onenortherndevon

HEALTH INEQUALITIES ENGAGING COMMUNITIES PROJECT

Update Report

16th June 2022

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Research Your Way.

Executive Summary

One Northern Devon (OND) began an *Engaging Communities Project* in April that will run until October 2022, with the aim of exploring the challenges that people across Northern Devon are facing as we emerge from the COVID-19 pandemic[1]. The *Engaging Communities Project* will feed into the development of One Northern Devon's *Health Inequalities Strategy* that will be published in November 2022. This will be updating the 10 Year Wellbeing Strategy from 2020, reflecting the impacts of COVID-19 and the cost-of-living crisis.

Phase 1 of the project began in April and will run until October. Quantitative and qualitative research and engagement methods are being used in the project, with members of One Communities and Devon County Council taking part in data collection, alongside two research consultants. *Phase 2* of project is to develop a sustainable consultation model for OND, based on analysis of the data collected in *Phase 1*.

Health inequalities are 'unfair differences in health outcomes between groups which are determined by circumstances that are largely beyond an individual's control' (NICE 2022). These differences are systematic and unfair. They arise because of complex interactions between individual and external factors which lead to varying health outcomes. People living in areas of deprivation often experience health inequity. 31,100 people in Devon are classified as within the most deprived 20% of England (IMD 2019). 4,800 of these live in the most deprived areas which are: Ilfracombe Central, Barnstaple Central Town, Forches & Whiddon Valley. Torridge falls into the most deprived quintile in England for living environment. Both Torridge and North Devon are in the most deprived areas for barriers to housing and services, as well as having higher than average rates for income and employment deprivation.

Covid-19 had a considerable impact on health inequalities and has brought the need for action into stark focus. The long-term implications of Covid-19 on health inequalities are still being determined. We know that people living in the most deprived areas had higher than average rates of covid, increased mortality, and increased amounts of excess deaths (PHE 2021). *Core 20 Plus Five* is the new NHS approach for Integrated Care Systems, aimed at targeting the most deprived 20% of the population and specific higher risk population groups, focusing on: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension. It is relevant for Northern Devon because some of England's most deprived areas are located here. Targeting a single aspect of

health inequality will not be effective without also tackling the interrelated factors. A cross-sector approach is vital, and it needs three key foci:

- **Person-centred:** understanding what matters to the user and providing tailored help.
- **Place-focused:** considering community context to balance individual needs with the assets available within that place to deliver services that are in line with the scale and intensity of need.
- **Systems-based:** organisations do the work to provide co-ordinated services and clear communication, so people are not left trying to find the pieces and understand how they fit together.

This co-ordinated approach has become a key focus for health inequalities work and is the approach taken by the One Northern Devon. Organisations across Northern Devon are working hard to help people with the challenges and difficulties they are facing. The engagement with organisations and community members has so far shown the biggest challenges people are facing to be:

- Poor transport infrastructure
- Lack of affordable housing
- Poverty
- Geographical remoteness and rurality
- Social isolation and loneliness
- Low wage economy

The project is gathering examples of best practice for supporting people to overcome their challenges and/or health inequalities can your organisation share with OND partner organisations. For organisations, two key questions that have emerged from the project so far are:

- Would the development of an OND Community Champions Programme (or similar, as in Ilfracombe in 2020) help to reduce health inequalities in Northern Devon?

- Would a centralised OND Information Hub/Website/App be useful for organisations to deliver services to people experiencing health inequalities across Northern Devon?

Introduction

One Northern Devon (OND) began an *Engaging Communities Project* in April that will run until October 2022, with the aim of exploring the challenges that people across Northern Devon are facing as we emerge from the COVID-19 pandemic[1]. The *Engaging Communities Project* will feed into the development of One Northern Devon's *Health Inequalities Strategy* that will be published in November 2022. This will be updating the 10 Year Wellbeing Strategy[2] from 2020, reflecting the impacts of COVID-19 and the cost-of-living crisis.

Phase 1

Phase 1 of the project began in April and will run until October. Table 1 shows the number of people who have participated in the community engagement project so far[3] and the ways in which they have engaged. The engagement and research methods that have been taking place are:

- Analysis of existing health inequalities quantitative data.
- Engaging with people who experience health inequalities through: online survey, in-depth interviews, focus groups, participatory research methods.
- People working with people who experience health inequalities through: online survey, semi-structured interviews.
- People who could be working with people who experience health inequalities through: online survey, semi-structured interviews.

Table 1. Project Participants (so far)

No. of Participants	Participant Type	Engagement Method
4	Younger people	Informal interviews
3	Younger people	Film
3	Adults	Interviews
1	Adult	Film
2	Older people (65+)	Interviews
4	Older people (65+)	Informal interviews
8	Organisation staff	Interviews
1	Organisation staff	Film
58	Organisation staff	Survey
6[4]	Community member	Survey
166	PCN Staff	Survey

[1] Research Your Way Ltd, a social research consultancy based in Barnstaple, has been contracted to carry out the project.
[2] The 10 priority areas identified in the strategy were: obesity/healthy weight; loneliness; crisis prevention and support; child poverty; fuel poverty; climate emergency; strong and resilient communities; supporting local employers; local supply chain development; increasing employment opportunities.
[3] Up until 16th June 2022
[4] This survey was launched on 15th June

Phase 2

Phase 2 of the project is to develop a sustainable consultation model for OND, based on analysis of the data collected in Phase 1. This will ensure community members are involved in the design of the consultation model, that it reflects a wide-range of needs and views, and that people have opportunities to be involved.

