DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2023

TAKING A PLACE-BASED APPROACH TO ADDRESSING HEALTH INEQUALITIES.

West Northamptonshire Council

Wellbeing WEST NORTHANTS

FOREWORDS

Dear Reader,

It is with pleasure I welcome you to the 2023 Director of Public Health Annual Report for West Northamptonshire. This year, the report focuses on the Place Based Approach to a really important issue, tackling health inequalities.

Health inequalities is something that affects nearly all communities in some way. Bridging the gap in life chances and health outcomes between those in our more affluent communities and those in our poorest ones, is something that myself and my colleagues are all devoted to doing. We are committed to community involvement and ensuring that our residents can be involved in the way that services are delivered and our new place-based approach will enable us to achieve this.

I am really excited by all the work that is happening here in West Northamptonshire particularly in our Local Area Partnership initiative which you will hear more about in this report.

Cllr Matt Golby,
Cabinet Member for Adult Social Care, Public Health and Wellbeing

FOREWORD FROM THE DIRECTOR OF PUBLIC HEALTH

2023 has been another busy year with many impactful projects happening. It has been particularly significant for my Public Health team as it is the first full year where public health has sat solely within West Northamptonshire Council, working closely with partners to serve residents of West Northants.

In Public Health terms, 2023 has also seen a number of unsettling events continue; the cost of living crisis (which was the focus of my 2022 report), the humanitarian crisis resulting from the war in Ukraine, and now also in the middle east. Whilst globally being downgraded from its pandemic status, the threat of COVID-19 and the recovery from this prolonged pandemic still very much continues to play a big part in the world of Public Health.

However, there has been a huge response effort from partners, both internal and external, to the Council that has quickly mobilised together, to put in place the right support for our residents. And this is something I am incredibly proud of to all involved.

As well as this, the world has seen a number of medical breakthroughs, successful vaccines and treatments being developed for diseases and illnesses such as cancer, Alzheimer's and malaria. Positive steps have also been taken to tackle some of the most worrying climate and environmental issues the world currently faces and on a local level, we have also seen lots of exciting progress within West Northamptonshire itself, particularly around a place-based plan to develop our Local Area Partnership approach. Great strides have been taken to work with our partners across each local area to help residents achieve our shared aim to 'Live your best life'. More about this is featured within this report.

The last year has certainly demonstrated to me that working together with our systemwide partners, ensuring that our aims and outcomes are properly aligned, can and will make a real difference to people and their communities. This report gives real examples of how we have worked with our partners, voluntary sector and communities to start to embed our place-based and 'asset-based' approach, ultimately helping communities and individuals alike to have hands on involvement in being able to shape services to meet their needs.

Whilst we have begun to address the poor health outcomes for those living within marginalised groups or areas of deprivation, health inequalities remains a big concern and it is clear there is still more to do to address the needs of all of our residents across such a diverse area. Within this report and its accompanying video, you will see how some of the work that has taken place, has started to address this issue and how the idea of taking a place-based approach embodies this way of thinking.

The hope is that together we can start to break down these health inequities so everyone in West Northamptonshire can live a long and healthy life.

Sally Burns,
Director of Public Health

INTRODUCTION

The previous Director of Public Health report made the recommendation to take place-based and asset-based approaches linking with the work of the emerging Local Area Partnerships.

This report provides an update on the progress made in implementing this recommendation and embedding place-based and asset-based approaches across West Northamptonshire.

To stay healthy, people need good homes, good jobs, friends and an environment that makes healthy choices possible[i]. However, we know that not all people in society have the same chance to be healthy, due to not having good homes, good jobs, friends and healthy environments to live in. This results in health inequalities, and they are due to:

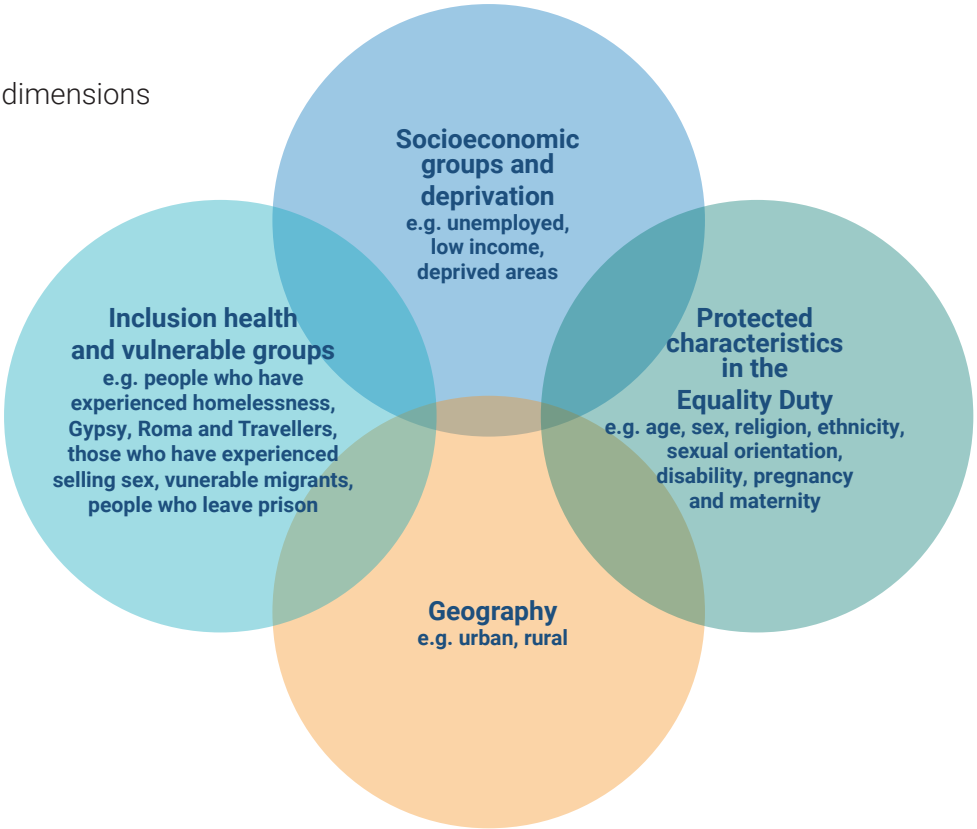
- wider determinants of health, eg quality of housing, employment, places people live
- behavioural risks to health, eg smoking rates and access to healthy food
- health status, eg health conditions
- access to care, eg treatments for ill health or advice on staying well
- quality and experience of care, eg levels of patient satisfaction[ii].

Health inequalities can be significantly reduced. The most effective way to do this is to improve the places people are born, live, work and age[iii]. Figure 1 shows the different groups that are most vulnerable to health inequalities and how these overlap. The different groups are:

- socioeconomic groups and deprivation i.e. people with low income / unemployment
- people living in deprived areas
- protected characteristics listed in the Equality Duty such as age, sex, ethnicity
- the places people live i.e. urban / rural areas
- inclusion health and vulnerable groups such as people experiencing homelessness, those w ho have experienced selling sex.

Many people fall into more than one of these groups and experience multiple disadvantages.

Figure 1
The overlapping dimensions of inequality



INTRODUCTION

Those described as inclusion health or vulnerable groups are particularly disadvantaged and excluded from society. In the UK, the concept of inclusion health has typically encompassed homeless people; Gypsy, Roma, and traveller communities; vulnerable migrants; and sex workers[iv] but other groups can be included. Social exclusion can be driven by unequal power relationships that interact across economic, political, social and cultural dimensions[v].

Inclusion health groups experience the poorest health outcomes and commonly have very high levels of morbidity and mortality, often with multiple and complex needs. This includes overlapping mental and physical ill-health and substance dependency, creating complex situations that health services are not always equipped to deal with and that traditional health and social care approaches generally fail to address[vi].

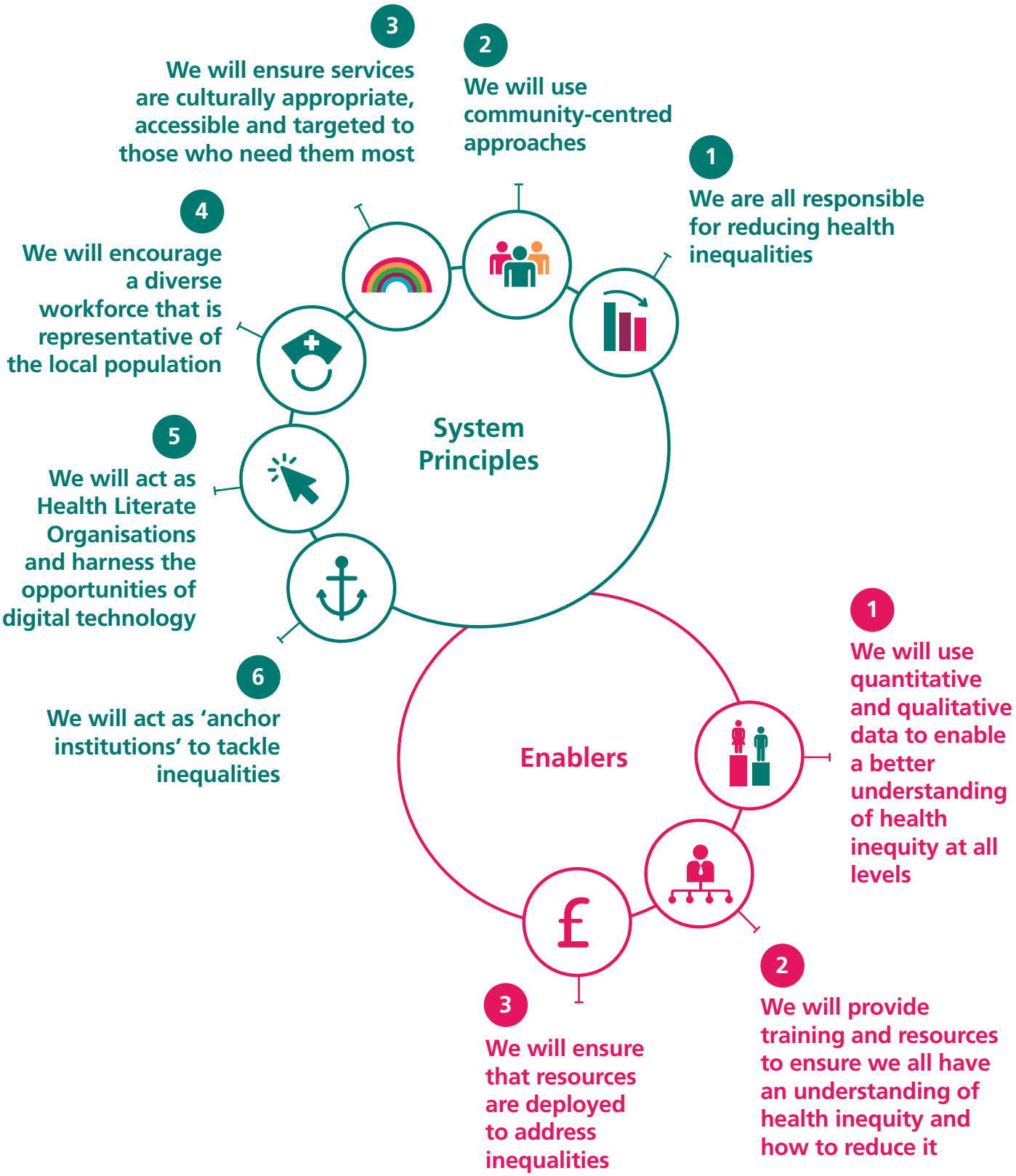
Common experiences cut across inclusion health groups. Most have been or are exposed to multiple, overlapping risk factors, such as adverse childhood experiences, trauma and poverty. Adding to this, many face multiple barriers in access to health services because of fear, language and communication issues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

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

In 2021 NHS England developed the CORE20PLUS5 framework to better understand health inequalities and target services to those most vulnerable to them. CORE20 represents those living in the 20% most deprived areas and PLUS represents the other groups represented in figure 2, considering the specific communities within an area. The 5 element recommends focussing on 5 areas most considered to reduce health inequalities in healthcare. For adults this is early cancer diagnosis, physical health checks for people with serious mental health conditions, hypertension case finding, continuity of care for Black, Asian and minority ethnic groups in maternity services and chronic respiratory disease. For children and young people, the 5 areas are epilepsy, asthma, diabetes, oral health and mental health.

