Social Wellbeing Needs Assessment

1. Overview

As noted by the Faculty of Public Health "Social wellbeing, or the lack of it, is familiar to public health professionals in the context of social and income equality, **social capital, social trust, social connectedness and social networks**…All these aspects of social wellbeing are known to have a profound effect on mental health and wellbeing individually and collectively"

Evidence from a meta-analysis of 148 studies on social relationships and mortality risk shows that communities 'with strong social relationships are likely to remain alive longer than similar individuals with poor social relations', with a 50% increase in odds of survival over an average follow-up of 7.5 years when integration in social networks, supportive social interactions and perceived social support were examined.[i]

While socioeconomic health inequalities are undoubtedly driven by differences in material factors (e.g. access to housing, education, employment, good income), there is also a marked social gradient across the social factors that support good health. The Marmot review shows how just under a fifth of people (19%) living in the most deprived areas of England have a severe lack of social support and around a quarter (26%) have some lack, compared to 12% and 23% in the least deprived areas.[ii]

At the extreme end of the gradient, a lack of social wellbeing may turn into social exclusion. Social exclusion can be defined broadly as processes driven by unequal power relationships that interact across economic, political, social, and cultural dimensions[iii]. There are some groups who are particularly disadvantaged, and in the UK, the concept of inclusion heath has typically encompassed homeless people; Gypsy, Roma, and traveller communities; vulnerable migrants; and sex workers [iv] but other groups can be included.

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

2. Purpose of this Needs Assessment

The purpose of this needs assessment is to understand who is affected by poor social wellbeing (or low social capital, social connectedness and poor social networks), identify the impacts, and to make recommendations on how this can be addressed in Northamptonshire.

3. Approach

Public Health have conducted a rapid desktop needs assessment, looking at those most at risk of poor social wellbeing in Northamptonshire using existing data, evidence review and engagement with stakeholders and residents. Engagement to date has included:

- In January 2020 Public Health held a Health and Wellbeing Board Development Session, which started to gather information from local stakeholders in the local

Voluntary and Community Sector, as well as other service representatives who were in attendance, on vulnerable groups and what the current local assets and needs are.

- Public Health also ran a survey from in September to gain feedback from the wider community on the issues faced by residents.

Public Health also recognise that a key element to any community development approach is to engage with communities to develop relationships and a shared understanding of the issues and to work in partnership to co-design and co-deliver interventions. This will be the first phase of the programme.

4. Risk Factors associated with lack of social wellbeing

<u>Deprivation</u>

24 LSOAs in Northamptonshire are amongst the top 10% most deprived in England and 38 fall within Decile 2 nationally. Thus, 62 (14.7%) of the LSOAs in Northamptonshire are amongst the top 20% most deprived nationally (see figure 1). See table 1 below for the 20 most deprived LSOAs.