OND Community Developers and Devon County Council's Community Engagement Team have had some research methods training and are involved in collecting data in communities across Northern Devon, alongside researchers from Research Your Way. It is hoped that this partnership approach also will be developed with the Kailo[5] and Pathways[6] projects. This partnership approach makes the most of the community engagement that has been ongoing across the area, and hopefully will reduce duplication and research fatigue in communities. Recent PCN survey data has also informed the development of the project.

What are Health Inequalities?

Health inequalities are 'unfair differences in health outcomes between groups which are determined by circumstances that are largely beyond an individual's control'[7]. These differences are systematic and unfair. They arise because of complex interactions between individual and external factors which lead to varying health outcomes. These factors are often described as social determinants of health and fall into four main categories: socio-demographic, geographic, protected characteristics, and vulnerable groups. Table 2 shows some key examples of each of these factors.

Table 2: Factors influencing health inequalities

Socio demographic	**Geographic**	**Protected characteristics**	**Vulnerable groups**
Income Education Employment Age Gender	Area level deprivation Housing Crime Access to green space Traffic and air pollution Transport links Availability of resources	Ethnicity Disability Sexual Orientation	Homeless Care leavers Carers Travellers Asylum Seekers

[5] Kailo is bringing resources to help young people, public service leaders, health practitioners and community members to explore, understand and respond to the local factors/causes of young people's mental health. It is operating in North Devon and Newham.
[6] Pathways are exploring health inequalities in the homeless population in North Devon.
[7] NICE (2022) NICE listens: Public dialogue on health inequalities. Final Report

As a result of the factors shown in Table 2, people who live in more deprived areas can have systematically worse health outcomes than those in less deprived areas.

How do we determine deprivation?

Areas are classified using the Index of Multiple Deprivation[8]. This measure divides the country into geographical areas, each with approximately 1500 people in. The measure then uses 39 indicators grouped into seven domains:

- Income
- Employment
- Education, Skills, and Training
- Health Deprivation and Disability
- Crime
- Barriers to Housing and Services
- Living Environment

The level of deprivation is calculated based on the circumstances of the people in that area. An area with a higher proportion of people classed as deprived will have a higher deprivation score. This is a general indicator. People may be deprived and not living in a deprived area – and vice versa; not everyone living in a deprived area is deprived.

Using these scores, we group areas of the country into deciles (tenths of the population) or quintiles (20ths of the population). We then measure the differences in health outcomes between these groupings. We measure these differences in several ways, but the different statistics all examine how long we are expected to live, and how much of that life we can expect to enjoy in good health, without significant life-limiting persistent illness.[9]

Deprivation in Northern Devon

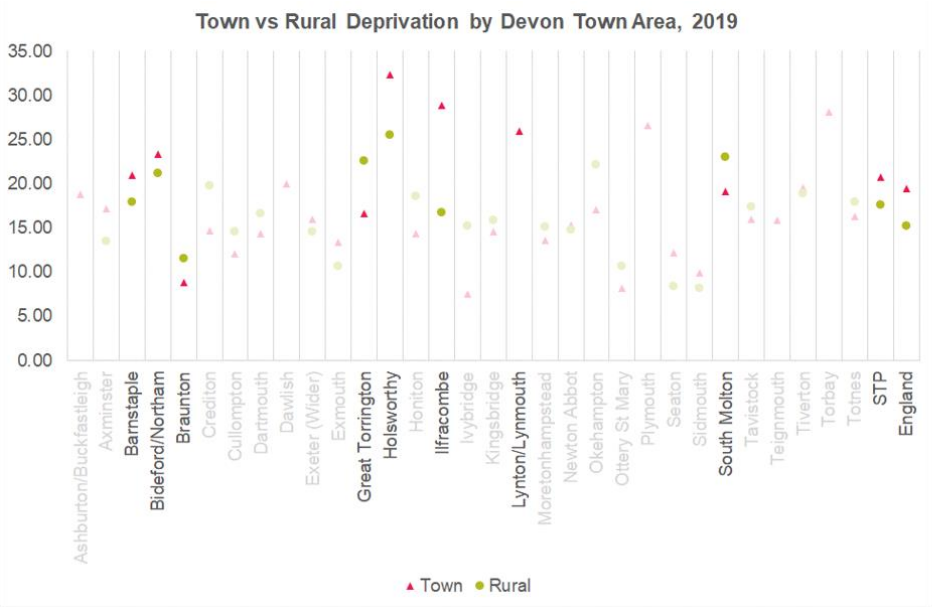
Nationally, Devon sits at 110th out of 151 local authorities (where 1 is the most deprived). Within Devon there are around 450 small areas. Each small area has approximately the same number of people living within them. Of these, 18 are within the most deprived 20% of England (with around 31,100 people) and of these, 4800 live in the most deprived areas: Ilfracombe Central, Barnstaple

