Annual Report of the Director of Public Health for North Yorkshire 2019

Life in times of change

health and hardship in North Yorkshire

Health and Wellbeing Board
North Yorkshire

North Yorkshire
County Council

Foreword

A few days before he died, a man visited his friends and had dinner with them. A woman came to him, and anointed his feet with expensive ointment. It was a controversial move, one that sparked a fierce backlash amongst his companions; they reckoned the money would have been better given to the poor than wasted in this way. Acknowledging an ancient tradition of preparing a body for burial, the man rebuked the woman's critics and told them that while they would soon be grieving his death, the poor would always exist. Jesus' words give witness to an age-old narrative of poverty.

Is poverty inevitable? What are its causes, and if and how can it be addressed? Bold questions without easy answers it seems. This report examines the issues in some depth, and invites us to consider where we fit into the picture it presents. Part of the difficulty in contemplating such an invitation comes from reading words on a page, and feeling a step removed from the range of problems it describes. What has struck me from the travels I have made around the region in my role as Bishop of Ripon is how poverty turns up in unexpected places, often hidden and silently borne. By a focus on public health, this report shines a light on a complex tapestry of issues that makes for salutary reading. It names a reality that we cannot ignore.

We get a sense of the longevity of the problem by the historical approach that the report takes. Workhouses represented a particular approach that sought to give 'the poor' a place to live with 'benefits'. While the institution of the workhouse acknowledged that people in poverty needed help, the result was a stark resignation of life that was forever limited rather than a hope that life could be lived in all its fullness. The emergence of the welfare state saw a move that held out the potential for life to be transformed. That remains the building block of social care to this day and yet, fractures are appearing. Inequality reveals poverty in a way that exacerbates the same sorts of issues that reach far back into human history, telling an age-old narrative of the haves and the have-nots. Attitudinal undercurrents remain, and old habits die hard. Faced with such depth of challenge, what should an appropriate response be? Dr Lincoln Sargeant's report rightly points out the variety of contexts in our region: coastal, rural (in all its variety), market towns, a spa town, a city, and of course the substantial military presence which is increasingly integrated into the wider civilian community. It will never be a case of attempting to impose a 'top-down' approach, or a 'one size fits all' mentality. The current political landscape is beset by anxiety and uncertainty; the horizon is far off, and does not inspire confidence that the persistence of poverty or its underlying causes will receive top billing (despite the rhetoric). This points to the need to upskill at a local level by listening to particular needs and aspirations. Communities can hold great strength, but to be effective, it takes courage and trust. Strong local networks where people are valued and supported can have an immensely positive impact on public health. It's a simple example, but the Parkrun movement demonstrates the power of community: organised, tasked, supportive and encouraging, with goals to aim for. Physical and mental wellbeing uplifted.

Above all, what Dr Sargeant points to is a need for creative and dynamic partnerships, confidence at the local level, and a purposeful use of resourcing. It invites a strategic and joined-up conversation approach to building strategy. The good news is that we can be part of this. Are we up for the challenge, and can we recognise our potential to join in?

The Right Rev'd Dr Helen-Ann Hartley, Bishop of Ripon in the Anglican Diocese of Leeds.

Dr Helen-Ann Hartley, Bishop of Ripon, and Dr Lincoln Sargeant, Director of Public Health - at the Ripon Workshouse Museum

Contents

Contributions from

The Right Rev'd Dr Helen-Ann Hartley - Bishop of Ripon in the Anglican Diocese of Leeds

Tracy Allen – Department of Work and Pensions (DWP)

Sheryl Bartliff – Catterick Riverside Beacon

Clare Beard – Public Health Consultant, NYCC

Tim Caswell – Strategy and Performance Officer, NYCC

Wendy Collins - Department of Work and Pensions (DWP)