Figure 1: Northamptonshire IMD National Deciles, 2019

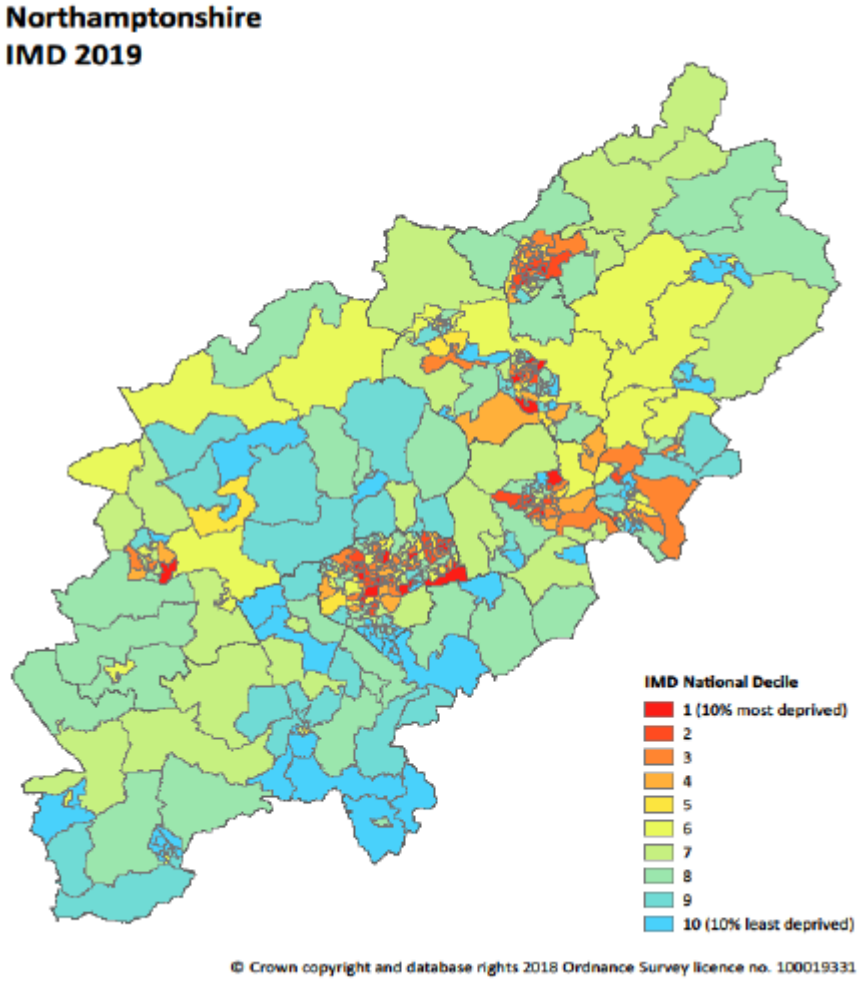


Table 1: Top 20 most deprived LSOAs in Northamptonshire

LSOA 2011	Name	LSOA Descriptive Name	IMD 2019 National Rank	IMD 2019 National Decile	IMD 2019 County Rank
E01027140	Northampton 011A	Bellinge: Field mill Road area, Billing Aquadrome	185	1	1
E01026968	Corby 006G	Kingswood: Dunedin Road, Vancouver Close, Kenilworth	440	1	2
E01027127	Kettering 005O	Kettering: Kathleen Drive, Washingon Square	748	1	3
e01027235	Northampton 026C	Briar Hill: Ringway, Southwood Hall	1139	1	4
E01026965	Corby 006O	Kingswood: Saxilby Close, Boston Close	1181	1	5
E01032979	Northampton 021F	Town Centre: Rail Station, St James Retail Park, St Peter's Way, Drapery	1372	1	6
E01027244	Northampton 017E	Kings Heath: Park Drive, West Oval	1398	1	7
E01027239	Northampton 017A	Dallington: Dallington Road Merthyr Road	1520	1	8
E01027334	Wellingborough 002E	Wellingborough: Finedon Road Ind Est, Nest Farm Cres, Fulmer Lane	1736	1	9
E01027199	Northampton 007D	Blackthorn: Blackthorn Primary School, Pikemead Ct, Hopemead Ct	1803	1	10
E01027083	Kettering 005C	Kettering Buccleugh, Walnut Crescent	1859	1	11
E01026960	Corby 006B	Maplefields School, Leighton Road, Turner Road, Constable Road area	1919	1	12
E01027310	Wellingborough 007B	Wellingborough: Minerva Way, Kiln Way	2182	1	13
E01027168	Northampton 012A	Eastfield Park, Grange Road	2238	1	14
E01027110	Kettering 007B	Kettering: Northfield Avenue (South), Silver Street	2269	1	15
E01027318	Wellingborough 008B	Wellingborough: Jubilee Crescent	226	1	16
E01027019	Daventry 008D	Borough Hill, Trafalgar Way, Tovey Drive, Long March, High March	2375	1	17
E01027153	Northampton 021C	Semilong and Barrack Road: Marriot Street, St Georges Street, Deal Street, Sheep Street	2420	1	18
E01027131	Kettering 009D	Kettering: Northumberland Road, Kettering Business Park	2492	1	19
E01026950	Corby 005B	Burghley Drive, Recreational Ground area	2643	1	20

For further detail please view the Index of Multiple Deprivation (IMD) 2019 Profile for Northamptonshire

Measures of social wellbeing

There is not a single measure of social wellbeing, or even of social capital, connectedness or networks. However, Northamptonshire does have a social isolation index which could be

used as a proxy measure. Public Health Northamptonshire developed the social isolation index based on methodology used by Gloucester County Council using Acorn demographic segmentation produced by CACI Ltd. The figure below shows social isolation by LSOA. The indicators used in this index are in box 1 below.

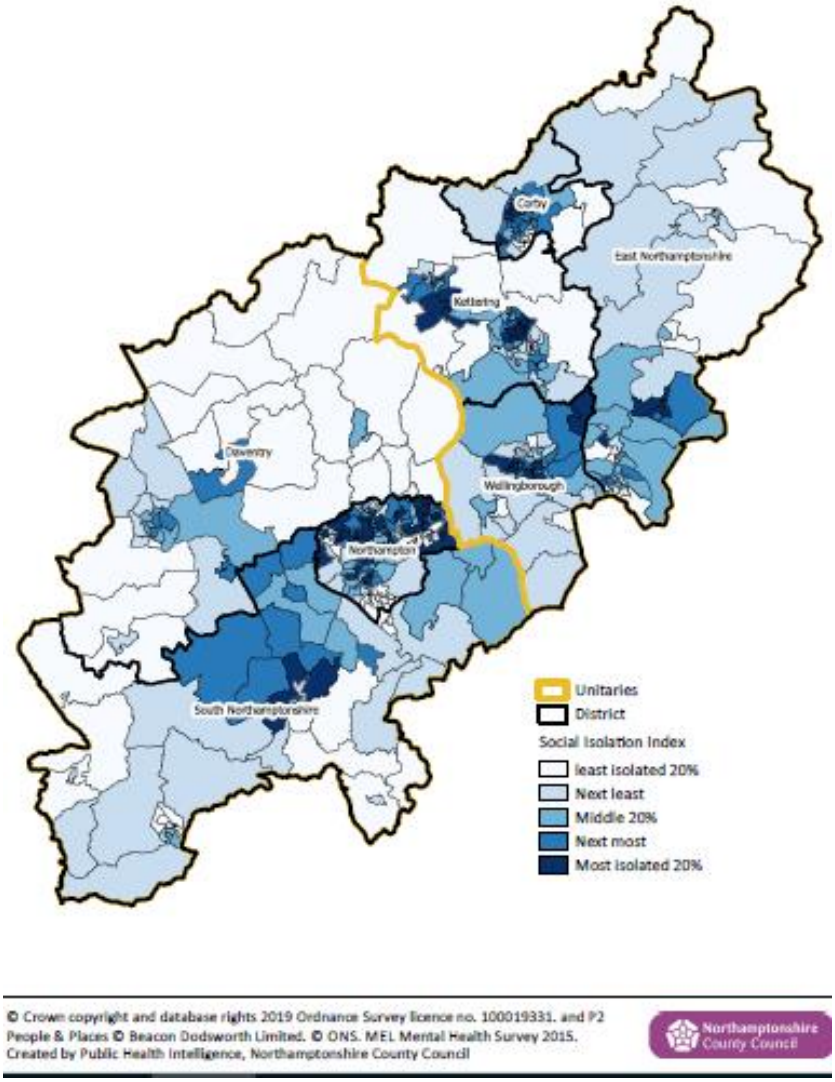
Box 1: Indicators for 2019 Social Isolation index
From P2 People and Places
Aged 65 - 74
Aged 75 +
Single household
No car
Earn less than £11,499
Earn between £11,500 - £17,499
Long-term Limiting Illness
From Mental Wellbeing Survey
ONS Life satisfaction (Inverted results)
ONS Worthwhile (Inverted results)
ONS Happy yesterday (Inverted results)
ONS Anxious yesterday
How often do you talk to any of your neighbours. (< once per month)
How often do you meet friends or relatives who are not living with you? (< once per month)