[8] HCLG (2019) The English Indicies of Deprivation 2019 (IoD2019) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/835115/IoD2019_Statistical_Release.pdf

[9] ONS (2021) Health state life expectancies by national deprivation deciles, England: 2017 to 2019. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/healthstatelifeexpectanciesbyindexofmultipledeprivationimd/2017to2019

Central Town, Forches & Whiddon Valley. Torridge falls into the most deprived quintile in England for living environment. Both Torridge and North Devon are in the most deprived areas for barriers to housing and services, as well as having higher than average rates for income and employment deprivation.[10] Figure 1 shows the urban and rural deprivation scores for towns and rural hinterlands in Northern Devon.

Figure 1. Urban and Rural Deprivation by Town in Northern Devon



(Source: Public Health Devon, Simon Chant, Feb 2022)

What are the impacts of health inequalities?

Health inequalities mean that people in more deprived areas are more likely to have unhealthy behaviours, more limited access to resources, and subsequently have poorer health outcomes. The social gradient seen in life expectancy and years of good health is also reflected in other priority health outcomes. More deprived communities experience much shorter life and health expectancies.

Health inequalities are being constantly measured and reviewed. Covid-19 had a considerable impact on health inequalities and has brought the need for action into stark focus. The long-term implications of Covid-19 on health inequalities are still being determined. We do know that people

[10] Community and Public Health Intelligence Team (2019) The Indices of Deprivation 2019. Devon County Council. https://drive.google.com/file/d/18Y-3VtpLRPdrKmGZPCTUhB-FoYFxehrT/view

living in the most deprived areas had higher than average rates of covid, increased mortality, and increased amounts of excess deaths.[11]

Core 20 Plus Five is the new NHS approach for Integrated Care Systems, aimed at targeting the most deprived 20% of the population and specific higher risk population groups, focusing on: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension. It is relevant for Northern Devon because some of England's most deprived areas are located here.

Mortality

Mortality from suicide is twice as high in the most deprived areas[12]. Despite the overall reduction in premature mortality rates from diseases such as cancer and cardiovascular disease in England, health inequalities mean that in 2015, premature death rates (<75) from cancer are twice as high in those from the most deprived areas, and almost four times as high from cardiovascular disease.[13]

Children and young people

Children born in the most deprived areas are twice as likely to have a low birthweight or die as an infant. Dental decay is three times higher and levels of overweight/obesity in children aged 10-11 is 1.8 times higher[14]. Young people (aged 10 – 25) in deprived areas are more likely to have unhealthy behaviours (be overweight or obese, smoke regularly) and be seriously injured or killed in road traffic accidents[15].

Health risk behaviours

The four major health risk behaviours are smoking, excess alcohol consumption, poor diet, and physical inactivity. Together these behaviours play a significant role in the development of non-communicable diseases such as cardiovascular disease, diabetes, and cancer. The presence of these behaviours has been shown to follow a social gradient – like that seen in health inequalities.[16]

[11] Public Health England (2021) Health profile for England 2021. https://fingertips.phe.org.uk/static-reports/health-profile-for-england/hpfe_report.html#mortality-and-life-expectancy
[12] Public Health England (2018) Chapter 5: Inequalities in health. https://www.gov.uk/government/publications/health-profile-for-england-2018/chapter-5-inequalities-in-health#inequalities-in-life-expectancy-and-healthy-life-expectancy
[13] Public Health England (2018) Chapter 5: Inequalities in health. https://www.gov.uk/government/publications/health-profile-for-england-2018/chapter-5-inequalities-in-health#inequalities-in-life-expectancy-and-healthy-life-expectancy
[14] Public Health England (2018) Chapter 5: Inequalities in health. https://www.gov.uk/government/publications/health-profile-for-england-2018/chapter-5-inequalities-in-health#inequalities-in-life-expectancy-and-healthy-life-expectancy
[15] McKeown, R. & Hagell, A. (2021) Clarifying what we mean by health inequalities for young people. AYPH. https://ayph-youthhealthdata.org.uk/wp-content/uploads/2022/05/AYPH_HealthInequalites_BriefingPaper.pdf
[16] Office for National Statistics. Health state life expectancies by national deprivation deciles, England and Wales: 2015-2017. 2017. https://cam.ldls.org.uk/vdc_100063278677.0x000001

Unhealthy behaviours cluster in some populations. Twice as many adults had three or more behavioural risk factors in the most deprived areas than the least[17].

Access to healthcare

Research completed in 2018 found that there were significantly fewer GPs per head in the most deprived areas (47 per 100,000) compared to the least (53 per 100,000). One in seven people in the more deprived areas were unable to get a GP appointment compared to one in ten in the least deprived, and emergency admissions were almost 30% higher in the most deprived areas[18].