Charlotte Fortune - Harrogate Homeless Project

Angela Hall – Health Improvement Manager, NYCC

Julie Hardiment – Scarborough and Ryedale CCG

Avril Hunter – Head of Commissioning, NYCC

Kathryn Ingold – Public Health Consultant, NYCC

Jo Ireland – Scarborough Borough Council

Neil Irving – Assistant Director, Policy, Partnerships and Communities, NYCC

Trish Kinsella – Scarborough Rainbow Centre

Leah Mellors – Ripon Workhouse Museum

Yvonne Parkes – Health Improvement Officer, NYCC

Emel Perry – Public Health Intelligence Analyst, NYCC

Carrie Phillip – Ripon Workhouse Museum

Julie Priestnall– Department of Work and Pensions (DWP)

Wendy Rice – Public Health Intelligence Analyst, NYCC

Kim Robertshaw – Ryedale District Council

Laura Thomas – North Yorkshire Warm & Well

Carly Walker – Health Improvement Manager, NYCC

Judith Yung – Public Health Intelligence Analyst, NYCC

Project Team

Eduardo Alegria
Graphic Designer, NYCC

Helen Bawn
Communications Officer, NYCC

Leon Green
Senior Public Health Intelligence Specialist, NYCC

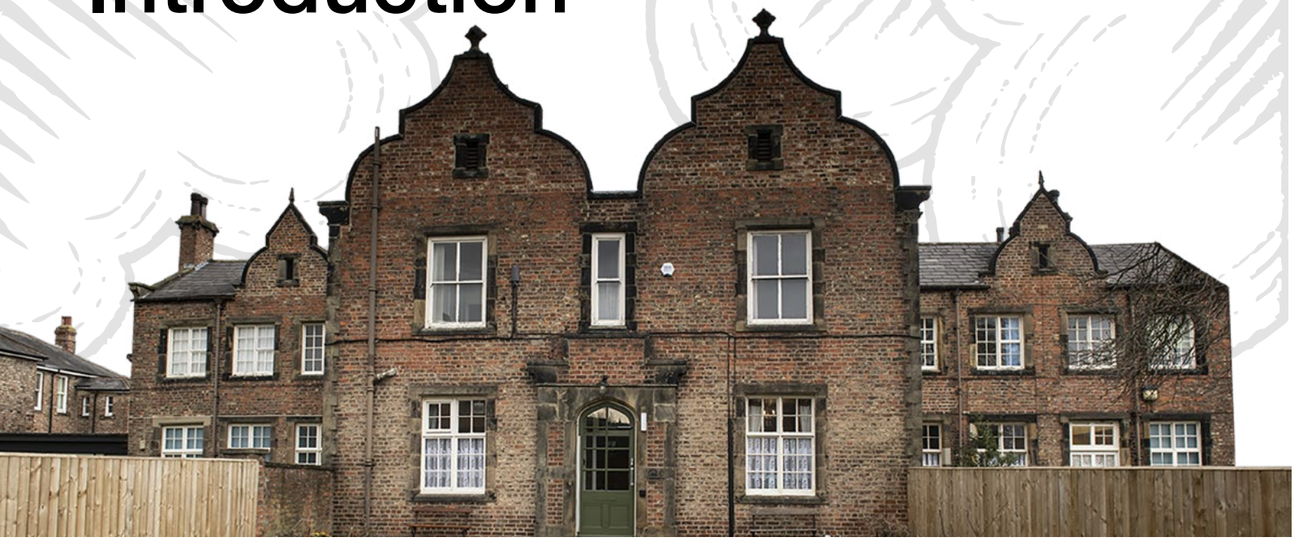
Jessica Marshall
Health Improvement Officer, NYCC

Rory O'Conor
Public Health Consultant, NYCC

Rachel Richards
Public Health Consultant, NYCC

Anthony Ruddy
Senior Strategy and Performance Officer, NYCC

Introduction



The Ripon Workhouse Museum is one of the best preserved Victorian workhouses in the country. It gives us valuable insights into how a previous generation addressed the issues of poverty, which despite some progress, still remains a feature of life in North Yorkshire today. The Victorian workhouse was the response to a system of poor relief that was perceived to be broken and about to collapse under the pressure of increasing numbers of poor people and the associated welfare costs to support them.