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

Table 2: The LSOAs with the highest scores (Most Isolated)

	Ten most isolated LSOAs using 2019 Isolation Index				
LSOA	Score	District	Local area descriptor	IMD decile	IMD quintile
E01027140	59.7	Northampton	Billing Aquadrome, Bellinge- Fieldmill Road	1	1
E01027249	54.3	Northampton	Thorplands- Holmecross Road, Waterpump Court	1	1
E01027177	54.1	Northampton	Ecton Brook Road, Pennycress Place	1	1
E01027195	54.0	Northampton	Lumbertubs- Penistone Road	1	1
E01027180	53.8	Northampton	Cherry Orchard	3	2
E01027083	53.8	Kettering	Kettering Buccleuch, Walnut Crescent	1	1
E01027342	53.0	Wellingborough	Wellingborough- Windemere Drive, The Dale	2	1
E01027106	52.7	Kettering	Nelson Street, Tresham Street	2	1
E01027214	52.5	Northampton	Ryehill, Knightscliffe Way	2	1
E01027245	51.9	Northampton	Southfields- Barley Hill Road, Round Spinney Industrial Estate (east)	3	2

Figure 2: Social Isolation Index by LSOA showing quintiles, Northamptonshire, 2019



5. Impacts of poor social wellbeing

Poor social wellbeing has an impact on health inequalities, and interventions to address social wellbeing can in turn improve health inequalities. Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society, which arise from the conditions in which people are born, grow, live, work and age. These conditions influence opportunities for good health, and how people think, feel and act, and this shapes mental health, physical health and wellbeing. Health inequalities can therefore result in differences in:

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

'*10 years on from the Marmot review*'[viii] observes that the last decade has been marked by deteriorating health and widening health inequalities: 'Since 2010, in many places levels of deprivation and exclusion have intensified and accumulated. Throughout England there are

communities and places, that have been labelled as 'left behind', where multiple forms of deprivation intersect and where deprivation has persisted for many years with little prospect of alleviation. Over the last ten years, these deprived communities and areas have seen vital physical and community assets lost, resources and funding reduced, community and voluntary sector services diminished and public services cut, all of which may have damaged health and widened inequalities'.

Inequalities in healthy life expectancy

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

Table 3: Inequalities between the most deprived and least deprived quintile in Northamptonshire in 2015-17

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

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

The districts/ boroughs with the greatest inequalities in life expectancy compared to the England average are:
1. Corby (2.8 years lower than England for males and 2.7 years for females)
2. Northampton (1.1 years lower than England for males and 0.6 years for females)
3. Wellingborough (0.7 years lower than England for males and 0.9 years for females)
4. Kettering (0.5 years lower than England for females)

For further detail please view the Inequalities in Life Expectancy in Northamptonshire (October 2019) Report.

Inclusion health groups

As stated earlier, social exclusion is at the extreme end of poor social wellbeing, and the concept of inclusion health looks at the needs of those who are excluded and most vulnerable, which result in poor health and wellbeing outcomes. Common experiences cut across inclusion health groups. Most have been or are exposed to multiple, overlapping risk factors, such as adverse childhood experiences, trauma, and poverty.

Adding to this unfavourable start, many face multiple barriers in access to health services because of fear, language and communication issues or negative past experiences, such as being turned away[ix]. This results in overuse of some services, such as accident and emergency departments, and underuse of others, such as primary and preventative care, resulting in inefficiencies and extra costs. Many of these populations are also highly mobile, making it difficult to ensure access and continuity of care from services that are typically designed for fixed populations[x].

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[xi]. These experiences can create a vicious cycle of health and social deterioration for those affected.

Vulnerable migrants and asylum seekers

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

In Northamptonshire the County Council reported that:

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

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

Homelessness

The average age of death for homeless people who sleep rough is just 43 for women and 47 years for men, and is associated with reduced quality of life caused by multi-morbidity. Homelessness is an independent risk factor for premature mortality and is associated with extremes of deprivation and multi-morbidity. Chronic homelessness is an associated marker for tri-morbidity, complex health needs and premature death. Tri-morbidity is the combination of physical ill-health with mental ill-health and drug or alcohol misuse. Oral health problems are very common amongst homeless populations. 32% of people who are homeless report dental pain, and have a greater number of missing and decayed teeth and fewer filled teeth.[xxx]

In Northamptonshire:

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

Sexual exploitation and sex workers

Sex workers are likely to experience poor health because of the risks associated with their work. Female sex workers in London have a mortality rate that is 12 times the national average. Up to 95% of female sex workers are problematic drug users. 68% of female sex workers meet the criteria for post-traumatic stress disorder – this is in the same range as victims of torture and combat veterans undergoing treatment. A comparatively low percentage of female sex workers have had routine health checks such as cervical screening, or attend antenatal checks when pregnant. Psychological and institutional

barriers to accessing healthcare include: fear of criminalisation, institutional factors (e.g. opening hours, location), stigmatisation and discrimination. [xxx]

In Northamptonshire

- There is no local data. The estimated total number of sex workers in the UK 72,800[xv], equal to 1.72 per 1,000 population, applied in Northants this is around 1,021.