In July 2021 Integrated Care Northamptonshire published its Health Inequalities Plan, which describes how we will work with communities so that everyone has the chance to thrive and to access quality services providing excellent experiences and the best outcomes for all. The Integrated Care Northamptonshire Health Inequalities Plan sets out the principles which all partners working across the system need to adopt to address health inequalities, as shown below in Figure 2.

Figure 2
Summary of the ICN Health Inequalities Plan system principles and enablers



TAKING A PLACE-BASED APPROACH

While action on behaviours and conditions is a necessary part of the solution to reduce health inequalities, these need to be addressed within the context of their root causes in the wider determinants of health. Given the range of causes of health inequalities, a joined-up approach that focusses on specific places/ communities is necessary.

COMMUNITY CENTRED INTERVENTIONS

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

There is growing evidence which supports the case for a shift to more community-centred approaches to health and wellbeing[xi]. They involve:

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

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

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

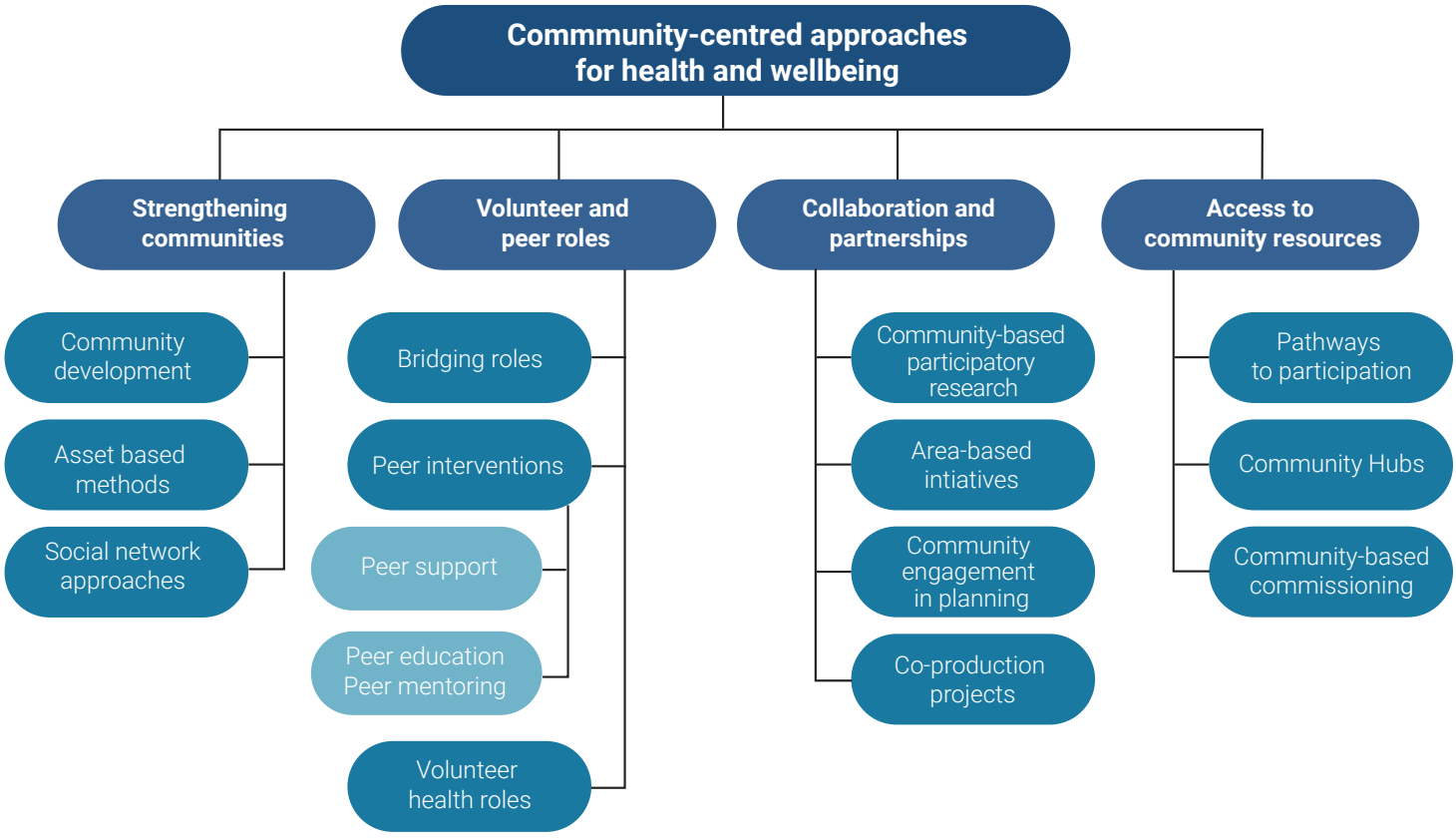
Community-centred approaches are about making the most of assets within communities, increasing people's control over their health and lives and ensuring everyone has the same opportunity to have good health and wellbeing. However, not all groups have equal access to community assets. Those who are socially excluded often do not have a voice in local decisions and are not given as many opportunities to participate in community life as others. Participatory approaches can directly address marginalisation and powerlessness that underpins this and can be more effective than professional-led services. Involving individuals and communities so that they define the problems and develop community solutions means we can shift power towards individuals and communities and address health inequalities.

COMMUNITY-CENTRED APPROACHES

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

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

Figure 3:
Community-centred approaches
for health and wellbeing



WEST NORTHAMPTONSHIRE
POPULATION AND INEQUALITIES HIGHLIGHTS

429,013 people live in West Northamptonshire, an increase of 14.4% since 2011.

In 2022 there were 4,540 live births and 3,502 deaths.

13.7% of the population live in the 20% most deprived areas.

The proportion who are not White British (nWB) increased from 8.8% in 2001 to 24.9% in 2021. This is below the England average of 26.5%. Of this population a significant number, about 9.7% are from Eastern European countries. 3.4% are Black Caribbean; 2.3% are Bangladeshi; 1.1% Asian Indian; 0.9% Black African.

6.6% of households contain no one who has English as their main language. (England 5.0%)

19.9% of residents (aged 3+) who do not have English as their main language, either cannot speak English well or cannot speak English at all. (England 20.2%)

The proportion stating, they have no religion has shifted from 17.4% (2001) to 38.2%. (2021)

There is a lower-than-average proportion of residents following religions other than Christianity (6.2% v. 11.0% in England). Since 2011, the WN area has logged a 43% increase in persons of Muslim faith and a 27% increase in Hindus.

2.7% of the population over 16 have a sexual orientation other than heterosexual. (England 3.2%)

The Gypsy and Traveller population in West Northamptonshire in 2021 was 340. Gypsy, Roma and Traveller women live 12 years less and men 10 years less than the general population.

Between 2018 and 2023, 706 in total were recorded as having an accommodation at the time of application that was either Rough Sleeping or No Fixed Address (NFA), while a further 301 had a history of Rough Sleeping.

Most people sleeping rough have been male, averaging 78.8% across each of these cohorts. The average age at death of people who sleep rough is 44 years for men and 42 years for women.

20,369 households (11.6%) were living in fuel poverty in 2021. (England 13.1%)

287 people were killed or seriously injured on Northamptonshire's roads in 2022. (an increase from 215 in 2021)

WEST NORTHAMPTONSHIRE POPULATION AND INEQUALITIES HIGHLIGHTS

Starting Well

- 21.4% (92,008) are children aged under 18.
- 19.8% of children live in relative low-income families. (England 19.9%)
- 9.7% of women smoked during pregnancy in 2022/23, significantly higher than England. (8%)
- 58.6% of babies were breastfed in 2022/23, (significantly higher than England 49.2%)
- 1.9% of term babies born in 2021 had a low birth weight, significantly lower than England. (2.8%)
- 3,504 children and young people have an EHC plan, 71.5% are boys, 32.9% have ASD.
- 8,167 have SEN Support, 62.9% are boys. 16.8% have social, emotional, or mental health needs.
- 68.6% of schoolchildren achieved a good level of development by the end of Reception in 2022/23. (England 67.2%)
- 19.9% of children in Reception and 34.3% in Year 6 were overweight or obese in 2022/23. Compared to England 21.3% and 36.6% respectively.

Living Well

- 60.8% (261,167) are adults aged 18 to 64.
- 69.4% of adults are classified as overweight or obese. (significantly worse than England at 63.8%)
- 65.3% of adults aged 19 and over were physically active (England 67.3%) and 24.0% were physically inactive in 2021/22. (England 22.3%)
- 12% of adults aged 18 and over were current smokers in 2022. (England 12.7%)
- 47.1% of adults do walking or cycling for any purpose at least 3 times a week in 2022. (England 45.8%)
- 83.2% of working-aged adults (16–64) were in employment in 2022-23 (England 78.6%); 2.9% were unemployed. (England 3.8%)
- The average annual salary for full-time workers was £31,776 per year in 2022 (England £33,106); for part-time workers, it was £12,203. (England £12,260)
- Average house prices were 8.4 times a person's average annual gross salary in 2022. (England 7.91)
- The average house price was £290,000 in Q1 of 2023. (England £277,732)
- 15.9% of households (27,457) did not have a car or van in 2021. (England 23.5%)

Ageing Well

- 17.1% (73,287) are aged 65 and over.
- 2.1% (8,957) of the resident population are 85 and over.
- Average life expectancy at birth for males was 79.4 years in 2021 (England 78.7) and 83.4 years for females. (England, 82.8 years)
- 1,293 people died before the age of 75 in 2021 (premature deaths); 641 people died before the age of 75 from deaths considered preventable.
- Estimated dementia diagnosis rate (aged 65 and older) was 62.3% for 2023. (England 63%)
- 1,343 Falls admissions for patients aged 65 and over.
- 34.9 percent excess winter mortality (% of extra deaths for all adults) in 2020/21. (37.5% nationally)
- The top 5 causes of death are cancer, dementia and Alzheimer disease, ischemic heart disease, chronic lower respiratory disease and cardiovascular diseases.

