme lead	✓				

Organisation and role	Interview	Workshop	Focus group 1-2: Challenge	Focus group 3: EDI	Focus group 4: Tools
NHS – Elective Care Programme manager	✓				
MHLDA – Programme lead	✓	✓	✓		
Healthwatch	✓				
Young Healthwatch	✓	✓			
Public health – Health inequalities lead	✓			✓	
VIN – Chief Exec (Voluntary Sector Assembly)	✓	✓			
NGH – Organisation Engagement lead	✓	✓			
NHFT – Head of Patient Experience	✓				
Acutes Group – Director of Comms and Engagement	✓				
West Northants Council – Head of Comms and Engagement	✓				
GP Chair – Primary care rep	✓				
Local Council Rep Lead North	✓				
Local Council Rep Lead West	✓				
Safeguarding and Wellbeing Services – Assistant Director	✓	✓			
NHCP – EDI Lead	✓			✓	
NHFT – Deputy Chief Exec	✓				
Chair – East Northants Patient Participation Group Association		✓			
ICB – Deputy Director Governance		✓			
CYP expert by experience		✓			
iCAN – Patient representative		✓			
NHFT – Patient representative		✓			
Northamptonshire Black Communities Together – CEO		✓		✓	
CCG – Primary Care lead		✓			
PA Consulting		✓			
Population health and social prescribing lead		✓			✓
Chair: Wootton Medical Centre and South Northamptonshire Patient Engagement Group		✓			
Queens view Medical Centre – PPG member		✓		✓	
Northampton General Hospital – Head of Communications and Engagement					
Northamptonshire Healthcare Foundation Trust – Corporate Governance		✓			✓

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Organisation and role	Interview	Workshop	Focus group 1-2: Challenge	Focus group 3: EDI	Focus group 4: Tools
ICS – Head of Programme Delivery		✓			✓
NHCP – Corporate Services & Governance Manager		✓			✓
West Northamptonshire Council – Consultation, Engagement and Public Relations Manager		✓		✓	
Northamptonshire CCG – Patient experience coordinator		✓			
Northamptonshire Healthcare Foundation Trust – Expert by experience		✓			
Involvee / Service User		✓			
Northampton General Hospital – Head of Patient Experience & Engagement		✓			
NHCP – Communications Manager		✓			
Northamptonshire CCG and NHCP – Communications Lead		✓			✓
NHCP – Senior Comms Officer		✓	✓	✓	✓
Northamptonshire CCG – Primary Care Development Manager		✓		✓	
CYP lead			✓		
Public Health – Commissioning Officer			✓		
NHFT and NHCP – Interim Senior System Communications Support	✓		✓		
Arden and GEM – EDI Manager			✓	✓	
Kettering General Hospital NHS Foundation Trust – Head of EDI				✓	
Northamptonshire Carers – Ethnic Minority Carers Lead				✓	

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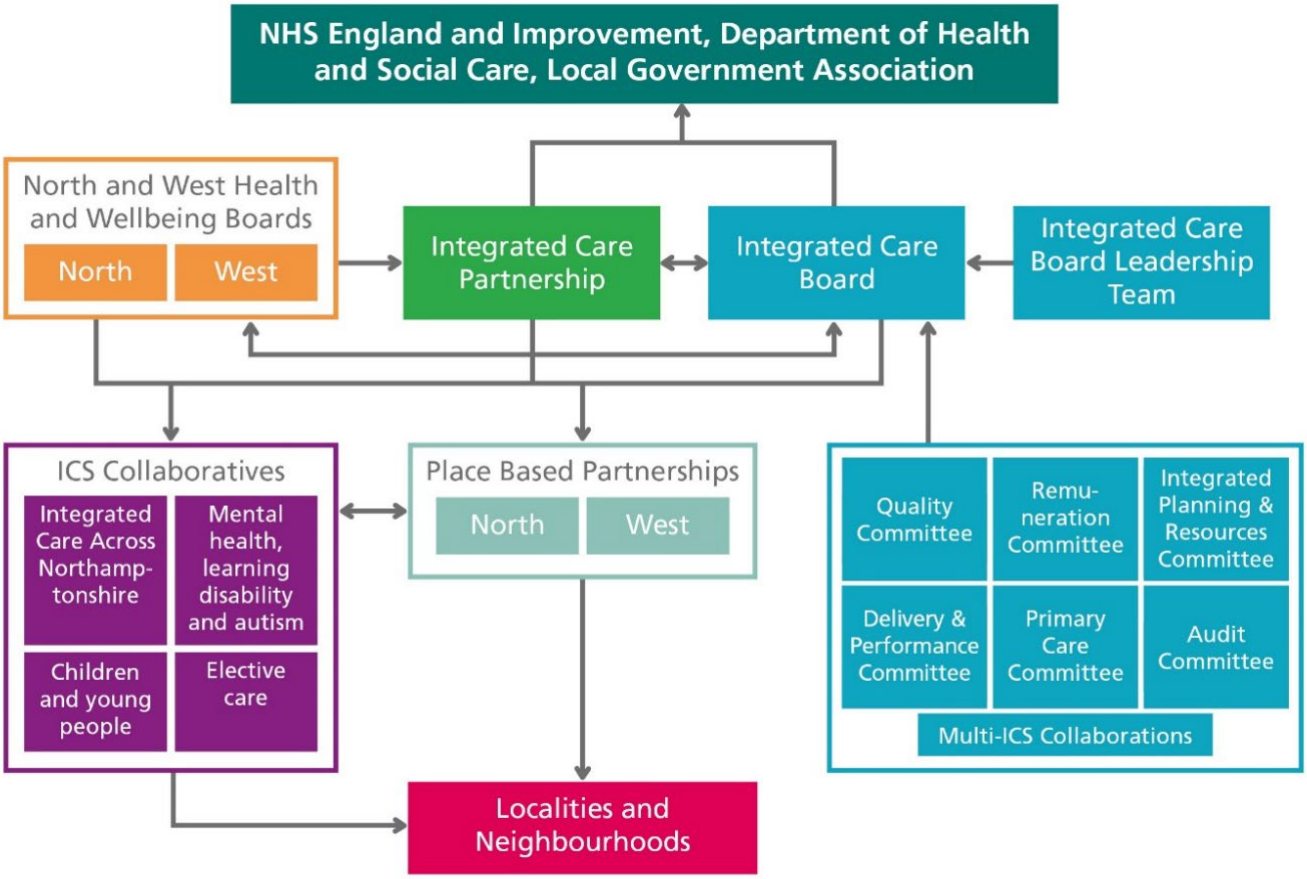
Appendix E: The Northamptonshire Integrated Care System Functions and Decisions Map

This Functions and Decision Map is a high-level structural chart that sets out where key ICB functions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision-making responsibilities that are delegated to the ICB (for example, from NHS England). Further details and context can be found online on the ICB constitutions NHSE pages.



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