Gypsies and Travellers

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

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

A 2012 report by the Ministerial Working Group on tackling inequalities experienced by Gypsies and Travellers confirmed that they have the lowest life expectancy of any ethnic group in the UK and continue to experience high infant mortality rates (18% of Gypsy and Traveller women have experienced the death of a child), high maternal mortality rates, low child immunisation levels (particularly where specialist Traveller Health Visitors are not available), and high rates of mental health issues including suicide, substance misuse issues and diabetes, as well as high rates of heart disease and premature morbidity and mortality. [xxx]

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

In Northamptonshire:

Table 4: Permanent traveller sites and pitches:

	Data from 2019				Data from 2017		
	Corby	Kettering	East Northants	Wellling-borough	Daventry	South Northants	North-ampton
Private sites	2	13	3	2	4	1	
Private pitches	17	69	72	62	28	3	
Public sites	2	2		1			1
Public pitches	18	72		3			35

Table 5: Number of households meeting the planning definition of gypsy traveller:

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

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

6. Impacts of COVID-19 Pandemic

The COVID-19 pandemic has resulted in impacts on social wellbeing, both positive and negative, and it has likely exacerbated some of the issues faced by those who are isolated and excluded. These impacts need to be factored in to the development of any service which addresses social wellbeing.

Positives

During the COVID-19 pandemic communities have shown and built their resilience. Neighbours are connecting and looking out for each other more than usual, informal support groups in local areas have organised to support people in need. ONS weekly research into social impacts of COVID-19 reported a steady increase in community spirit during the lockdown period.[xvi]

In Northants nearly 14,000 registered to volunteer and support those within our community during COVID, and the Community Resilience Hub have reported that it appears that local communities were able to quickly help with neighbours needs and the council's system filled in the gaps in those areas the response was not as timely or comprehensive.

Table 6: Community Resilience Hub data on volunteers and requests for help

Location	Number of volunteers	Number of requests for help
Corby	445	306
Daventry	2,156	215
East Northamptonshire	2,040	375
Kettering	653	434
Northampton	4,682	1,124
South Northamptonshire	2,723	229
Wellingborough	892	348
Out-of-county/ postcode error	290	41
TOTAL	**13,881**	**3,071**

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

Negatives

However, despite some positive experiences during the pandemic, a lack of resilience can also be seen in communities. For example, recent research demonstrates the links between the absence of civic assets, community engagement and connectivity and economic and social deprivation, and the erosion of this social fabric over time.[xvii]

Unemployment benefit claims have risen most in those areas that were already suffering from high rates of claims. Those neighbourhoods in the highest 10% of unemployment benefit claims prior to Covid-19 have seen a 5.4 percentage point increase in claims, compared to a 2.3 percentage point increase for those in the 10% with the lowest claim rate prior to Covid19. It seems likely that some groups will suffer more than others. Those likely to be hardest hit include the young (under 25), older employees (over 55s) and a range of already disadvantaged groups.[xvii]

Mental Health

The COVID-MINDS Network aims to bring together researchers in exploring the psychological impact of the COVID-19 pandemic. They have been providing a summary of research into the impact of the COVID on global mental health and wellbeing (all articles described below are from this summary[xviii]):

1. Mental health and wellbeing during lockdown have been worse than prior to the COVID-19 pandemic.
    a) An analysis of the UK Household Longitudinal Study (UKHLS) panel highlighted the psychological impact of COVID-19 using data preceding the pandemic compared to data captured during the pandemic. In a sample of 42330 UK adults, clinically significant levels of mental distress increased from 18.9% in 2018 to 27.3% in April 2020.
    b) Data from COVID-19 surveys nested within the Avon Longitudinal Study of Parents and Children (ALSPAC), showed increased anxiety and lower wellbeing during COVID-19 from pre-pandemic levels. Furthermore, the percentage of participants classified as experiencing “probable anxiety disorder” was almost double during COVID-19.
    c) Students in the US have been completing weekly assessments about anxiety and depression over a two-year period. Participants reported increases in anxiety and depression in comparison with the term preceding the COVID-19 pandemic. Viewing COVID-19-related news was significantly associated with psychological impact.

2. Mental health and wellbeing could potentially return to pre-pandemic levels as lockdown restrictions are lifted
    a) Researchers in the UK collected data on a weekly basis exploring the longitudinal psychological impact of COVID-19. Depression and anxiety levels have been decreasing throughout the 18 weeks of the study. Whilst the overall level is still higher than pre-pandemic averages, the results indicate that levels are returning to normal levels.
    b) The COVID-19 Social Study showed that in depression and anxiety levels, life satisfaction and happiness were impacted when lockdown came in, but all improved over lockdown and as lockdown eased.
    c) The Avon Longitudinal Study of Parents and Young Children (ALSPAC) found that anxiety levels initially increased from pre-pandemic levels and remained stable

between April and June, even after the easing of lockdown restrictions. So younger adults may be taking longer to re-adjust.