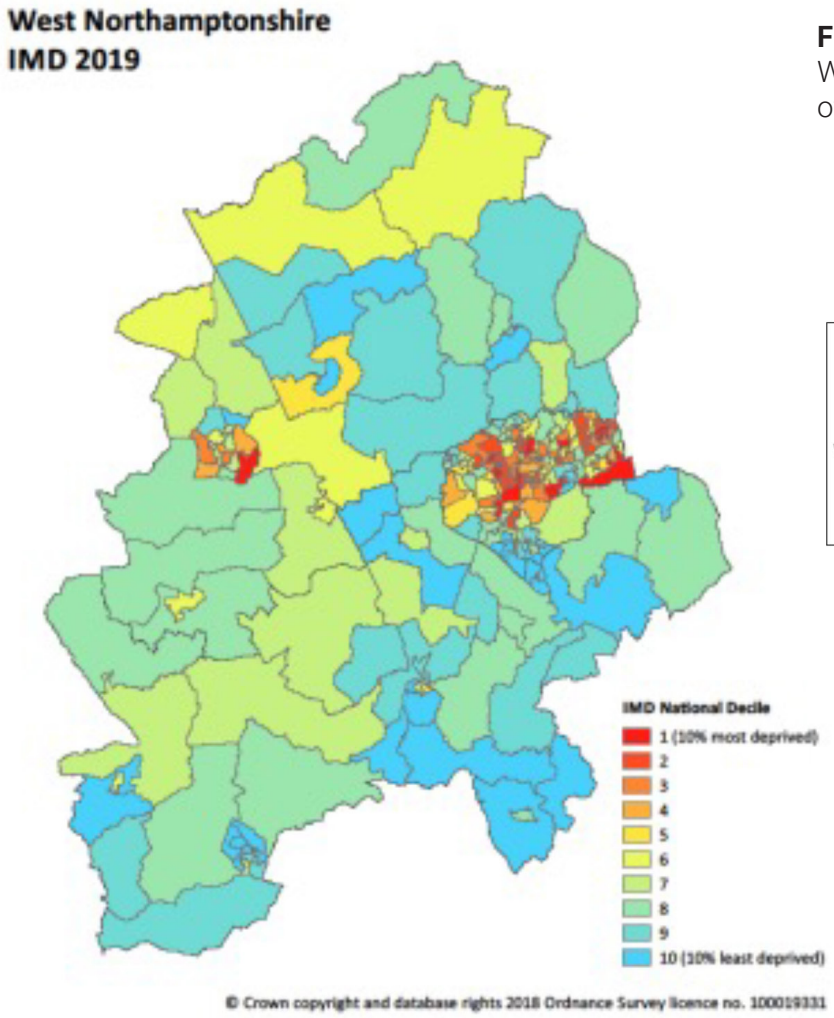
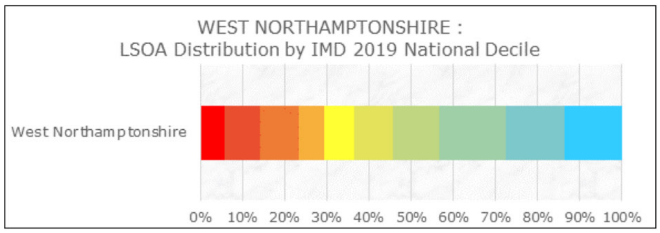
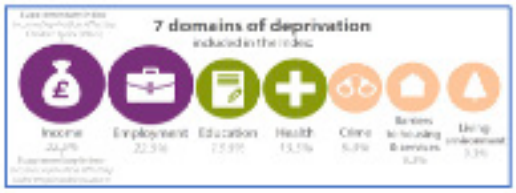


Figure 4:
West Northamptonshire Indices of Multiple Deprivation 2019





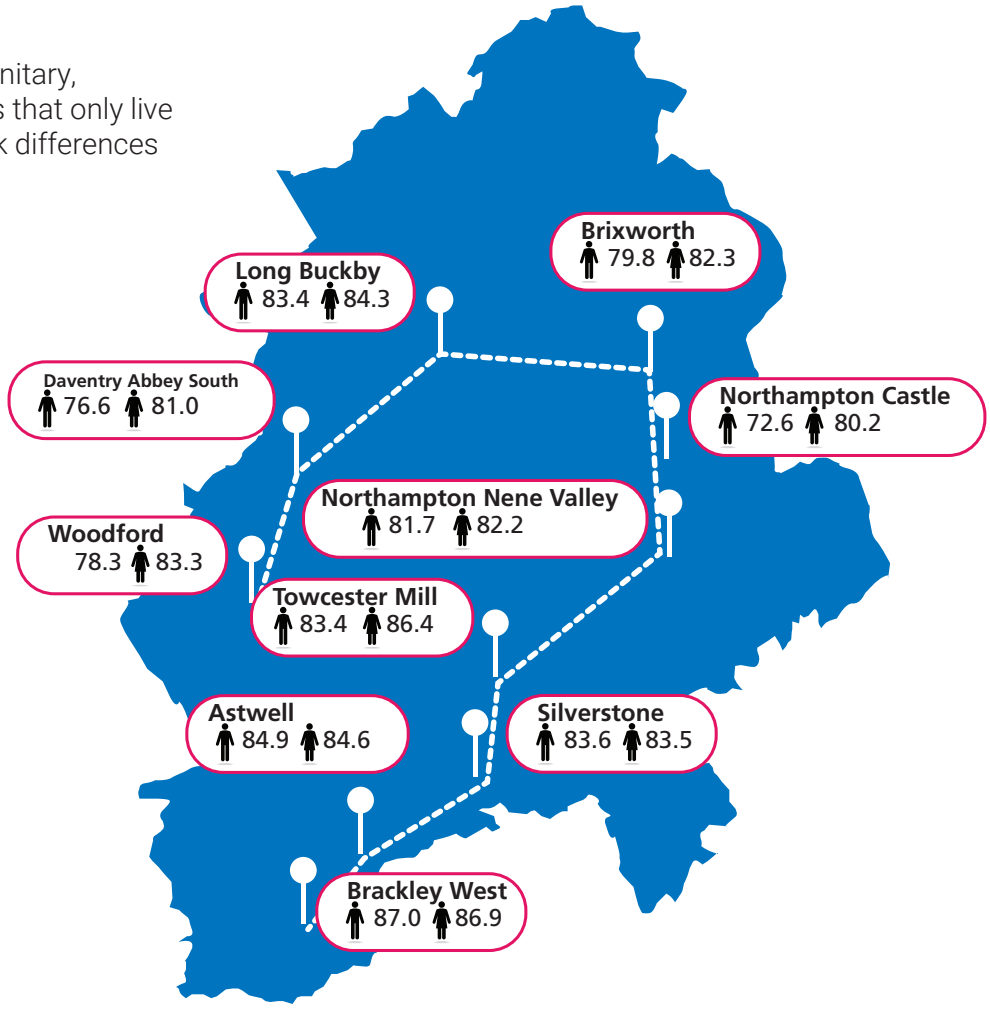
Deprivation Affected Population Counts based on the Index of Multiple Deprivation 2019 and the ONS Mid-Year Estimates 2018

WEST NORTHAMPTONSHIRE	Total Population	Aged 0-4	Aged 5-15	Age 16-17	Aged 18-24	Aged 25-44	Aged 45-64	Aged 65-84	Aged 85 & Over
West Northamptonshire Population Living in Top 20% most Deprived LSOAs Nationally IMD 2019	55779	4751	9554	1520	5361	16822	12016	5141	614
% of total population		8.5%	17.1%	2.7%	9.6%	30.2%	21.5%	9.2%	1.1%
West Northamptonshire Population Living in Bottom 80% LSOAs Nationally IMD 2019 (Not Deprived)	346366	20942	46887	7547	25285	86048	94969	56772	7916
% of total population		6.0%	13.5%	2.2%	7.3%	24.8%	27.4%	16.4%	2.3%

The table shows the approximate number of residents of West Northamptonshire (by age) who live in the top 20% most deprived LSOAs nationally based on 2018 mid-year estimates.

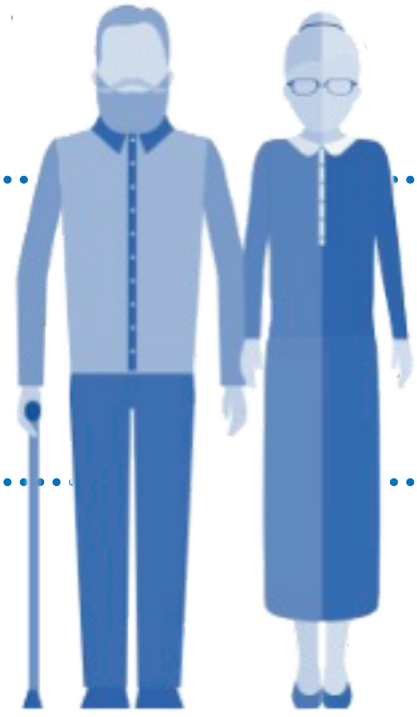
LIFE EXPECTANCY ACROSS WEST NORTHAMPTONSHIRE

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



Average life expectancy at birth for men is 79.4

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 83.4

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

CHILDREN IN RELATIVE LOW-INCOME FAMILIES IN WEST NORTHAMPTONSHIRE

In 2021-22, 19.8% of children aged 0-15 in West Northamptonshire were living in relative low income. This was just short of the England average (19.9%).

This number has increased by 42.1% compared to two years ago, compared to an increase of 1.2% across England as a whole.

50.3% live with lone parents above the England average (44.5%) - 70.9% increase in children in two years. 72.7% live in working families 2% above the England average.