Poor relief had been organised locally through parishes and there was inevitably variation in the support offered from one parish to the next. The solution seemed to be to centralise the system and establish national standards for efficient delivery of poor relief. It is interesting to note that the workhouse in Ripon was not built until 20 years after the New Poor Law of 1834 – an example of Yorkshire people wishing to maintain control over their own affairs.

The workhouse did ensure that inmates had access to secure housing, food, basic healthcare and education for children that was not always available for the poor who remained in their own homes. Despite these benefits, however, our perception of the workhouse is predominantly negative. This is partly because the workhouse gave expression in bricks and mortar to some widely held beliefs about poverty.

The Victorian mind-set drew a distinction between the deserving and undeserving poor. The able-bodied poor had themselves to blame for their circumstances and therefore should be discouraged from being a burden on the public purse. Consequently workhouses were deliberately designed to be harsh and were built and operated to mimic prisons. It is one thing to hold these opinions about poverty privately, but when they gained the force of law and poverty was effectively treated as a crime, few could stomach the lack of compassion and fairness that was apparent in how workhouses functioned.

Workhouses did not solve the problem of vagrancy. Mental illness and addiction were major contributors and were not well understood. The system was more compassionate to those with physical illnesses and disabilities. Neither did the workhouse discourage worklessness. We know that there

were widespread changes to the economy that left many people without jobs or skills to access other employment. The able-bodied shirkers that the system was designed to address turned out not to be as common as the popular imagination might have suggested. Furthermore, the workhouse would generate its own scandals and examples where they failed the deserving poor would multiply - providing plots for authors such as Charles Dickens.

Poverty remains a public health issue in North Yorkshire in 2019. Locate the areas with the greatest concentration of poor people and there is a strong chance you will find that these are the areas that have higher than average levels of ill health and early death. We have an NHS that is free to all but we know not everyone can access health services with the same ease. Before he or she can access free healthcare, the single parent living on their own who finds their child is unwell must consider the costs of taking the day off from work and arranging childcare.

We have free education but the quality varies across the county. If we are not able to provide local examples of educational attainment leading to social mobility, the challenge of motivating our pupils to excel at school becomes harder.

The cost of maintaining a warm home varies across the county and will limit the ability of some families to engage fully in the social life of their communities as well as threatening their physical and mental health.

Poverty is more than material deprivation. It is about the basic conditions that each of us needs to play our full part in society without shame. We need access to an income that is adequate to maintain a reasonable standard of living but also the opportunities to make a contribution to our families, communities and wider society. We need the basic conditions to maintain our independence and control our destiny. We are poor without them.

This report looks at poverty from a public health perspective. Our vision for North Yorkshire is that all have a chance to thrive and can benefit from an economy that allows “everyone to fulfil their ambitions and aspirations”, but 1 in 10 children live in households that are currently excluded from that vision through poverty. That exclusion not only harms children and their families but undermines our collective wellbeing.

In providing a review of the health of our population, I will focus on some of the areas where we can take collective actions to promote an inclusive economy that works for everyone and highlight the support that public services can offer to protect people from the worst effects of poverty. My thanks to those who contributed to this report and I look forward to working with you to make a difference to the health and prosperity of people in all our communities in North Yorkshire.

Dr Lincoln Sargeant, Director of Public Health for North Yorkshire - October 2019

Chapter 1:

Poverty – a very wicked problem?

"A wicked problem is a social or cultural issue or concern that is difficult to explain and inherently impossible to solve. Examples of wicked problems in today's society include things like income disparity, poverty, hunger, health care, obesity and terrorism."