COVID Social Study

University College London: a panel study of over 70,000 respondents focusing on the psychological and social experiences of adults living in the UK during the Covid-19 pandemic, data from the last 26 weeks.[xix]

Figure 3: Depression by age groups (as measured by PHQ-9)

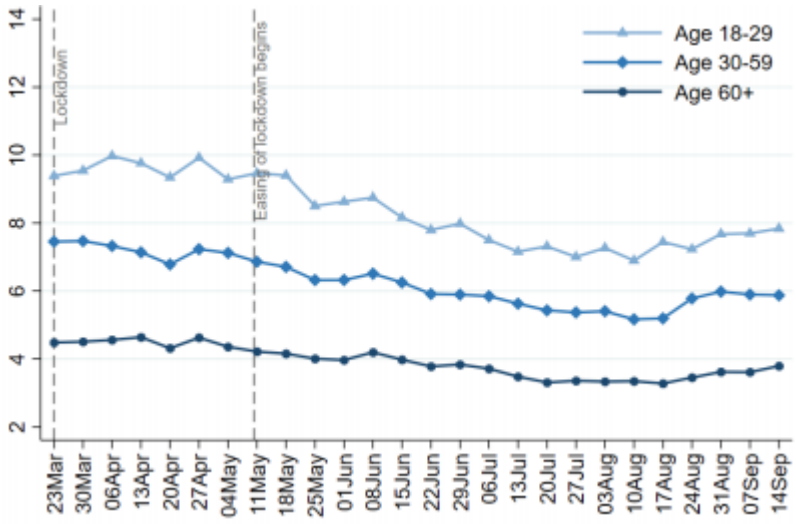


Figure 4: Anxiety by age groups (as measured by PHQ-9)

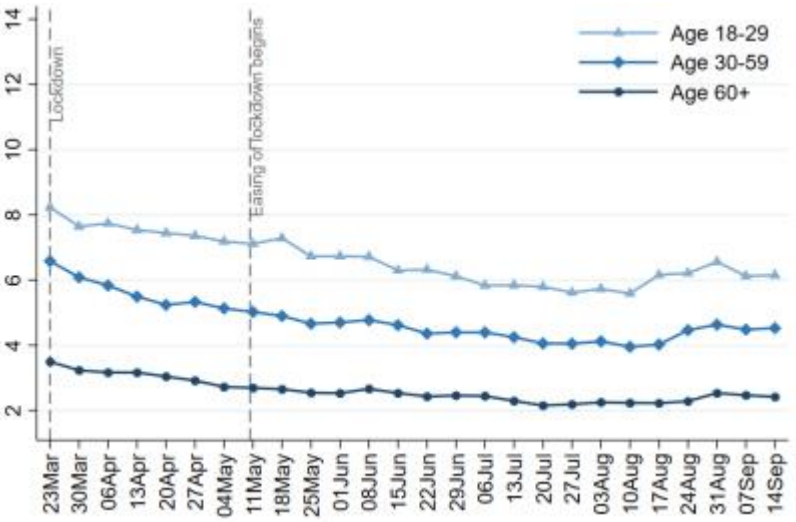
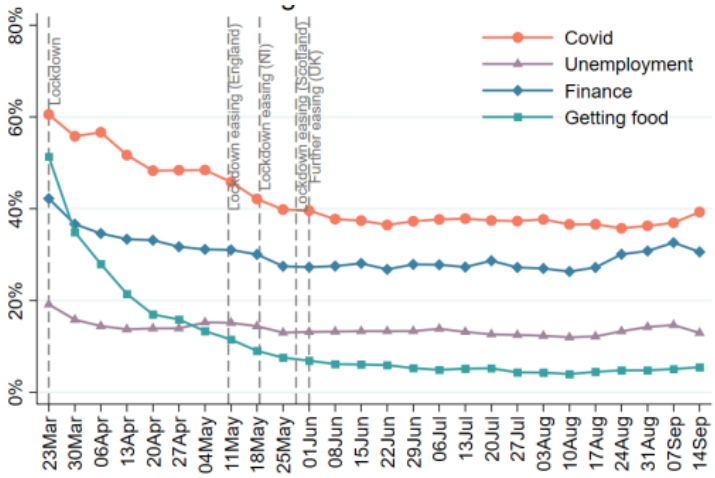


Figure 5: Stressors



3. COVID-19 is not affecting us all in the same way
   a) Across multiple studies, younger adults, people of female gender and people from BAME groups, those with financial problems and being a working parent have been experiencing worse psychological responses to the COVID-19 pandemic.
   b) Findings from the UK COVID Social Study reported that levels of depression and anxiety are highest in young adults, people living alone, people living with children, those with a lower household income, people from BAME groups, and people living in urban areas. People living with a pre-existing mental health problem also reported higher levels of depression and anxiety.
   c) However, results were not as stark amongst children and adolescents, implying that they may not be as adversely affected as adults. Further research is needed to understand the longer term impacts.
   d) A UK-based study of secondary school students showed overall improvements in anxiety and wellbeing during lockdown in comparison with pre-pandemic levels. The authors speculated this may be due to the removal of stressors within the school environment, but also offered the caveat that the second survey was completed a number of weeks after lockdown officially began and when some restrictions were beginning to ease.
   e) Analysis of data from the UK Household Longitudinal Study (UKHLS)[xx] highlighted that working parents experienced worsening mental health in comparison with working adults without children and that financial insecurity predicted worsening mental health in both households.