What can be done about health inequalities?

Whilst health inequalities might be persistent and challenging, there is evidence that we can reduce them. The health inequalities programme implemented in England between 1997 and 2010 saw an average decrease in the gap in life expectancy of 0.91 months each year for men, and 0.50 months per year for women. As a result of this programme, the gap in life expectancy was 1.2 years (men) and 0.6 years (women) smaller than if the policy had not been implemented[19]. Since the end of the policy inequalities have increased, and indeed been exacerbated by Covid-19[20].

There is a recognition that the causes of health inequalities are often beyond the scope of the NHS to influence. People get sick earlier and spend more of their shorter lives in ill-health because of the wider social determinants of health. To reduce these differences, we need to have co-ordinated action across several sectors. There are several different approaches to determining which sectors should be focused on. The Marmot Review[21] in 2010 introduced six indicators which are commonly used. A 10-year review of progress showcased some examples of effective action against each of these indicators[22]. Some key examples are shown in Table 3.

[17] Williams, E., Buck, D., & Babalola, G. (2020) What are health inequalities? The Kings Fund https://www.kingsfund.org.uk/publications/what-are-health-inequalities#:~:text=Inequalities%20in%20behavioural%20risk%20factors,people's%20health%20in%20England%20today.

[18] Nuffield Trust (2018) Poor areas left behind on standards of GP care, research reveals. https://www.nuffieldtrust.org.uk/news-item/poor-areas-left-behind-on-standards-of-gp-care-research-reveals

[19] Nuffield Trust (2018) Poor areas left behind on standards of GP care, research reveals. https://www.nuffieldtrust.org.uk/news-item/poor-areas-left-behind-on-standards-of-gp-care-research-reveals

[20] Public Health England (2021) Health profile for England 2021. https://fingertips.phe.org.uk/static-reports/health-profile-for-england/hpfe_report.html#mortality-and-life-expectancy

[21] Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., & Geddes, I. (2010). Fair Society, Healthy Lives (The Marmot Review). Institute of Health Equity. https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

[22] Marmot, M., Allen, J., Boyce, T., Goldblatt, P. & Morrison. M (2020) Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on?gclid=CjwKCAjwv-GUBhAzEiwASUMm4jif02lH1FBIEW7_cUp5xKSgkC004FZhmnFmpLOytztuSYIs3Eqy6BoC82YQAvD_BwE

Table 3: Case studies of effective actions against the Marmot indicators.

Marmot indicators	**Case study examples from The Marmot Review 10 years on[23]**
Giving every child the best start in life	*Greater Manchester:* a series of programmes were implemented with the aim of improving school readiness. This resulted in 68.2% of children achieving a good level of development (up from 47.3% five years earlier). Programmes included early years pathways, universal and targeted parenting and child development programmes, the development of an early year's workforce academy and a focused programme to promote children's and young people's wellbeing. *The stepping stones for family wellbeing service* is a holistic service for families of pre-school children attending nurseries in parts of Glasgow. It offers support on poverty, social isolation, mental and physical health, addictions, and parenting. The service has been shown to positively impact parenting skills, resilience and relationships as well as improving social isolation, mental health, and confidence.
Enabling all children, young people, and adults to maximize their capabilities and have control over their lives	*Football beyond borders* is an education and social inclusion charity that uses football to tackle the underlying causes of low educational attainment, poor attendance, and challenging behaviour. The programme reported 93% of students at risk of exclusion at the start of the year stayed in school and finished the year. Partner schools spent on average £11,150 less on the FBB group than the control group due to reductions in exclusions, respite, and interventions. *Richmond Academy* is a primary school in one of the most deprived areas in the UK. In 2013 it was rated as inadequate with only 40% of pupils reaching national average expectations at age 11. More than 2/3rds were unable to read or write appropriately, they had low aspirations, negative attitudes to learning, poor attendance and challenging behaviour. The school implemented a range of actions both within the school and the wider community. This includes a targeted parental engagement programme, community coffee mornings and classes to support adult learning and employment. Within two years pupils aged 11 were meeting the national expectations.
Creating fair employment and good work for all	*Returning to work in middle-age,* a drop-in centre run by Redcar FC, was set up to support unemployed men aged 45 and over as a result in the collapse of the town's steel industry. Utilising a resident-led approach to targeting health inequalities, the centre runs regular morning and afternoon sessions to build social connections, skills, and confidence. As a result, 85% of participants reported feeling more connected and 75% felt encouraged to take a lead and contribute to the project development. *Coventry Job Shop* is delivered in conjunction with a wide range of partners who work in a variety of sectors including training, housing, charity, wellbeing, mental health, disability, and childcare. The service supports job seekers by tailoring support to the individual's needs, offering training and development opportunities, supporting job