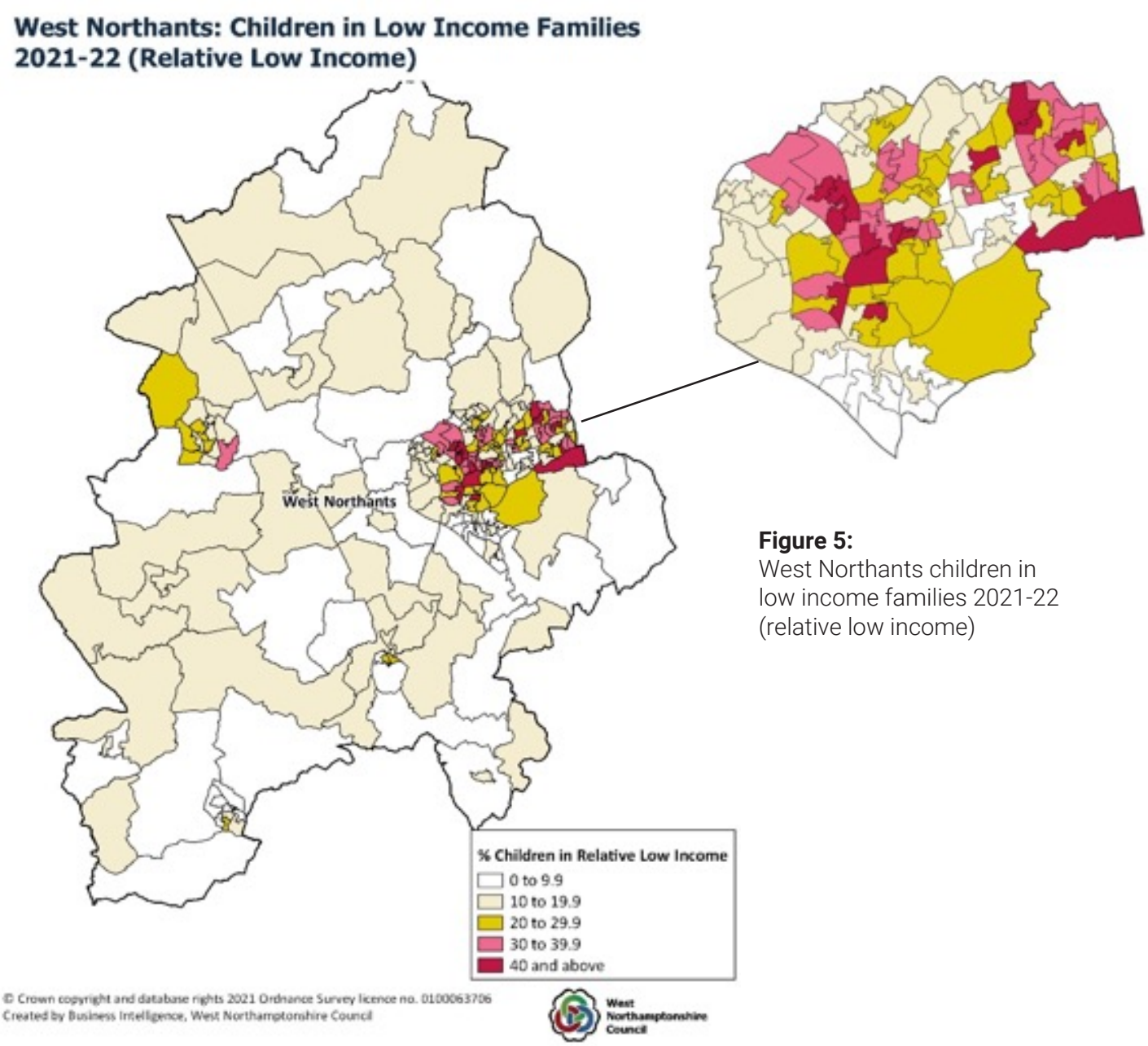


Figure 5:
West Northants children in low income families 2021-22 (relative low income)

Dependent Children in Low Income Families (CinLIFs) are those under 16 years or aged 16 to 19 in full-time non-advanced education or in unwaged government training, living in families with a gross income before housing costs of less than 60% of the median income. 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. Relative CinLIF measures children in low-income families before housing costs, in the reference year.

WEST NORTHAMPTONSHIRE'S PLACE-BASED APPROACH

In June 2022 the new Integrated Care System was adopted across Northamptonshire. Partners in the system committed to working towards the delivery of 10 ambitions and a set of common metrics. West Northamptonshire's Health and Wellbeing Board, Joint Health and Wellbeing Strategy 2023-28 sets out the actions all partners working in West Northamptonshire will take to deliver these ambitions, recognising the importance of place-based approaches. Outcomes will be improved through collaboration, integration and listening to the needs of local people.

Figure 6:
Summary of ICN ambitions, outcomes and system measures

Ambition	Key outcomes	Available system priority metrics
Best start in life	Women are healthy and well during and after pregnancy. Children are healthy from birth. All children grow and develop well so they are ready and equipped to start school. Children in care are healthy, well and ready for adulthood.	% achieving good level of development at age 2-3
Access to best education and learning	Children and young people perform well at all key stages. SEND education meets the needs of children locally. Schools serve all children and young people well and nobody misses out on learning. Adults have access to learning opportunities which supports employment and life skills.	Average attainment 8 score of all pupils % of SEND children electively home educated Rate of permanent exclusions (per 100 pupils)
Opportunities to be fit, well and independent	Adults are healthy and active, and enjoy good mental health. People experience less ill-health and disability due to lung and heart diseases.	% of adults currently smoke (APS) % Adults classified as overweight or obese Adolescent self-reported wellbeing (SHEU) Standardised rate of emergency admissions due to COPD
Employment that keeps you and your families out of poverty	More adults are employed and receive a 'living wage'. Adults and families take up benefits they are entitled to.	Gap in employment for those in touch with secondary mental health services
Good housing in places which are clean and green	Good access to affordable, safe, quality, accommodation and security of tenure. The local environment is clean and green with lower carbon emissions.	Number of households owed a prevention duty under Homelessness Reduction Act
Safe in your homes and when out and about	People are safe in their homes, on public transport and in public places. Children and young people are safe and protected from harm.	Number of re-referrals to MARAC for children experiencing domestic abuse
Connected to families and friends	People feel well connected to family, friends and their community. Connections are helped by public transport and technology. Improving outcomes for those who are socially excluded.	% adult social care users with as much social contact as they like
The chance for a fresh start when things go wrong	Homeless people and ex-offenders are helped back into society. People have good access to support for addictive behaviour and take it up.	Number of emergency hospital admissions for those with no fixed abode
Access to health and social care	Timely access to all health and social care services when it is required, life course from conception to end of life. People are supported to live at places of their residence and only spend time in hospital to meet medical needs. Services to prevent illness (all health screening and vaccinations) are easy to access with quality service provision. People are treated with dignity and respect in all care provisions including end of life.	% Cancer diagnosed at stage1/2 % of people discharged from hospital to their usual place of residence Rate of emergency department attendances for falls in those aged 65+ % eligible adults with learning disability/ severe mental illness receive annual health check
To be accepted and valued simply for who you are	Diversity is respected and celebrated. People feel they are a valued part of their community and are not isolated or lonely. People are treated with dignity and respect.	Metrics to be developed

During 2023 the new Place Operating Model was rolled out across West Northamptonshire. The model is underpinned by targeting local needs and improving outcomes for local communities, adopting the community-centred approaches to health and wellbeing. It is delivered through nine Local Area Partnerships (LAPs), which are now in place, and they include local membership from a wide range of system partners who know their local population. The key to success of the LAPs is the range of agencies and services working in partnership at a very local level to reduce organisational barriers and drive integration. This provides focus, reduces duplication and improves efficiencies. A diagram illustrating the geography of the nine LAPs is shown below.

WEST NORTHANTS LOCAL AREA PARTNERSHIPS (LAPs)

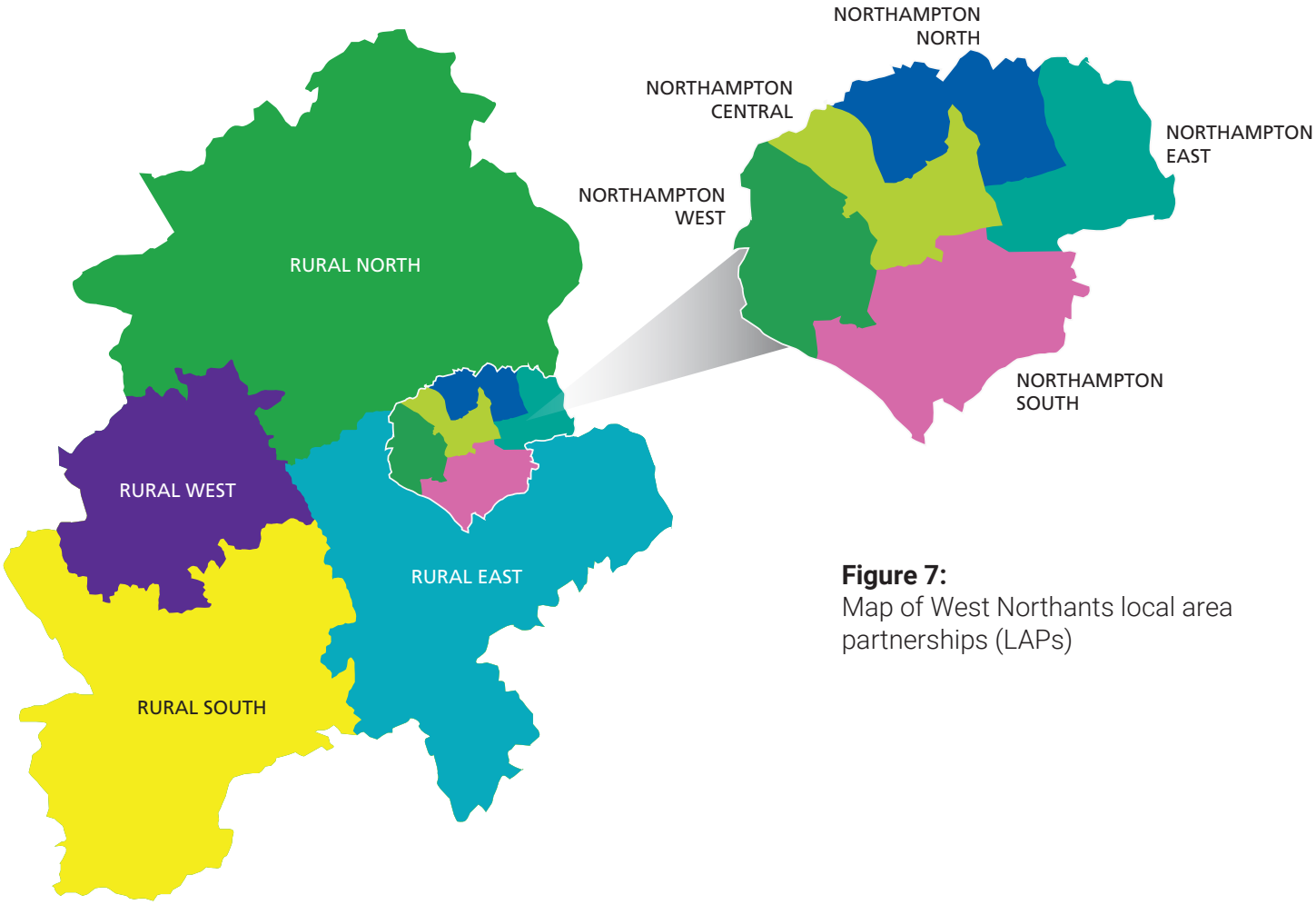
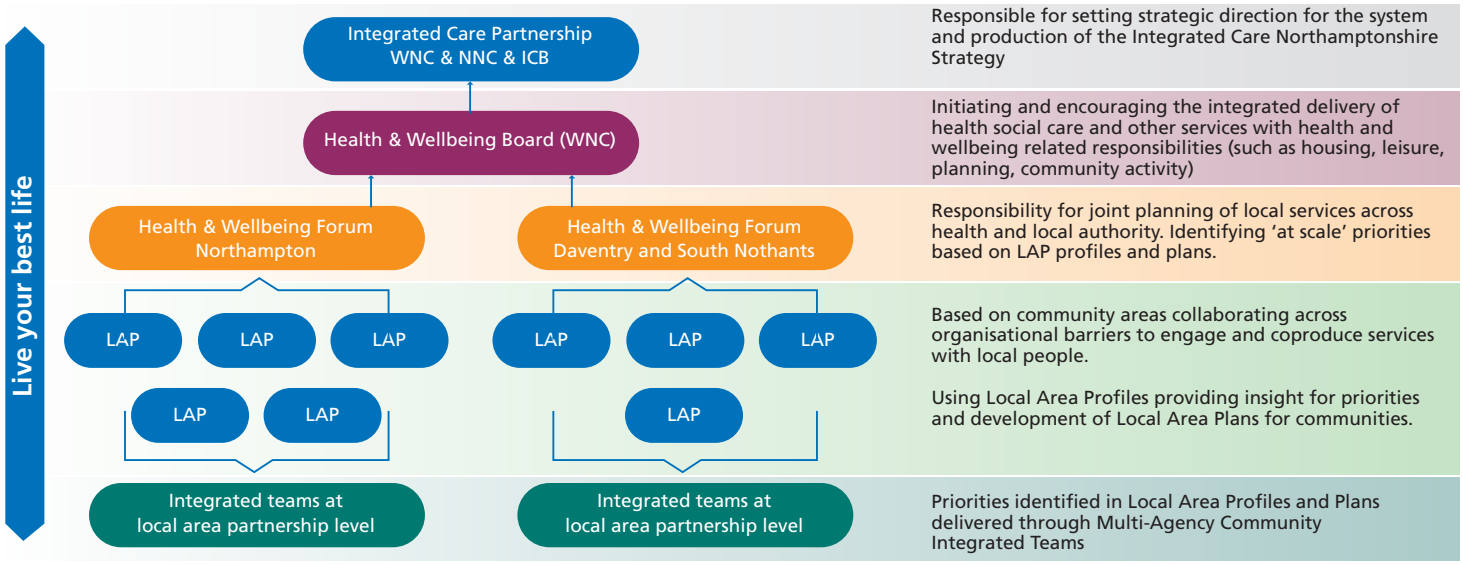