4. People's health behaviours are affected by the COVID-19 pandemic.
   a) Data obtained via mobile phone sensing and self-reported momentary assessments showed that a US student sample were more sedentary in comparison to the term preceding the pandemic.
   b) A comparison of health-related behaviours pre-pandemic and during the pandemic using data from the UKHLS showed that smoking and e-cigarette use declined but the proportion of people drinking on four or more days per week and binge drinking increased.
   c) The UK COVID Social Study[xxi] has shown that health behaviours during the lockdown has stayed constant for the majority of respondents. However:
      i. 17% of adults have reported eating more than usual
      ii. 23% have reported eating less healthy than usual

iii. 40% have reported weight gain
iv. 17% have reported drinking more than normal
v. 33% have reported smoking more than normal.

The report also highlights some key between-group differences in health behaviour changes. These include older adult respondents being the least likely to have changed health behaviours, and younger adults, women and people from BAME groups being more likely to have drunk less than usual.

5. Sleep appears to be one of the pathways linking stress with poor mental health
   a) There is still limited evidence regarding the factors that may mediate the relationship between the COVID-19 pandemic and mental health outcome, but researchers in China reported that the impact of COVID-19 death on levels of stress, anxiety and depression were significantly mediated by decreased sleep quality.
   b) A further study in China reported that the degree of threat individuals experienced from COVID-19 was significantly correlated with insomnia.
   c) Data from the COVID-19 Social Study showed that that the number of adversity experiences and number of adversity worries during the pandemic were associated with reduced sleep quality.

6. Specific characteristics and behaviours may help to buffer the detrimental psychological impact of COVID-19
   a) The UKLS found that the altruistic behaviour of providing financial assistance to those in need had a positive impact on givers' subjective wellbeing during the pandemic.
   b) A survey of adults in the US reported that trait resilience was associated with better overall mental health. Experiences of positivity resonance (a marker of high quality social interactions) mediated this effect, suggesting that high-quality social connection may have played an important role in maintaining mental health during the pandemic.
   c) Analyses of data from the Zurich Project on the Social Development from Childhood to Adulthood (z-proso) revealed that several coping strategies, specifically keeping a daily routine, positive reappraisal/reframing, physical activity, acceptance and staying in contact with friends and family were associated with reduced emotional distress.
   d) Data from the COVID-19 Social Study showed that increases in time spent gardening, exercising, reading and other hobbies were associated with decreases in symptoms of depression and anxiety and increases in life satisfaction.

7. Time spent accessing COVID-19-related media content may contribute towards adverse psychological impacts
   a) Higher worry was significantly associated with regularly focusing attention on media information about the prevalence of COVID in Serbia.
   b) Researchers from the COVID-19 Social Study reported that following news about COVID-19 predicted increases in depression and anxiety and decreases in life satisfaction.
   c) Data from the z-proso study revealed that frequent COVID-19 news seeking was associated with perceived stress and anger.

Loneliness

Data collected by the Covid Social Study[xxii] has shown how loneliness has been affected between March and July 2020. Prior to Covid-19, the Understanding Society (USoc) Survey found that 8.5% of people in the UK answered that they were often or always lonely. Covid Social Study data found that data collected between 21st March and 10th May, this was 18.5%. The average score for adults on the UCLA scale was 5 (the highest score is 9) during the most stringent period of lockdown. Between March and July, the UCLA score has fallen slightly, with people feeling less lonely in the period since measures were eased, however this has not yet fallen to pre-Covid levels.

This average hides significant variation between individuals and groups. Analysis of the data identified the characteristics of people at higher risk of loneliness.

Important risk factors for adult loneliness are:

- Being young (18-30)
- Living alone
- Having low income
- Being unemployed
- Having a mental health condition

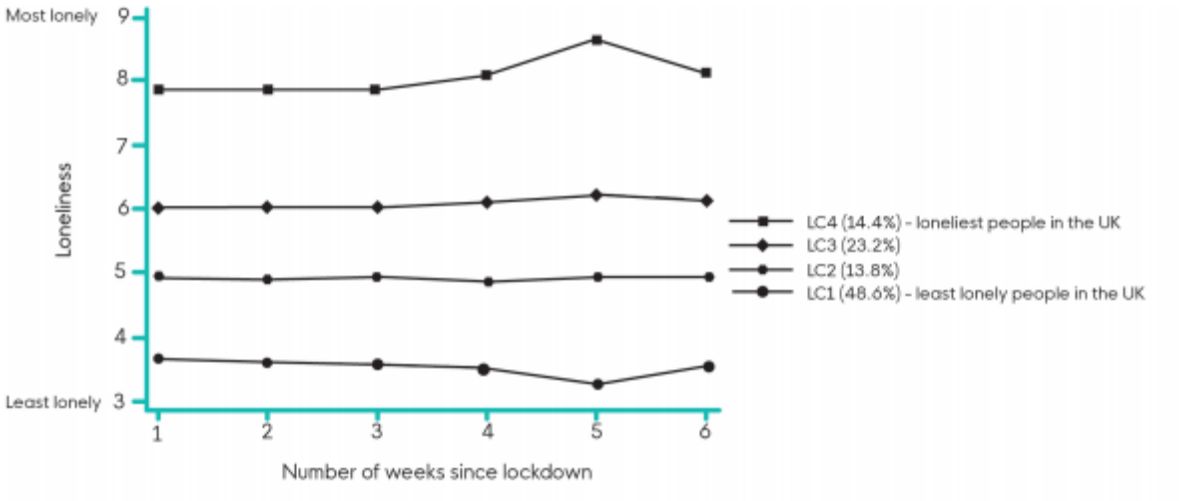
Other characteristics carry a small increase in the risk of being lonely, both before and during the pandemic.