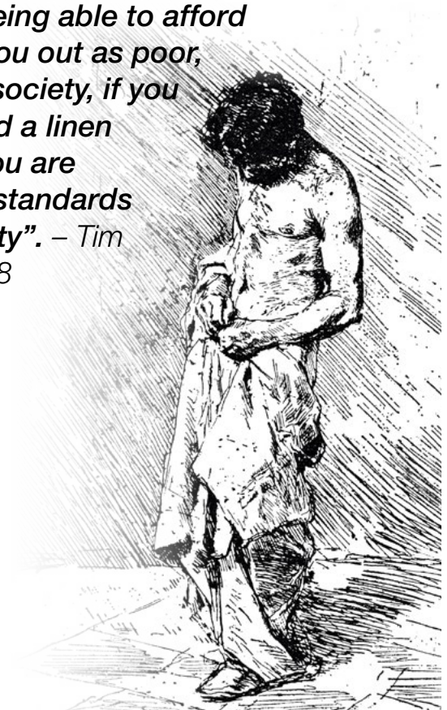
Poverty, by its very nature, is a wicked problem. Explaining poverty is not easy or straightforward - and poverty is difficult to define and hard to measure. It is multi-faceted and cuts right across all our major institutions – political, public, social and economic. Poverty is everywhere – in towns and villages, the countryside and along the coast. Poor people live in wealthy places and vice-versa, and poverty affects every demographic you can think of – including age, gender, ethnicity, and disability – and affects every aspect of daily life for those who are experiencing it (Alston, 2018).

Poverty also divides opinion, there are lots of truths about poverty and lots of inaccuracies too. Poor people are often seen as work-shy and portrayed unkindly. They can be desperate to take part in activities in their communities, but quite often they can't afford to, and they can feel ashamed. Some poor people deny their own poverty and try to project a wealthier image so they can fit in.

Poverty can also make you ill, and illness can trap people into further poverty. However, not all poor health is caused by poverty and the wider issues that surround it. Sometimes unhealthy options are more accessible for poor people, but we can help to empower them by improving the options available to live healthy lives and reduce the impact of the harmful effects of poverty.

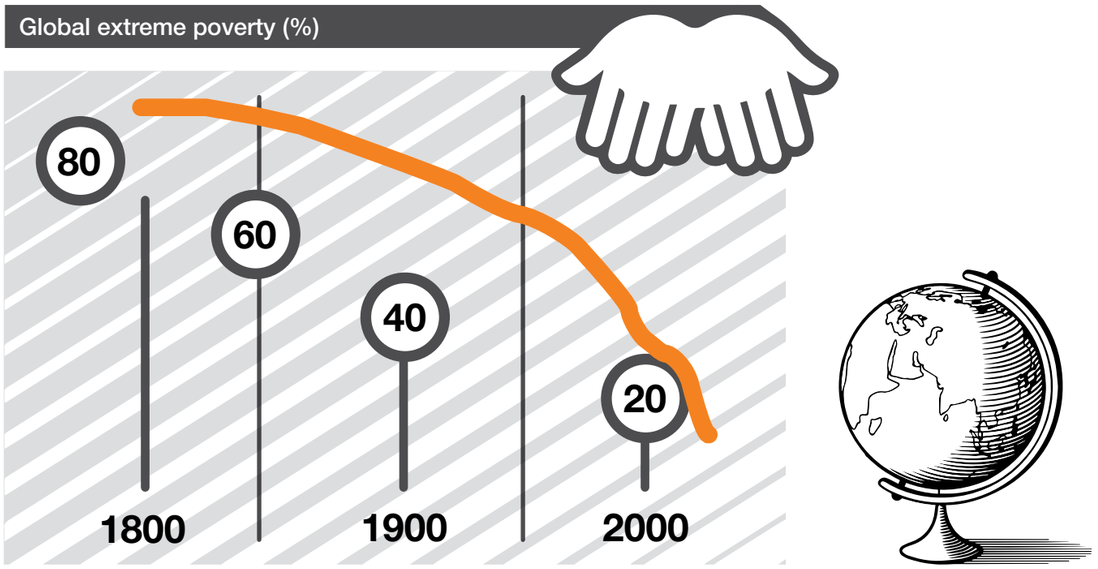
Scottish philosopher and economist, Adam Smith (1723-1790), was one of the earliest social commentators. He used the example of affording a linen shirt to explore perceptions of poverty:

"Adam Smith uses the example of a linen shirt. His point being that one can live just fine without one. Yet if you're in a society where not being able to afford one marks you out as poor, then in that society, if you cannot afford a linen shirt, then you are poor by the standards of that society". *– Tim Worstall, 2018*



Whatever we might think about poverty today, whether personally, professionally or politically, we should all agree that we cannot just keep on saying that poverty is complex – a wicked problem. In order to tackle poverty systematically, effectively and fairly, we need to recognise the problem in the first instance and understand what poverty is, and how we can measure it by scale, distribution, and the effects on our health.

That is the focus of this chapter. It is important to note that the story of poverty is not all negative. In fact, over the past 200 years there has been huge progress towards the reduction of poverty.



In 1800, 85% people around the world were living in extreme poverty (on less than £1.60 a day in today's terms), but by 1996 this rate had gone down to 50% of the global population and today it is estimated that there are less than 1 in 10 people who are living in extreme poverty (Rosling, 2018).

"If you do get a job here it's normally not that great for like pay anyways, like cos obviously, I don't know ... we do like arrange stuff and then it just never happens, cos we don't have the money"

"Money for myself it is fairly difficult because I don't have any"
- Quotes from the Growing up in North Yorkshire survey

Great searching of heart: A brief history of poverty

"That in this land of abounding wealth, during a time of perhaps unexampled prosperity, probably more than one-fourth of the population are living in poverty, is a fact which may well cause great searching of heart" *(Rowntree, 1899).*

Seebohm Rowntree (1899), son of the chocolate manufacturer Joseph Rowntree, undertook an early, detailed study of poverty in York. He discovered that a large proportion of the people who were living in households experiencing chronic economic hardship were doing so because of lack of income. Rowntree's pioneering research was based on a measure of poverty which took the basic costs of food and housing needed to sustain 'physical efficiency'. He captured the extent of poverty at a time when the country as a whole was generating unprecedented levels of wealth for the nation. The Joseph Rowntree Foundation was set up as a result of his investigation and provides valuable social commentaries.

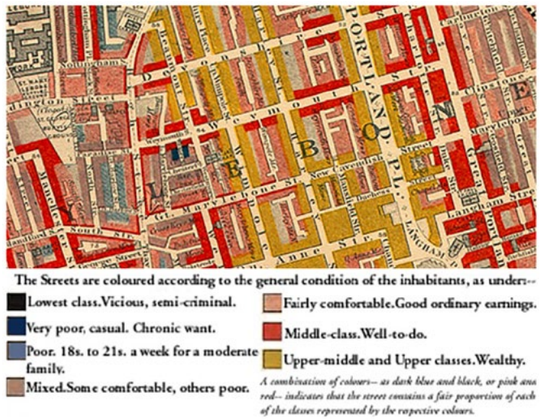
Although pioneering, these surveys were quite basic in some ways and in spite of some striking similarities between now and then, they no longer reflect some of the dimensions of poverty that we see today.

Some of the most notable differences relate to demographic changes in the population and family structures. In the past, for example, large family households accounted for many of those who were poor but this is not prominent today. Instead one-parent households are now among the groups at highest risk of poverty.

However, despite the changes that have taken place, there is still a striking similarity between poverty in the past and poverty today. Just as Rowntree's pioneering work showed, the main causes of poverty are still largely due to unemployment and relatively low household income.

These causes in turn are influenced by how society responds to internal and external factors in shaping political and economic policies. A discussion of the political and economic choices, such as that society takes in its approach to generating and distributing wealth, is beyond the scope of this report but these choices have profound consequences.

Life and labour of the people in England - Charles Booth 1889.



From physical efficiency to relative poverty and material deprivation: How is poverty defined and measured

In 1979 Peter Townsend developed the standard definition of poverty: "Individuals, families and groups in the population can be said to be in poverty when they lack the resources to obtain the types of diet, participate in the activities and have the living conditions and amenities which are customary, or are at least widely encouraged and approved, in the societies in which they belong. Their resources are so seriously below those commanded by the average individual or family that they are, in effect, excluded from ordinary patterns, customs and activities".