[23] See 20

	applications, and working with local employers to improve the quality of jobs on offer.
Ensuring a healthy standard of living for all	*Salford living wage city* action group aims to double the number of real living wage employers to get almost 20,000 people (particularly those in typically low-paying sectors) to have fairer pay. *The CAP debt support group* runs weekly coffee mornings (supported by collecting members to attend if needed) where people get together, provide mutual support, and build connections whilst working with the debt service.
Creating and developing sustainable places and communities	*The local conversation* is run by a community interest company working with residents of a socioeconomically deprived district. Activities are led by residents and prioritise the local environment, ensuring fresh fruit and veg is available and affordable, employability, and reducing social isolation. 98% of residents are satisfied with the local area compared to 64% in similarly disadvantaged areas. *The brick project* captures people falling through the cracks between services. It works with people who are homeless, in poverty, or facing a debt crisis. It includes a food bank, charity shop (providing clothes free of charge to those who need it), training programmes, and a recycle/reuse project which provides restored furniture to those in need. Between 2017 and 2018 it reduced the number of rough sleepers by 43% and for every £1 invested, £2 is saved through reduced demands on care, health, and criminal justice services.
Strengthening the role and impact of ill-health prevention.	*StreetGames Social Prescribing* works with young people aged 14 -25 to address problems such as loneliness, social isolation, poor mental health, debt, and unemployment. Preliminary findings suggest a reduction in GP appointments by 28% and A&E attendance by 24%. *Wellsbourne Health Care CIC* was formed by three GPs and a nurse prescriber. The community interest company employs a social prescriber, health engagement worker, mental health worker, community pharmacist, and community project manager. They co-design primary and secondary prevention strategies alongside the local population and reach out to those in greatest ill-health who do not find their own way to GP services. Results include increased cancer screening and vaccination rates.

What many of the examples above have, is a combined approach. Partnership working between public, private, and third sector organisations and local communities – across a variety of sectors – to help people overcome challenging factors. However, this cannot work if each sector works in isolation. Challenging factors can occur together and compound over time – as shown in Box 1[24].

[24] Marteau, T. M., Rutter, H., & Marmot, M. (2021). Changing behaviour: an essential component of tackling health inequalities. Bmj, 372. https://www.bmj.com/content/372/bmj.n332

Box 1. Interrelation of Challenging Factors

An area has lower **educational attainment** and an over-reliance on short term, temporary jobs to suit a seasonal tourist trade. People leave school with limited qualifications and have precarious low paid seasonal **employment**. They have low **income** and poor-quality **housing** that is poorly insulated. Due to **fuel poverty** they struggle to heat their house and eat, which impacts their health. Because of the tourist trade there is significantly higher concentration of tobacco retailers, cheap alcohol sales, fast-food outlets and limited availability of healthy food, resulting in higher **smoking** rates, **obesity,** and **alcohol** related harm. There is an increased density of traffic resulting in higher risks from **road accidents** and increased levels of **air pollution.** There is also limited access to **green space** and leisure facilities resulting in lower levels of **physical activity**, **self-reported health**, and **mental wellbeing**. As a result, the area has higher levels of unhealthy behaviours which cluster together, impacting not only the individuals themselves, but also unborn children, babies, and young people.

Targeting a single aspect of health inequality will not be effective without also tackling the interrelated factors. A cross-sector approach is vital, and it needs three key foci:

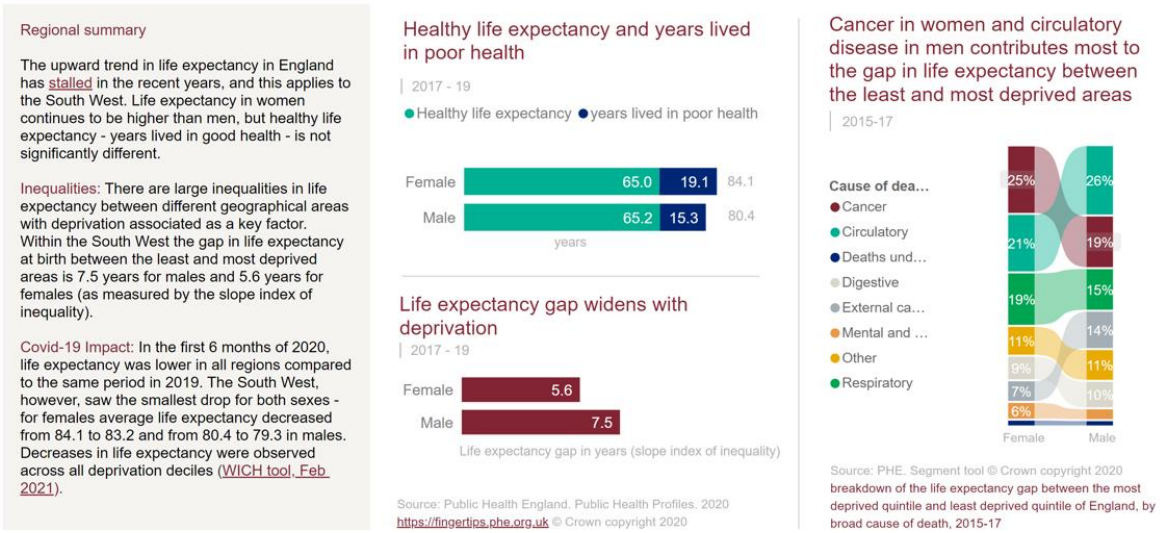
- **Person-centred:** understanding what matters to the user and providing tailored help.
- **Place-focused:** considering community context to balance individual needs with the assets available within that place to deliver services that are in line with the scale and intensity of need.
- **Systems-based:** organisations do the work to provide co-ordinated services and clear communication, so people are not left trying to find the pieces and understand how they fit together.