- Non-white ethnicity
- Low educational attainment
- Being female
- Living in urban areas.

The loneliest have become lonelier. In the first six weeks of lockdown the increase in score was the highest for this group. The least lonely have become less lonely. Living with others or in a rural area, and having more close friends or greater social support were protective.

Increased loneliness is likely to compound other impacts on our wellbeing from the health, economic and social changes.

Figure 6: Estimated growth trajectory for each latent class based on the 4-class unconditional GMM with free time scores



Evidence shows that effective interventions to alleviate loneliness include:

- Interventions that take into account things like access to technology, people's interests and where they live
- Reducing stigma of loneliness
- Supporting relationships are important.[xxiii]

8. Evidence base for improving reducing inequalities though improving social wellbeing

Community based approaches to addressing health inequalities

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

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

Social capital is the links that bind and connect people within and between communities. It provides a source of resilience, a buffer against risks of poor health, through social support which is critical to physical and mental well-being, and through the networks that help people find work, or get through economic and other material difficulties. The extent of people's participation in their communities and the added control over their lives that this brings has the potential to contribute to their psychosocial well-being and, as a result, to other health outcomes. Therefore, it is vital to build social capital at a local level to ensure that approaches are shaped and owned by local communities.

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

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

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

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

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

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

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

A whole system approach

People are complex: everyone's life is different, everyone's strengths and needs are different. The issues and systems that respond to these issues are complex: the range of people and organisations involved in creating 'outcomes' are beyond the management control of any person or organisation.[xxix] Therefore a holistic approach is needed to engage people with multiple needs that is based on an understanding that the people being supported are part of a wider system. For example**,** homelessness is rarely the result of a single lifestyle choice, but rather the outcome of numerous systematic failures and problems. For many disadvantaged groups, clinical encounters and contact with service providers are characterised by suspicion, indifference and occasionally hostility, rather than dignity and respect. [xxx]

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

parts[xxxii].

9. What existing provision seeks to reduce inequalities through improving social wellbeing?

There are a number of existing services and programmes which look to improve social wellbeing in Northamptonshire that any new programme of work must align with. These include:

- Existing Social Wellbeing Contract, which ends in March 2021. This current focusses on reducing social isolation through the provision of day services and preventing homelessness through the provision of wrap around accommodation support.
- Primary Care Network Social Prescribing Link Workers (SPLW), who work to connect those with long term conditions to community programmes, groups and activities.
- The Northamptonshire Directory of Services (MiDOS) which offers a single directory of services and activities available to professionals and the public.
- The Social Prescribing Social Impact Bond seeks to expand on the existing social prescribing function as part of a county-wide programme.
- District and Borough Communities Teams. Each District and Borough have a different approach and team structure, but all have a community development and engagement function, and it is key that we work in partnership to develop this programme.
- The Supporting Independence Programme provides a programme of support to those who are mildly frail to improve health and wellbeing and reduce frailty.
- The 3 Conversations Model, the new approach being developed by Adult Social Care based within Community Hubs. It is key that we align our work with these and there is an opportunity to be part of the Hubs.

10. Engagement with communities

In September Public Health ran a survey to find out what communities views are on taking a community based approach to addressing health inequalities in vulnerable groups. 395 people responded; 293 residents; 21 Councillors; 64 working in services and 17 other.

A summary of key points is below, and the full report can be found in Appendix 1.

Residents

- The results reflect the needs mainly of residents who are older and white British.
- The results have shown that the impact of the COVID restrictions have affected people, showing that people are affected by not being able to socialise or access activities, and social isolation is an issue. People want opportunities to do activities or socialise with people and they need to be able to access this, either through being based locally or with transport options.
- While a large number of people said they were physically active and ate healthily, a large proportion also said that they would like to be more active.
- The environments in which people live are really important for their wellbeing, and access to green spaces has a positive impact.

11. Engagement with other key stakeholders

A summary of the stakeholder feedback to the survey is below.

- People from a range of backgrounds and localities responded.
- There was really good support for a community based approach, with people recognising the importance of working in partnership with communities to understand local needs and assets and coproducing solutions. Working in specific localities was important, with some comments suggesting the needs of rural communities need to be considered.
- A partnership approach is key to the success of this work, working across local government, the NHS and VCS, as well as Parish and Town Councils.
- People felt that we need to take a holistic approach, addressing the issues around housing, employment, finances, education and training as well as health and wellbeing needs.
- Support around digital technology was another theme.
- In terms of vulnerable groups, while the above approaches were highlighted, some more specific needs were also highlighted:
    - For all groups, more people said that there were not sufficient services in place than those that said there were. However, this was higher for people who are socially isolated, living in areas of deprivation, people with complex needs at risk of homelessness and rough sleepers.
    - There were fewer responses to the questions for sex workers, refugees and migrants and Gypsy, Roma and Traveller communities. This may reflect hidden needs for these groups, or may be because people do not feel this is a priority for the areas they work in. More work is needed to understand the local needs of these groups, working with organisations that work with them.

12. Conclusions

This needs assessment aimed to understand the impacts of poor social wellbeing, who is affected and make recommendations for action.

Those most at risk of poor social wellbeing are those living in deprived areas as well as those who are socially isolated or excluded. Poor social wellbeing and its impacts are not evenly distributed in society and so lead to an increase in health inequalities.

Local data on deprivation, risk factors for social isolation, and inequalities in life expectancy show that the communities at highest risk of poor social wellbeing are in areas of Corby, Kettering, Northampton and Wellingborough.