Figure 7:
Map of West Northants local area partnerships (LAPs)

The diagram below illustrates how the local community approach influences the decisions of the Integrated Care System and contributes to the 10 LYBL (Live Your Best Life) ambitions.

Figure 8:
West Northants Place governance structure



WEST NORTHANTS LOCAL AREA PARTNERSHIPS (LAPs)

LAPs are the focus of how partners within local communities co-design activities and services to improve outcomes, reduce health inequalities and contribute to the 10 LYBL ambitions.

The LAPs aim:

- To represent local areas and give a voice to residents.
- To empower residents to co-produce new services and solutions for their local area.
- To ensure local services are appropriate and delivered in a way that will meet the needs of the community.
- To contribute to West Northamptonshire priorities by utilising evidence-based information and local insight from frontline services and communities.
- To empower local leaders to take accountability for local action.

The LAP membership includes representation from a wide range of local partners including West Northamptonshire Council (WNC), Public Health, Adult Social Care, Police, Fire and Safety, Voluntary, Community and Social Enterprise (VCSE), GPs, local Elected Councillors, Northamptonshire Children's Trust and others.

As the LAP local leadership team their role is to:

- Determine two to three priorities that need addressing to reduce inequalities and oversee development of groups to take action to address these.
- Oversee the development of the LAP communications, engagement with communities and local websites.
- Escalate any areas of concern to the local Health and Wellbeing Forum.

Through discussions and agreements many partners have aligned themselves to the local areas including Adult Social Care aligning services to the LAP areas based on need, Northamptonshire Police aligning all their beats to the LAP areas, VCSE colleagues identifying representatives for all the LAPs based on the LAP priorities.

Partnership working in the LAPs provides the opportunity to share data and insights at a very local level which in turn means that the LAP leadership is able to identify meaningful specific priorities for the local population.

The majority of LAPs are focusing on children and young people, with others targeting the needs of older people and social isolation. The high level priorities are included in the figure in the next page.

WEST NORTHANTS LOCAL AREA PARTNERSHIPS (LAPs)

Rural West

Children & Young People:

- 20% of population are 0-16 yrs. old
- Mental health issues high with self-harm higher than average
- 5.6% youth unemployment higher than England average 4.9%

Families:

- 49.1% of families on relatively low incomes
- High proportion of obesity in adults
- Lower levels of achievement in education
- Development in EYFS (0-5 yrs.) falling below regional and national averages

Social Isolation:

- Connection to secondary schools for some is poor
- Low satisfaction scores for belonging.
- Some areas in Daventry town have high levels of income deprivation
- 7.7% of pensioners living in poverty

Rural North

Older People:

- High population age 65+ (21%)
- Higher life expectancy
- Poor mental health indicators

Carers:

- 8.5% of the population are providing unpaid care for others
- Almost 26% of carers deliver more than 50 hours per week.
- Majority of care is for older people

Social Isolation:

- Highest number of rural aging residents of all LAPs
- Furthest to travel for secondary education
- High food vulnerability index score
- High numbers attending Welcoming Spaces

Rural South

Older Population:

- 20.06% of population is aged 65+
- Highest proportion of persons 75+ of all LAPs
- Highest loneliness index score

Children and Young People:

- Average travel time to facilities and amenities is higher than England average.
- Prevalence of depression is high at 13.2%••
- Percentage of children (15+) smoking is high at 8.7%

Rural East

Older People:

- Higher proportion of population is aged 65+ (20%) & 75+ (8.8%) greater than England averages
- Number of pensioner households is rising, up to 23.7%

Families:

- High proportion of children in relative low-income lone parent families (51.1%)
- Percentage of children (15+) smoking is high at 8.6%

Transport & Services:

- High number of people living in rural location (31.1% compared to England average (10.5%)
- Higher levels of depression than England average

WEST NORTHANTS LOCAL AREA PARTNERSHIPS (LAPs)

Northampton North

Older People:
- Highest numbers of people aged 65+ of all LAPs
- Higher than average proportion of Pension Credit claims 12.2% compared to England average 11.3%

Anti-Social Behaviour & Youth Provision:
- High levels of neighbourhood level incidents of anti-social behaviour
- A higher-than-expected number of children live in relative low-income families

Children & young people:
- High levels of mental health needs

Northampton West

Youth Provision:
- Highest proportion of Children 0-16 of all LAPS
- High proportion of children smoking
- Nearly a third of children obese in Yr. 6
- High than average number seeking help for depression
- More UC claimants from single parent households

Multi-Agency Education Team:
- Suspensions is 2nd highest in WNC
- Seven-fold increase in exclusions relating to drugs and alcohol. High numbers of exclusions for disruptive behaviour and other reasons

Digital Information (Safeguarding):
- There is a need to improve the customer experience and communication routes across social care

Northampton South

Supporting families & pupils where English is not their first language:
- 30% identify as non-white British, 22.3% born outside the UK
- 8% of households have no English Speakers
- Significant increase in numbers from ethnic minorities

Early Years:
- Area of high levels of deprivation some wards in the 20% most deprived areas of England
- High numbers of lone parent families

Active Travel:
- Highest Carbon footprint of all the LAPs
- High average number of vehicles per household 35.6% compared to England average 26.1%
- Lowest average walking distance to key services
- Highest proportion of LAP populations that are of working age

Northampton Central

Multi-Agency Education Team:
- Suspensions and exclusions mean a loss of 12.5yrs of education
- Highest suspension rates in West Northamptonshire
- High numbers of exclusions for disruptive behaviour or for inappropriate use of social media

Access to Community Space for Youth Provision:
- 33.7% of children live in relative low income
- High youth involvement in anti-social behaviour; drugs weapons crimes
- Higher than average number of reports of feeling unsafe

Comprehensive COPD Programme:
- Significantly higher rates of COPD related illnesses
- 30% of residents smoke
- Of those with diagnosed COPD just 25% access services

Women's Health Inequalities:
- Life and health expectancy of women lowest in Northants.
- Largest non-white population in West Northants.
- Women have fewer years of healthy life due to poorer reproductive and gynaecological health.

Northampton East

Community Safety:
- High level of recorded crime over a 12-month period
- Violent crimes are higher than national average
- High numbers of burglaries and anti-social behaviour reports
- Low level of satisfaction score

Anti-Poverty/Cost of Living
- LAP area is ranked in the 20% most deprived areas of England
- 30% of children live in relative low-income families.
- Largest % of people claiming Disability Benefits
- Higher than average number of homes have no central heating
- Youth unemployment is higher than the national average

Youth Provision:
- Highest proportion of 0–16-year-olds of all the LAPS
- 4 in 10 children in Year 6 are overweight or obese
- High Proportion of lone parents
- Greater Socio-Cultural barriers such as beliefs and traditions

WEST NORTHANTS LOCAL AREA PARTNERSHIPS (LAPs)

Partners work together on the emerging issues to bring about positive impact on wellbeing, using a range of different approaches. An example is included below.

Central Northampton LAP

When compared with the West Northamptonshire LAPs, this LAP has:

- A total population of 59,083, with the lowest proportion of persons aged 75 and over
- The highest proportion of non-white British residents (50%)
- 5.8% that do not speak English at all or do not speak it well
- 17.7% households where no one speaks English as their main language
- The highest proportion of residents working in elementary occupations (25%)
- The highest proportion of no qualifications (19%)
- The highest proportion of deprived households: 50% of households living with 1 deprivation dimension; 5.2% of households living with 3 or more deprivation dimensions
- Highest number of people with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and high rates of emergency admissions, for both all ages and those under 75 years.

Based on the data, Northampton Central LAP identified poor respiratory outcomes as a priority. We have worked with partners across the NHS, VCSE and local authority to develop a test and learn programme to test a place-based approach to addressing inequalities in respiratory outcomes in this area.

It included reviewing the pathway for respiratory care, looking at the factors that influence respiratory health, starting with the wider determinants of health (the places people live and work), the opportunities to live healthy lives through to the opportunities to access support for people with respiratory conditions, considering both children and young people and adults. The model was developed in partnership with a range of stakeholders through a process of engagement, which was initiated at a Health and Wellbeing Board development workshop (attendees included elected members, local authority, NHS, VCSE partners) and refined through an iterative process in discussion with stakeholders.