This co-ordinated approach has become a key focus for health inequalities work and is the approach taken by the One Northern Devon. Organisations across Northern Devon are working hard to help people with the challenges and difficulties they are facing.

Health Inequalities in Northern Devon

There are large inequalities in life expectancy between different parts of Devon and deprivation is a key factor. Figure 2 outlines the life expectancy gap and causes affecting people living in the South West.

Figure 2. Life expectancy gap/causes in the South West



(Source: Public Health Devon, Simon Chant, Feb 2022)

Recent research has been carried out by the Chief Medical Officer focused on health inequalities in coastal towns[25]. This has shown that there is a higher burden of disease and health risk factors in coastal areas, including heart disease, diabetes, cancer, mental health and Chronic Obstructive Pulmonary Disease (COPD). This difference is partly explained by age and deprivation. However, even after adjusting for these factors (and others, including ethnicity), there remains a 'coastal excess' in the prevalence of disease and risk factors which are important to consider in relation to health inequalities in Northern Devon.

The key issues identified in One Northern Devon's 10 Year Strategy, that have been the focus of attention so far were:

- Child poverty: North Devon/ Torridge worst in Devon
- Excess weight in 11yr olds: Torridge worst in Devon
- GSCE attainment: Torridge worst in Devon
- Teenage conception: Torridge worst in Devon
- Physical activity: Worst in Devon
- Alcohol related admissions: North Devon worst in Devon
- Domestic violence: North Devon 2nd highest after Exeter
- Rough sleeping: North Devon highest after Exeter
- Fuel poverty: Highest in Devon

[25] Chief Medical Officer's Annual Report (2021) Health in Coastal Communities – Summary and recommendations. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005217/cmo-annual_report-2021-health-in-coastal-communities-summary-and-recommendations-accessible.pdf

Since the pandemic, public health focus in Devon has been on the Marmot Principles, i.e., reflecting the social determinants of health[26]. These are:

- Giving every child the best start in life
- Enabling all children, young people and adults to maximise their capabilities and have control over their lives
- Creating fair employment and good work for all
- Ensuring a healthy standard of living for all
- Creating and developing healthy and sustainable places and communities;
- Strengthening the role and impact of ill-health prevention

One Northern Devon is focused on supporting organisations to work together to help to overcome the challenges people are facing, with a particular focus on reducing health inequalities that arise from deprivation. Examples of best practice are being collected in the *Engaging Communities Project*, alongside people's accounts of the challenges they have faced and what has helped them to overcome them.

Project Findings (so far)

Data collection and analysis for the project is ongoing. However, some common themes have emerged from the organisation survey and interviews carried out so far with organisations. Interviews and focus groups are underway with community members and some case studies are presented below.

Biggest Challenges

People working for organisations in North Devon and Torridge who filled in the project survey think that the biggest challenges facing people in Northern Devon are:

- Poor transport infrastructure
- Lack of affordable housing
- Poverty
- Geographical remoteness and rurality
- Social isolation and loneliness
- Low wage economy

[26] https://www.devonhealthandwellbeing.org.uk/wp-content/uploads/DCC-Public-Health-Annual-Report-2021-Accessible-Version.pdf

'There is a lack of good quality social housing for rent. There has been a centralisation of health services, both clinical and mental, which has made access difficult and expensive for many residents and has meant that many can no longer access them.' (Organisation survey respondent)

'Transport to services, distance to secondary care, isolation in rural communities, access to online services - good connection.' (Organisation survey respondent)

'Geography; poor transport and digital connectivity. Pressure of living in a 'holiday' economy. Lack of meaningful job and economic opportunity.' (Organisation survey respondent)

'Housing and employment opportunities are the biggest challenges. There needs to be more investment in services, as is so often the case.' (Organisation interviewee)

'Reaching under-represented groups is a big challenge. For refugee groups there is lack of engagement with services due to the language barrier. Leaflets are only written in English at present as well, although we are working to add languages to them and also to the website.' (Organisation interviewee)

Overcoming Biggest Challenges

People working for organisations in North Devon and Torridge who filled in the project survey think that these challenges can be overcome by:

- Improvements to public transport links
- Provision of more affordable transport
- More investment in public services
- More investment in affordable housing
- Improvement in outreach into communities
    - e.g., through groups, befriending services, intergenerational connections