There is national evidence of the poor health and wellbeing outcomes for inclusion health groups, however, apart from the homeless community, there is little local data on the other groups.

National and international data shows that COVID has had a significant impact on the mental health and loneliness of the population. However, locally we have also seen that communities can come together to support one another during a crisis.

Overall there is a strong and growing evidence base for community-based approaches to improve wellbeing and reduce inequalities. Taking this approach is supported by residents and other stakeholders.

13. **Recommendations**

1. Reducing inequalities requires action at all levels of government, and locally requires action from civic services, health and care services and, importantly from communities. There is a need for greater **partnership** working as we move into an Integrated Care System and two new Unitary Authorities to achieve effective place-based approaches to reducing inequalities.

2. While there are a number of programmes of work in the county that seek to improve access to community resources (PCN social prescribing link workers, MiDOS among others), there is a relative gap in community-based approaches that seek to understand needs and build on community capacities to take action together on health and the social determinants of health. It is recommended that this should be the focus of a public health social wellbeing programme.

3. The programme should have two areas of focus:
    a. Working with inclusion health groups
    b. Working in hotspot areas identified using the social isolation index and IMD, however, should also take into consideration those who have been most affected by COVID, which includes young people and BAME communities.

4. The programme should aim to improve:

    a. wellbeing
    b. social connections
    c. neighbourhood environment
    d. community resilience

5. The programme will need to take a holistic approach to supporting people. It needs to be part of a system wide approach to ensure that the systemic issues that result in the poorer health outcomes and inequalities faced by those who are vulnerable or

marginalised are addressed. We need to work in partnership with commissioners and providers and this is key to identify and address some of the barriers to accessing services.

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

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

8. This program of work will be led by those who have good links with local communities.

Appendix A

In January 2020, Public Health led a Health and Wellbeing Board development session to work with local Voluntary and Community Sector and statutory partners, to understand the local needs and assets of vulnerable groups. Below is a summary of the feedback:

Ex-offenders

The importance of employment and deinstitutionalisation was highlighted as well as taking a trauma-informed or “ACEs” (adverse childhood experiences) approach. A gap identified was support for female offenders with experience of domestic violence and a relative gap in data/information particularly on health and wellbeing.

Carers

A strategic needs assessment for carers is currently in development. Young carers were identified as a group that need more recognition. Training for carers – the support to help them do their role through peer and professional support was highlighted. Also the need for specialist advice on benefits, housing etc.

Older people and frailty

A recent older people’s needs assessment has been published. Many agencies, services and sources of information listed and known about. Frailty a particular priority for the health and care partnership. Continuing concerns around access to services due to high level of demand and need to continue funding community and voluntary sector input.

Serious Mental Illness

Poor mental health more broadly is a cross-cutting theme across all the vulnerable groups. Key gaps were thought to be prevention and early intervention in those with serious mental illness, as well as services for those with hoarding disorder (recognised as a MH condition). Noted that those with poor mental health will be core cohort for new county-wide social prescribing service. Many collaborative groups/partnerships focusing on MH agenda.

Sex workers – sexual exploitation

A more appropriate heading would be sexual exploitation (+/- VAWG – violence against women and girls). The key gap identified here was around the link to homelessness and availability of safe and stable accommodation (particularly for those with substance misuse issues also). Noted that there may be less visibility of potential safety issues of this group due to industry moving online.

Vulnerable migrants and asylum seekers

By definition few national statistics for this group. Providing services for people with no recourse to public funds was a key issue identified, alongside exploitation and modern slavery as well as access to legal advice and support.

People with disabilities

Hard to navigate through maze of information and services. Reported lack of benefits advice and appeals support for people with mild disabilities. Cuckooing and hate crime were also identified as key issues as well as co-morbidity (particularly mental health comorbidities).

Rough Sleepers

There is a gap with pathways and joining up services, a lack of appropriate housing available and issues with accessing services, eg MH and night shelter. There is a need to address cuckooing.

Gypsy Roma and traveller communities

Recognition that there are multiple, individual closed communities- not just one and there is a lack of shared intelligence on health and wellbeing needs. There are some female specific issues – e.g. women's health, coercion and DA, and some community members are vulnerable to organised crime and modern slavery.

Substance Misuse

There are issues with access to other services for substance misuse service users, in particular MH and issues with dual diagnosis. There is a gap in join up with safety access for users- home safety visits. Earlier interventions are needed – eg working with primary schools.

Armed forces community

There is already a Board and action plan in place. There are a number of services available and funding available for services, however, the challenge is getting people to engage with these. There is a relative lack of data about this community.

Looked after children

There is lots of work going on in this area with investment in new services, and a needs assessment is in development. However, there is a need for better coordination and alignment of services. A similar HWB development session with a focus on children and young people would be useful. There is a gap in support for children who transition from CYP to adult services.

Other topics important to consider

- Food poverty
- People from ethnic minority backgrounds
- Domestic abuse – MARAC
- Hoarders (recognised mental health condition – lack of coordinated support)
- Socially isolated adults & children
- Families – parents/carers and services – home start which county wide
- ACE's & adverse experiences –
- Low level mental health - impacts on the groups
- Benefits claimants / people on low income
- Residents & family living with dementia – dementia pathway
- Think of people as individuals rather than conditions/illnesses/vulnerability factors - Holistic approach vs service/siloes
- Those in institutionalised employment
- People/children/families affected by serious organised crime, gang related crime – county lines
- "Cuckooing" victims

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