The programme uses a number of approaches from the family of community approaches and is working with a number of partners across West Northamptonshire:

- Working with community organisations to conduct community engagement work to better understand experiences of respiratory conditions and identify opportunities for action.
- Develop a 2-year community health champions programme to recruit volunteers that represent local communities who will be trained and supported to be a link into communities and share information on health-related matters and signpost to services and support.
- Deliver a targeted outreach offer to bring health improvement services into the community, including a Stop Smoking Service, health checks, immunisation and screening.
- GPA recruited Health and Wellbeing Coaches, to engage with and offer 1:1 support for over-looked groups in the local community who are not currently accessing support to manage their COPD diagnosis.
- Engage with existing service providers to support and develop services currently available for people with a COPD diagnosis, such as Pulmonary Rehab and Breathing Space.
- Develop a digital exclusion project to increase access and improve engagement on the myCOPD self-management app.
- Develop an air quality project to increase awareness and reduce poor air quality in and around schools.
- Develop a children and young people with asthma project to support them, parents/carers and schools with effective asthma action plans and develop an Asthma Friendly Schools programme.
- Working with an evaluation partner to evaluate this place-based programme of work.

AN ASSET-BASED COMMUNITY DEVELOPMENT APPROACH

Through the LAPs, West Northamptonshire Council want to build community capacity to enable people to come together to identify local issues, devise solutions and build sustainable local action on health and the determinants of health. Well Northants uses an asset-based community development (ABCD) approach, targeting specific groups who are most vulnerable to health inequalities.

Well Northants

Asset Based Community Development's premise is that communities can drive the development process themselves by identifying and mobilizing existing, but often unrecognised assets. This means that communities are able to respond to challenges and create local social improvement and economic development.

Through the 'Well Northants' programme, community development workers are embedded within local communities with high deprivation (St David's Kingsthorpe, King's Heath, Blackthorn in Northampton and Southbrook in Daventry) or shared experiences (currently Gypsy Roma Traveller Community and Sex Workers) to better understand local needs and assets and to coproduce interventions to improve individual and community wellbeing.

AN ASSET-BASED COMMUNITY DEVELOPMENT APPROACH

The overall outcome it seeks to achieve is improved health, wellbeing and resilience. The model adopted for this work is the Well Communities Programme developed by the University of East London. The figure below shows the process taken to achieve this outcome, starting with engagement and capacity building, developing local projects and integration of work to build community involvement, empowerment, self-esteem and community cohesion. This results in improved access to services and better health and wellbeing outcomes.

Figure 9:
Well Communities model

WEST NORTHANTS LOCAL AREA PARTNERSHIPS (LAPs)

Community and Stakeholder Engagement, Assessment and Design (CSEAD)

This engagement uses the Community and Stakeholder Engagement in needs assessment (CSEAD) process which leads to local programme co-design. This begins with talking directly to residents through street interviews, ensuring that their views are heard and that they are involved from the outset. Intelligence gathered from residents is then used to conduct a needs assessment, followed by a coproduction workshop with the community and stakeholders to develop an action plan.

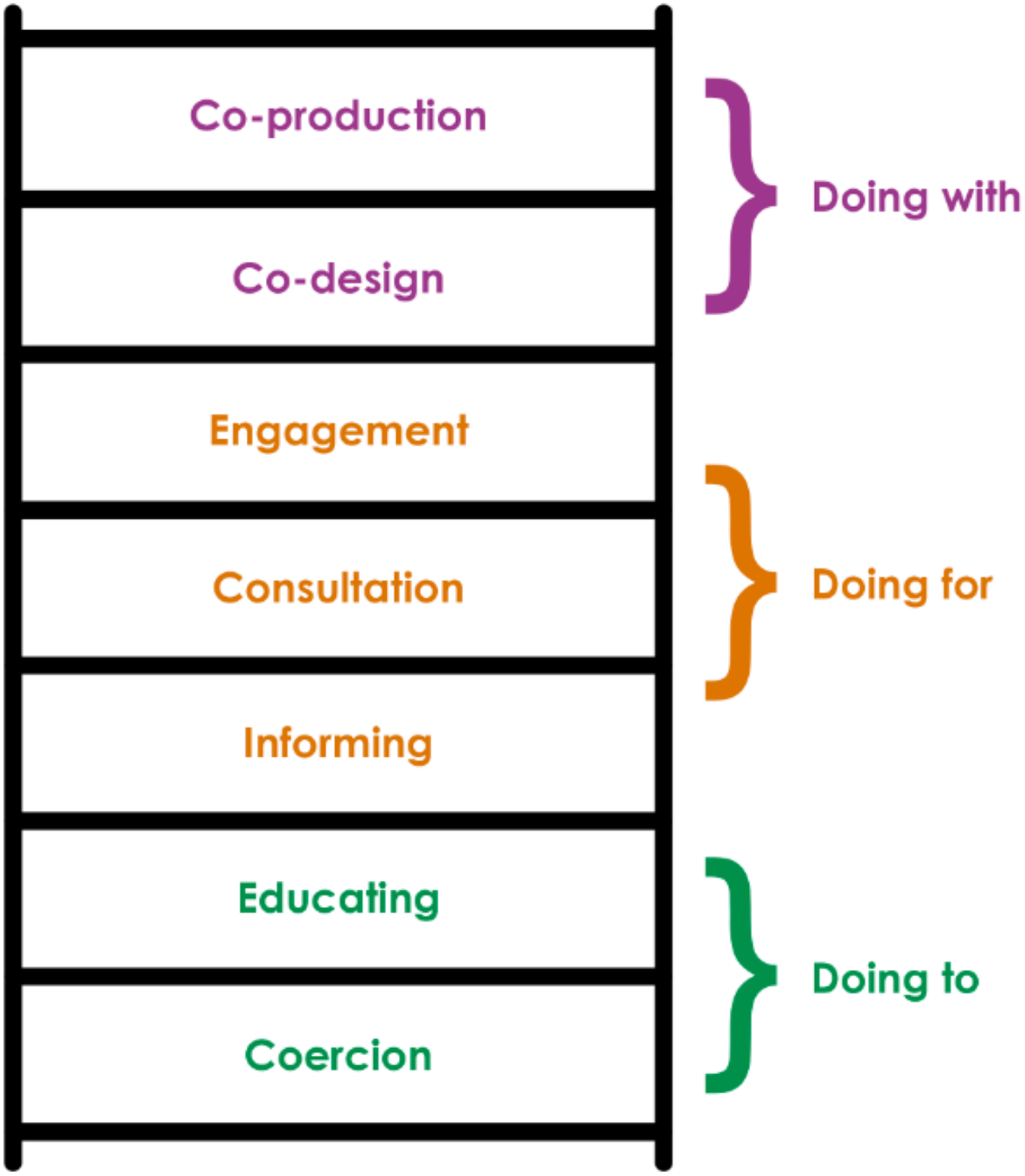
Community development workers have been working with local people and partners to develop neighbourhood, action plans and to implement the actions and monitor progress. Residents, groups and organisations from each community have been invited to bid for funding for an idea that addresses a theme identified through the feedback and insight received from residents. Inviting them to be involved in making decisions about how to spend public money, based on ideas from people who live in their neighbourhood can help achieve involvement. All bids for funding have been voted on by residents in the neighbourhood to choose the ideas they would like to see happen, with the proposals with the most votes receiving funding until the allocated budget is used.

For the long-term impacts of this programme, it is important to build social capital and community resilience. The ambition is for local needs to be met, with improved social connections and networks that reduce risk factors like smoking, obesity, drug and alcohol use and psychological stressors. Due to the nature of the programme targeting, we expect these outcomes will reduce health inequalities in those groups and ultimately result in an increase in life expectancy and healthy life years.

One of the local activities moving forward include the empowerment of a group of vulnerable women, some of whom are involved in sex work, to set up their own peer led beauty and support session, with a team of volunteers accessing training on a pathway to employment. The aim was to provide a safe space for vulnerable women to come together and feel good about themselves, and to provide an opportunity to get to know other people with the same lived experiences. The volunteers involved reported this has had a positive impact on their wellbeing, confidence and self-esteem and provided them with opportunities previously unavailable to them. This has also resulted in a recommendation by the women to develop a harm reduction pack to be given to vulnerable women by health professionals, with training to enable professionals to be able to support sex workers to reduce risk of harm.

ENSURING COMMUNITIES HAVE A VOICE

The Integrated Care Northamptonshire (ICN) and WNC are developing a set of principles for engagement, to ensure that all partners working in West Northamptonshire agree to working in partnership with communities to inform everything we do, based on the ladder of coproduction to move towards coproduction of services. WNC have also developed a coproduction charter to embed coproduction in everything we do and these principles were used to develop the Special Educational Needs (SEND) Strategy.



WEST NORTHANT'S CO-PRODUCTION CHARTER

West Northants Co-production Charter

'Together we are stronger'

This Co-Production Charter outlines the shared values that all partners have agreed to adhere to when working with children, young people and their families.

What is Co-production?

Co-production means working with people who use services as equal partners, to make a decision or shape a service that works for them.

Why co-produce and how do we know it makes a difference?

- Everyone feels equally valued and listened to.
- It leads to better services that improve people's lives.
- It is a legal requirement for all agencies to co-produce with children, young people and families.

This co-production charter outlines the 5 values that all parties will use to work together.

Communication

We will make our communication clear, consistent informative and timely.

Transparency

We will be open and honest as we make decisions.

Accountability

We will take responsibility, find solutions and regularly review to ensure we make a real difference.

Respect

We will listen to and empower people and treat them as equal partners.

Working together

We will work together and recognise that everyone has valuable contributions to make.

West Northamptonshire Council · Northamptonshire Children's Trust · Integrated Care Northamptonshire · NPFG

CASE STUDY: COPRODUCING THE SPECIAL EDUCATIONAL NEEDS (SEND) STRATEGY

- 3,504 CYP aged between 3 and 25 years have an EHCP plan
- 50.5% attend a mainstream school and 38.% attend a special school
- 32% have autistic spectrum disorder
- 22.6% have a speech, language or communication difficulty
- 18.6% have a social, emotional or mental health need
- 14.1% have a moderate learning difficulty

A multi-agency working party was established to scope the task of developing a partnership SEND and Alternative Provision Strategy that will improve the outcomes for children and young people; improve the lived experiences for families, reducing the current adversity and frustration they face; and deliver financial sustainability. Over a 4-month time frame a series of partnership co-production events and discussions took place across West Northamptonshire. Children, young people and their families and all partners across Education, Health and Social care, engaged in robust discussions about past, present and future needs. This included elected members, early years providers, mainstream and special schools, alternative providers, further education colleges, the University of Northampton, local voluntary/community organisations and employers. Mentimeter was used to capture views. The resulting strategy emerged from 21 drafts developed through an iterative process and reflects the aspirations of more than 800 people and more than 3,200 individual inputs. More than 50% of comments came from children, young people and their parents, supported by Northampton Parent Forum Group and other parent groups. The final SEND and Alternative Provision Strategy is the partnership's ambitious vision, aims and priorities co-produced with and by the community to ensure that system change can happen.

CASE STUDY: COMMUNITY WELLBEING FORUMS

As part of the engagement framework, WNC have a number of community forums, which provide a safe, accessible space to engage our communities, particularly our seldom heard communities, who we know may not ordinarily engage. The community forums are aligned to various protected characteristics including disability, gender, sexuality, age, religion, faith and ethnicity. Members can be individuals who live, work or are otherwise involved in community life in West Northamptonshire, or may attend on behalf of a business, community, voluntary or faith organisation. Each forum has a councillor co-chair appointed by the Council and a community co-chair, elected from its members.