'We need to engage people in thinking creatively about how we can increase wages and opportunities for people for employment. The Universal Credit system pushes people into debt. The taper needs to be much more gradual over 2 years to allow people to adjust and build up their income.' (Organisation survey respondent)

'Community champions who support community developers/One communities with outreach work, similar to volunteer support workers, buddying up with people to increase confidence and socialisation.' (Organisation survey respondent)

'People need to be able to put down roots to feel secure, build a community and feel less isolated. Needs real affordable housing, high taxes on 2nd homes, limitations on air bnb and holiday lets and investment in our area for community resources.' (Organisation survey respondent)

'Subsidised or free hospital transport to appointments available 24/7.' (Organisation survey respondent)

Main Priorities for OND

People working for organisations in North Devon and Torridge who filled in the project survey think that the main priorities for One Northern Devon in helping to overcome inequalities should be:

- Improving public transport
- Improving support services
    - e.g., mental health, loneliness, isolation, families, dementia
- Helping organisations to collaborate
- Creating a hub/portal for organisations to access
- Finding out what people's needs are by going out into communities
- Listening to people
- Realising one approach does not fit all
- Empowering people
    - e.g., Local Community Champions

'Empowering local communities to improve facilities in their area as each town has differing needs and priorities. Work with statutory services in improve access to health care & affordable housing.' (Organisation survey respondent)

'Listening to the community members and those who advocate for them. Collaborating with community members to develop solutions together through lived experience. Ensuring sustainable long term financial security of services working to overcome inequalities.' (Organisation survey respondent)

'Continue to build the network of organisations and to encourage partnership working. You may already have a directory? We need a community hub.' (Organisation survey respondent)

'As I understand it One Northern Devon will focus on health inequality in which case, I think mental health should be a priority. It would also be interesting to explore links between improved wellbeing and employability.' (Organisation survey respondent)

Barriers to Collaborative Working

People working for organisations in North Devon and Torridge who filled in the project survey think that the barriers to organisations working together to overcome inequalities in Northern Devon are:

- Lack of funding
- Time-limited nature of funding
- Organisations not always sharing information with each other
- Lack of capacity
- Competition for funding within the sector
- Lack of knowledge and understanding of needs

'Wider determinants of health are not per se the responsibility of a national health service. Properly resourced public health and local authority services would go a long way towards addressing inequalities.' (Organisation survey respondent)

'Each Community has different needs and one size will not fit all. There is a danger of a 'top down' mentality rather than bottom up with the Community identifying need and developing ways to address these. Inequity has many shapes and sizes. Organisations can have very different views n a problem and it is really important to agree aims and resources if work is to be successful.' (Organisation survey respondent)

'Software systems - one system where information can be accessed by all agencies supporting a family, clarity around GDPR and sharing information. Communication between agencies and professionals and their varied ways of working.' (Organisation survey respondent)

Organisational Engagement

People working for organisations in North Devon and Torridge who filled in the project survey would like to engage with other organisations working with communities across Northern Devon through:

- Face-to-face meetings
- Networking
- Online meetings
- Forum

- Identifying common goals
- Knowing who represents which service
- Collaborative working

'I'd like to know who we could work with, who does what locally and how to let them know about what we do.' (Organisation Interviewee)

'Being proactive and practically helping each other!' (Organisation survey respondent)

Case Studies

As the project is ongoing, it is too early to highlight emerging themes from the community interviews and focus groups. However, some examples of the challenges people are facing are presented below, in order to inform discussion at the workshop on 29th June.

Elizabeth[27] is in her 70s and lives in a town in Northern Devon. She has experienced multiple health difficulties for 40 years and feels that she has received very little help from statutory services. She is paying to have a stairlift fitted to her home and said:
'I'm battling to get disabled access to my home. Because I'm mobile, and I don't look ill, people assume I'm ok. I'm not 'poorly enough'.

Her family live locally and they help to care for her but she doesn't receive any formal care support. Her family members are in employment so cannot always help when she needs it:
'I had no help during Covid. I slept in my own sick. I lost all my dignity.'

She feels unsupported by services she has been in contact with – social services, the council, her MP and the police. This lack of support reduces her quality of life in several ways.
'If I want to go anywhere, I have to pay for taxis and that's expensive.'

There are rats and flies outside her house due to rubbish that has been dumped there but the council have said: *'I will have to pay £700 to have it removed and I can't afford it.'*

She feels let down by the police: *'I made a complaint about my neighbour who was threatening me but they took 19 days to come to me.'*

She feels that the whole system *'needs a shake-up'.*

(Interview at a social group, May 2022)

[27] Pseudonym

Joanne[28] is in her 40s and lives in a village in Northern Devon. She has been made homeless twice in the last 15 years, along with her children.

'I lost my house [in first town]; it wasn't my fault it was someone else's. Then we were in a B&B for 7-8 months in [second town]. They don't put people in them for so long now. It was awful – we had no cooker, we had breakfast but we couldn't have tea, it was sandwiches or takeaways. Then we got a private rental and she [landlord] said we could stay but then after 6 months she wanted her house back! So, then we were put in the caravan park in [third town] for 8 months. [Name of child] had to change school again. Then we were moved to a council house in [fourth town] and then I got a house swap as I needed to move back to [first town] to get support from my family. Then I got given another house that was bigger but it was still too small for us [more children were in the family now]. I fought for my council house. I didn't want to give it up but I got married, we needed more space.'

She feels that there is a lack of transparency around how social housing is allocated and feels that local people do not get priority:

'No one would rent a house to a single mum on benefits. I went round and asked everyone and they all said no one would rent their house to a person like me. I was discriminated against because of the people who trash their houses, even though I'm not like that. I spent 4-5 years trying to get rehoused into a house that was big enough for us and didn't have mould and damp everywhere. I don't know how people got houses and I didn't. Not being horrible or anything but they give houses to people who aren't born here.'

Family support really helped Joanne to cope with homelessness and housing insecurity:

'My mum helped me. She would come and see me, pick me up, take me to where I needed to go.'

Joanne felt that statutory services were not joined-up and people did not work together. She found social services to be supportive but although they said they would help her, they referred her on to other services who then '*hit a brick wall*' with any support for her:

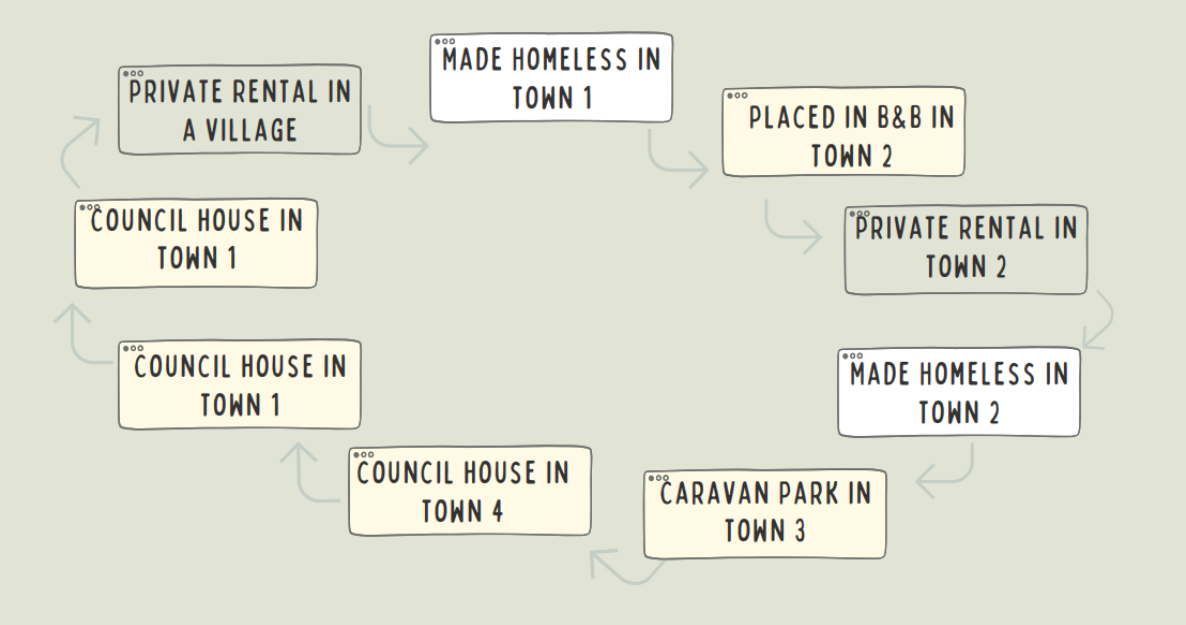
'A lot of people are worried about social services because sometimes they have to take kids away but, in my case, they would say they could see my children were loved and I was doing my best, we just needed more space. They would give me a mould spray for the house but it wasn't enough. The mould was everywhere and even when they painted the house the mould came back straightaway. […] I was ok, I got a bit depressed sometimes but I just got on with things. I got less help because I was getting on with stuff!'

(Interview via 'phone, June 2022)

[28] Pseudonym

It can be helpful to use life-journeying or life-mapping when analysing people's experiences. An example is shown in Figure 3. More of analysis of this type, as well as creative research methods, will be used in the next few months of the Project.

Figure 3. Joanne's Housing Journey



Discussion Points for the Workshop on 29th June

- What examples of best practice for supporting people to overcome their challenges and/or health inequalities can your organisation share with OND partner organisations?
- Would the development of an OND Community Champions Programme[29] (or similar, as in Ilfracombe in 2020[30]) help to reduce health inequalities in Northern Devon?
- Would a centralised OND Information Hub/Website/App be useful for organisations to deliver services to people experiencing health inequalities across Northern Devon?

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[29] https://disabilityunit.blog.gov.uk/2021/05/25/what-is-the-community-champions-scheme-and-how-is-it-supporting-local-communities/
[30] https://swahsn.com/wp-content/uploads/2020/06/SWAHSN-Social-Prescribing-Case-Study-7_FINAL.pdf