The priority, aims and objectives of the forums are to:

- Give people a way to have a dialogue with WNC and its partner organisations
- Provide feedback on issues of concern
- Pass on ideas for future plans for West Northamptonshire and services provided locally, including those provided by the Council and its partners
- Help improve the quality of life for the community they are representing in West Northamptonshire
- Help community groups identify, develop and support people in the community
- Support community groups to raise awareness and educate people about related health and discrimination issues.

The forums seek to monitor the effectiveness of our services in relation to equality by:

- Providing information about services and how to access them
- Identifying and removing barriers to ensure access to services
- Promoting dialogue about issues of concern between us, our members and officers and other people in the community
- Identifying the specific requirements of the people the forums represent.

The forums meet at least every eight weeks and are part of our wider community engagement strategy and network.

The Diverse (Ethnicity and Faith) Communities Forum is an important networking, coordinating and information sharing platform for professionals, partnering organisations and community groups. The forum engages and has representation across a wide range of faith and ethnic groups, providing a mechanism to bring forward issues and barriers to accessing services, exchanging information, developing events, projects and programmes, resulting in it being a first point of contact for many services and organisations wanting to engage with specific communities.

This forum also supports community events that bring our communities together to foster good relationships and celebrate diversity. Including Black History month, Windrush, Independence Day celebrations and faith events such as Diwali and the Ukrainian flag raising event. Recently this forum has been used as a focal point by both the police and fire service in their recruitment to help increase diversity within both organisations. By having constant representation at the meeting, they are able to provide updates, share new information, and seek new advice and perspectives.

The LGBTQ and Allies Forum brings together partners from local LGBTQ+ services, volunteers and community members, marking events such as International Day Against Homophobia, Biphobia and Transphobia and World Aids Day.

Recent forum discussions include:

- The care of LGBTQ+ people in older age groups
- Social care staff, care providers and LGBTQ+ organisations
- Improving services for LGBTQ+ people
- Domestic Abuse and Sexual Violence and support services for the LGBTQ community
- A review of policy providing an LGBTQ+ lens

CASE STUDY: WORLD SUICIDE PREVENTION DAY 2023

In the UK, 115 people die by suicide every week – with 75 percent of those deaths being male (ONS), 1 in 5 people have suicidal thoughts (NHS Digital) and 1 in 14 people self-harm (NHS Digital). ONS figures report that there were 36 suicides in West Northamptonshire in 2022, which is a reduction from 43 in 2021.

World Suicide Prevention Day takes place annually, and this year's theme was 'Creating Hope Through Action'. For World Suicide Prevention Day on 10 September 2023, a sofa travelled around Northamptonshire giving people the opportunity to sit and chat about their mental health. The 'Take a Break' campaign encouraged passers-by to stop, sit and talk, to help to raise awareness of suicide prevention and the services that can provide support, as well as reducing stigma around suicide and self-harm. It provided a relaxed environment for people to chat, share any concerns and find out how to get help.

The brown leather two-seater sofa was transported to different locations across Northamptonshire, over six days at varying times, with different organisations supporting at each place.

The campaign was run by Northamptonshire Healthcare NHS Foundation Trust (NHFT) with support from West Northamptonshire and North Northamptonshire Public Health teams.

In West Northamptonshire, the sofa visited Brackmills Industrial Estate, Becket's Park and The Amazing Northampton Run 2023.

CASE STUDY: A PARTNERSHIP APPROACH TO WORKING WITH ROUGH SLEEPERS

Individuals and families experiencing homelessness are more vulnerable to health inequalities and have disproportionately poor health outcomes and as a result, people experiencing homelessness and rough sleeping have a greatly reduced life expectancy (44 years for men vs. the national average of 79.4 and 42 years for women vs. national average of 83.1). This is underpinned by poor health outcomes, with 73% of people experiencing homelessness suffering from a physical health problem and 80% from a mental health problem (UKHSA, 2019). According to the British Red Cross (2021 in NHSE, 2022) homeless people are significantly less likely to be registered with a GP meaning preventable healthcare needs are not treated in a timely fashion, making hospital attendance more likely. Therefore, public health services play a pivotal role in enhancing the wellbeing of these vulnerable individuals and communities by preventing diseases and injuries, detecting health issues early, and responding promptly to avoid the development of severe illnesses. While public health may not always be at the forefront of our minds, it is crucial in maintaining a healthy society, and increased life expectancy. Unfortunately, individuals experiencing acute homelessness and hardship face unique challenges in accessing healthcare, including barriers related to transportation and lack of structure to their lives.

WNC worked in collaboration with The Northampton Hope Centre and Bridge Substance Misuse Programme to organise a range of successful Health and Wellbeing events, benefiting those who are homeless, rough sleeping and in temporary accommodation within our community. This initiative aimed to provide crucial public health services to the community, with a focus on preventive healthcare measures. The team worked with providers to offer a range of essential services, including COVID-19 and flu vaccinations, NHS health checks, sexual health consultations, drug and alcohol support, hepatitis C testing, stop smoking services, smear testing and access to optical care.

Alex Copeland, the CEO of Northampton Hope Centre, emphasized the importance of easy access to public health services, especially given the increasing numbers of individuals experiencing homelessness in Northampton. He stated, “With the numbers of individuals presenting themselves as homeless at Hope, now often into the 50’s and 60’s daily, it is crucial that we work together on initiatives like this to make access to public health services as easy as possible to the most in need.” Copeland added, “Collaborating with Public Health with events like this will be important as we tackle homelessness head-on, particularly as we head into winter and need to avoid deaths on the street.”

Karl McGuiness from the Hepatitis C Trust said “Really well planned and executed, great number of people tested, and a lot of people also educated about transmission routes and risks.”

Bridget Carroll, a Director of the Bridge Substance Misuse Programme, commented that “the whole day was a success. Having all the providers in one room meant it was a relaxed and comfortable environment and welcoming to their clients. The service users who attended have been telling others about the day and are looking forward to attending the next event with the Public Health Team”.

These initiatives have received positive feedback from service users and our team are committed to continue working in partnership with settings to provide similar interventions throughout the year.

PROVIDING COMMUNITIES WITH A MEANS TO DRIVE POSITIVE CHANGE

Community funding is the way the council supports the local voluntary and community sector with grant awards to help them deliver projects and services within our communities. During the first six months of this financial year, we have awarded just short of £1.4m in community funding grants.

Demand for community grant funding, post-covid and with the cost-of-living increases, is exceptionally high, so it is not possible to satisfy all requests. But the Community Funding Grants team has introduced a framework which targets funding towards projects and services that support the delivery of the council's strategic aims and priorities and crucially, where there is the greatest need within the population or local community.

Community funding grants offer a wide range of benefits that contribute to the wellbeing and development of our communities and residents. Grants empower local organisations and residents' groups to take ownership of projects that matter to them. After all, they know their communities needs and aspirations best.

Grants can be tailored to address specific needs, targeting issues within a community whether it's youth engagement, money advice, food support, arts and cultural opportunities or other priorities.

They are also a great way to strengthen local communities, with people coming together to achieve a shared ambition, and many of the projects that receive funding focus directly on improving people's lives and generating a positive social impact. Whether it's access to mental wellbeing support, food banks or community fridges or youth clubs, grants contribute to the overall wellbeing of a community as a whole.

Participatory budgeting

Participatory Budgeting (PB) is a process that has co-production at its core. Working within the targeted communities, it puts local people at the heart of prioritising need. It enables the community to set their own criteria, and encourages them to have their say, through a Community Voting process. The process enables the community to select the projects and initiatives that they believe will best deliver their outcomes.

As a successfully developed methodology, the PB engagement process seeks to raise awareness and interest from both traditionally engaged sectors of the community, as well as those who are seldom heard. It involves encouraging all those connected to use their formal and informal local networks to spread awareness of the opportunity.

Where there is interest and potential in the community, additional support will be given to capacity-build parties to be deliverers of projects and initiatives. Existing local organisations are encouraged to become sponsor organisations to monitor progress, provide 'umbrella' governance and support burgeoning groups and individuals to pilot projects.

From the outset, the key message is 'You decide!' making it clear that local residents are in charge of deciding the priorities, as well as which projects get funded to deliver. This results in:

- a range of projects addressing community identified health needs
- a more engaged and connected community, empowered to create solutions to health needs.
- improved access to, and communication of, health interventions and improvement opportunities.
- strengthening of the voluntary and community sector in local communities.

Well Northants used participatory budgeting to provide funding to local areas. To ensure ease of community understanding, the term 'Community Voting Day' (CVD) was adopted to replace the term Participatory Budgeting, as it emphasises in simpler terms what the project is about.

The initial community voting days were delivered in the style of a 'Dragons Den" in which applicants bid for funding by pitching their project ideas to the community. A list of projects to be funded, would then be decided via a voting process, with the pitches with the highest scoring votes prioritised first. The results were then announced and applicants informed of the outcome.

PROVIDING COMMUNITIES WITH A MEANS TO DRIVE POSITIVE CHANGE

In 2023, Well Northants successfully delivered funding to the value of £60,784 to enable 31 community projects to be delivered in Well Northants communities.

Feedback from participants included:
"Amazing to see the community coming together to support each other – THANK YOU!!"

"A truly lovely day. Fantastic new opportunity for community groups to meet and hopefully work together in future"

"Great to connect with so many organisations and people trying to improve the community, I feel more part of community and curious about all the things that are happening. I now have information to share with people who complain that nothing happens/no-one cares!"

"Good to meet the organisations – inspiring to hear about the groups and learn that so much is available in my community"

The team listened to what people said about the community voting day and adapted how it was delivered on the day to increase reach, make the events easier to access and engaging. The latest community voting day was less of a dragons den and more of a market place. Overall attracting more residents in a more informal way, this was an opportunity for people to meet, learn about projects and talk about how they can get involved.

Examples of some projects funded:

- Fruit trees for the new community orchard at Bradlaugh Fields and Barn
- Discover yourself workshops for children and young people delivered by Lemon Pop
- Resources for the Keep Ever Young (KEY) club, supporting friendships and reducing isolation amongst older people.
- Gardening after school club at Blackthorn Primary school so children can grow their own and learn where their food comes from.
- Parenting workshops delivered by Free2Talk, helping to build confidence.

DEVELOPING COMMUNITY HUBS

The cost-of-living crisis created unprecedented pressures on people already in poverty, and despite central government support, many people in West Northamptonshire have been unable to afford to heat their home. Working with parish and town councils and partners in the voluntary and community sector we created a network of 96 Welcoming Spaces - non-judgemental, safe and welcoming places where people can come together to stay warm, and perhaps enjoy a hot meal or a cup of tea and a biscuit.

WNC offered grants of between £500 to £1,500 to support the creation and development of these spaces, and during the winter of 2022/23 the grant-funded spaces had 58,600+ attendees, referring over 3,500 clients on to wrap-around support services.

Below are a number of testimonials from different settings that host welcoming spaces:

Brackley Library

"One of our customers has been struggling with his electricity. Through coming to the library, we've been able to talk to him and signpost him to the Citizens Advice Bureau (CAB), who come on Fridays. With their support, he has been in contact with other council teams and charities that have helped him. We always check in to see how he is doing when he visits, and recently he said how grateful he is that the library, CAB and charities have offered him support. The help alleviated his stress, and he is finally getting to a point where he feels he is more financially settled."

Broadmead Church

"We have a lady who comes in every week from work, she has a break of four hours and can't afford to travel home so she comes and sits in the café, and we serve her drinks and food."

Bugbrooke Parish Council

"One of our regular visitors is elderly and partially sighted. His wife died last year so he now lives alone. He really enjoys coming to the Warm Space to chat to friends. He's sometimes tearful, but his friends are very supportive. He is determined to learn to cook for himself and has been getting advice from some of the other attendees."

The Hope Centre

"One client used the Warm Space to simply keep warm and avoid the cost of putting his heating on. When he first came, he wouldn't talk to anyone and sat quietly in the corner. Over the week his confidence grew, and he began talking to other clients and staff. He became interested in helping in the café and after chatting with the team it was agreed that he could begin working there. He later told staff: 'I wouldn't be here if it weren't for Hope'. Before finding the Warm Space, he'd tried to take his own life, but supporting the Warm Space has given him purpose and a reason to carry on."

The team at the Hope Centre are currently working on a plan to deliver sustainable services in these local trusted settings, where local people need them the most. They are working with partners to provide outreach for money and debt advice, mental health support, housing and employment, public health services and training for frontline workers and volunteers through the Community Training Partnership.

Welcoming Spaces form part of our Anti-Poverty Strategy, which sets out how the council will work with partners to support people who are struggling financially and what can be done to help prevent people falling into poverty. These spaces continue to develop, and are part of the WNC programme to develop one-stop shops, that bring together a range of services within a community to improve access to services.

VOLUNTEER AND PEER ROLES

Another strand of the family of community-based approaches are volunteer and peer roles, which enhance individual capabilities to provide advice, information and support or organise activities in their own or other communities – community members use their life experience and social connections to reach out to others. Common models include:

- peer support
- peer education
- health trainers
- health champions
- community navigators
- befriending and volunteer schemes such as health walks

Recognising the value of these approaches, WNC commissioned Grow! Cook! Eat! to build community capacity for healthy living in our communities through growing and cooking in West Northamptonshire. It is a collaborative project run by The Northampton Hope Centre and Health Works. The project has coined the phrase, 'A community that grows together, cooks together, eats together, stays together'. The programme recruits and trains community champions to grow and cook healthy food and share their new knowledge and skills to those around them, and provides small grants (£500 - £3000) to enable this to happen. An example is C2C Grows – Gardening for Wellbeing, which was established during lockdown (Autumn 2020) when they acquired a double plot at the Kingsthorpe Park Allotments. As a charity C2C has a proven track record of working with women on the fringes of society. The majority of the women who attend the allotment sessions have had some life changing challenges either with the criminal justice system, the impact of neglectful lifestyle choices, abuse through alcohol, drugs or violence, and some struggling with loss and bereavement. C2C Grows is a social and therapeutic gardening project that offers wellbeing gardening sessions for women and aims to build women's confidence in growing food and giving them a safe space to do this.

Prior to being involved in Grow!Cook!Eat! C2C struggled to get women up at the allotment consistently but with the grant funding and offering to cover transport this has been a game changer. C2C have been running weekly gardening for wellbeing sessions on Thursdays for women since April 2023. They focus on a different topic of gardening each week and aim to incorporate aspects of wellbeing into the sessions, such as looking at the healing properties of plants e.g., lavender to aid sleep. They always offer the women attending a chance to learn a new gardening skill – e.g., seed sowing, pricking out, pruning and plant care/ maintenance. The main focus of the project is to offer the vulnerable women a safe, green space to garden, grow a variety of fruit, vegetables, herbs and flowers, and gain a sense of meaningful purpose to their day. C2C used April and May to plant and sow a wide range of vegetables and fruit including runner beans, broad beans, peas, potatoes, lettuce, parsnips, beetroot, chard, carrots, cucumbers, tomatoes, pumpkins, sweetcorn, radishes and butternut squash. Fruit currently growing includes plums, apples, redcurrants, gooseberries, blackcurrants, strawberries, raspberries and cherries. The women harvested all of this produce to take home, alongside cooking sessions on site using as much of the vegetables as possible.

C2C have received positive feedback from the women attending the sessions so far, with one woman saying that coming to the sessions really lifts her mood and another saying that she leaves her troubles at the gate and can forget about everything else whilst being at the sessions. The project is providing a unique safe, green space for vulnerable women in the local community. C2C are now taking referrals from local GP surgeries who are offering the project as a green prescription.

New Life Amalgamation is another organisation who have received training and a community grant from

VOLUNTEER AND PEER ROLES

Grow!Cook!Eat!. New Life Amalgamation was established after Amanda Tandoh saw the need for both the spiritual and physical needs of her community to be met. Since its conception Amanda has been running weekly church services, a weekly foodbank, support groups and recently health heart checks. There is a mixed group of people who come along to the various sessions put on at the church, both men and women, young and old. After attending the champions training, Amanda established a session to teach participants to grow, cook and eat healthy on a budget. It is called 'cooking with a twist' because it teaches people to cook even with food they have been cooking before but in different and interesting ways. Amanda encourages participants to come with recipes and to teach the group how the meal is made. One of the ladies was amazed at how easy it was to prepare a healthy meal using simple ingredients. She said she would come back for more of the cooking sessions. The classes also provide an avenue to meet other people and foster a sense of community around food.

WNC also commission the Bridge Substance Misuse Programme, which is a Lived Experience Recovery Organisation (LERO). LEROs are organisations led by people with lived experience of drug and alcohol recovery, for the benefit of the recovery community. We believe in the therapeutic value of one addict helping another.

Bridge recruit, train and supervise volunteers who have had drug or alcohol problems themselves, or close contact with people who have. They act as mentors or support workers to clients with drug or alcohol problems. The aim is to help Bridge members deal with their substance misuse by providing practical support in relation to social aspects which impact negatively on their lives.

People who have experienced substance misuse problems have a role to play in helping others. Their experience and understanding should not be wasted when it can be used to support people trying to recover from their own substance misuse. The experience and learning that mentors gain should be a valuable aid to them in their personal or career development.

As well as offering members the opportunity to engage with a mentor, Bridge have developed, and constantly review, a programme of physical and other activities that are available to members. Many of these sessions are led by peer mentors.

Coproduction is an important part of their offer and ensures that the service user's needs are heard. Bridge regularly host members meetings. These are service user meetings that provide the opportunity for members to provide feedback on the service, and to make suggestions and requests. Bridge also use suggestion boxes for the same purpose. They regularly implement requests from service users – such as event days, or activities for the timetable.

CONCLUSIONS

This report has provided an update on how WNC has adopted the new place operating model, utilising the range of approaches in the family of community-centred approaches to addressing health inequalities. As this way of working becomes more embedded across the council, we expect more services to be utilising these types of interventions to improve the health and wellbeing of residents and to support delivery of the 10 Live Your Best Life ambitions. Below are a number of recommendations to help us further address health inequalities.

RECOMMENDATIONS FOR THE 2023 REPORT

1. We will ensure that the Joint Strategic Needs Assessment considers the needs of the CORE20PLUS groups, including developing community fact sheets for diverse ethnic communities and inclusion health groups and this is used to inform further actions to address health inequalities in West Northamptonshire.

2. Produce a Community Cohesion Action Plan for West Northamptonshire.

3. Develop a set of systemwide principles for community engagement and coproduction, ensuring that all staff adopt the recommended principles and practices.

4. Build, expand and promote our community engagement network across the system.

5. Develop a system inclusion health strategy and action plan.

6. Refresh the ICN Health Inequalities Plan.

7. Ensure appropriate training is provided and carried out and guidance and toolkits are provided to foster a consistent approach to community-based models of work.

8. Ensure training and tools are developed to enable staff to better understand health inequalities and their role in addressing these.

RECOMMENDATIONS FROM 2022 DPH ANNUAL REPORT

The DPH Annual Report for 2022 looked at the effects of the cost of living crisis for resident's of West Northamptonshire. Below are the recommendations from that report and updates of the actions taken to address each recommendation.

	Recommendation	Action taken
1	Continue to deliver urgent support to those struggling right now – ensuring good access to rights advice and easy access to hardship support.	• Funding for debt and money advisors in the VCSE sector in place • Transformation of WNC revenue and benefits team underway • Community Training Partnership launched with ongoing training offer for front line staff • Continuation of energy support and advice service for winter • Roll out of Household Support Fund 4 • Preparation of welcoming warm spaces for winter
2	Ensure that the impact of financial stress on mental health is understood and addressed.	• Implementation of an all-age mental health and suicide prevention training framework aimed at frontline workers and volunteers across the system as well as the general public. Key elements include increasing knowledge in relation to what can have a negative influence on our mental health and wellbeing, signs to look out for in relation to poor mental health, and strategies and approaches to support their own and the mental wellbeing of those they support. Training also includes understanding of what is available to support mental health, signposting and referral to appropriate support. • System-wide alignment of messaging related to the promotion of positive mental health and wellbeing underpinned by the A4H 10 Keys to Happier Living. This includes a campaign starting in early 2024 aimed at working age men, using the 10 keys to happier living to promote actions to support positive mental health and wellbeing.
3	Continue to build on the collaborative working to ensure partnership working is at the centre of anti-poverty action including the wider Integrated Care System constituent organisations.	• Anti poverty oversight group continues to meet with representation across statutory services and voluntary sector • Upstream anti-poverty actions including supporting employment and economy discussed at a system level by ICP Board and with West Northamptonshire Health and Wellbeing Board. Recognition at these meetings of the importance of the wider social and economic impact of the ICS partners (4th aim of Integrated Care Systems as set out by Integration White Paper)
4	Take place-based and asset-based approaches linking with the work of the emerging Local Area Partnerships.	• Wrap-around support at welcoming spaces delivered in close collaboration with LAP teams

RECOMMENDATIONS FROM 2022 DPH ANNUAL REPORT

	Recommendation	Action taken
5	Develop longer-term strategic approaches to reduce and prevent poverty and its impacts, focusing on: • Fuel poverty and warm homes • Sustainable food • Skills and access to employment •Homelessness and rough sleeping.	• Housing partnership board subgroup focussing on quality and sustainability of homes • Support for food banks through HSF4 to improve sustainability and community food larder offer • Working group established to look at spend of UKSPF people and skills and prepare for work well partnership bid to support employment opportunities Homelessness and rough sleeping needs assessment published and work underway on the homeless and rough sleeping strategy
6	Keep learning and reflecting and ensure that evaluation results in improved outcomes.	• Outputs and outcomes of activity closely monitored to ensure progress of projects • In addition to hard data, qualitative feedback from service providers and service users sought to be able to understand impact of interventions.

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