There is also a further important distinction between relative poverty and material deprivation. Material deprivation is related to, but differs significantly from, relative poverty because deprivation relates to the wider material conditions experienced by people who are living in poverty, without taking household income into account. Poverty, on the other hand, relates to the lack of income and other financial resources which results in material deprivation. In other words, material deprivation is the consequence of relative poverty resulting from low household income.

Townsend's definition makes the important distinction between **relative** and **absolute** types of poverty: poverty is not something that should only be understood in absolute terms - it is also something which is relative to the place where people live. The definition of relative poverty we use today is more about income and resources, and having the ability to feel part of, and take part in, all of the activities which are shared by the general population. It is much less about the basic necessities needed to sustain Rowntree's 'physical efficiency'.

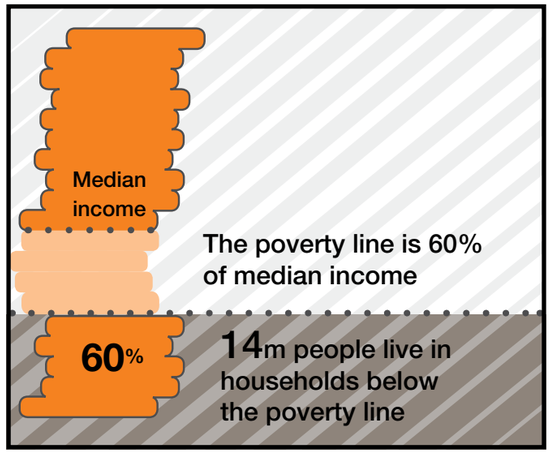
Official measurements of poverty and the value of the national poverty line

The UK Government publishes an annual survey of income poverty called Households Below Average Income (HBAI). The HBAI survey sets the UK poverty line at 60% of the average (median) UK household income.

Any household with a combined income of less than 60% of the national average is officially categorised as living in poverty.

Based on a household with two adults and two dependent children, the current annual value of the Government's HBAI poverty line, after housing costs have been deducted, is set at £22,100.

The deep poverty line is measured at 40% of the annual average income, which is £14,733, based on the same family structure of two adults with two dependent children.



Households Below Average Income (HBAI) adapted from Child Poverty Action Group (2019)

The latest report from the Social Metrics Commission (2019) report on UK poverty estimates there are approximately 14.3 million people living in relative poverty in the UK today – equivalent to more than 1 in 5 of the total population.

The report looks at how UK poverty has changed over the past few years, as well as over the longer term. Key findings from the report show that child poverty has been rising since 2011/12 - 4.6 million children now live in poverty in the UK. The vast majority of this rise has taken place in working families.

Four million UK workers are also living in poverty – a rise of more than half a million over five years, and in-work poverty has been rising even faster than employment, driven almost entirely by increasing poverty among working parents. Pensioner poverty has also risen in recent years, especially amongst those living in rented accommodation, in particular the private rented sector.

Overview of the number of people in poverty and the poverty rates for different groups 2017/18

Group	Number in poverty
People in poverty	14,300,000
People in persistent poverty	7,000,000
Children in poverty	4,600,000
Working-age adults in poverty	8,300,000
Pensioners in poverty	1,300,000
Disabled people in poverty	3,700,000
Working-age adults in poverty lone parents	1,000,000
Working-age parents in poverty in couple families	2,800,000
Working-age adults in poverty in workless households	2,800,000
Children in poverty in workless households	1,200,000
Full-time workers in poverty	2,800,000
Part-time workers in poverty	1,800,000

Source: Households Below Average Income (HBAI) and Family Resources Survey (FRS) 2016/17 (JRF Analysis, 2018)

The average household disposable income in 2019 in the UK is £28,400 per year or £546 per week (ONS, 2019). The UK poverty line is currently valued at £22,100 per year or £425 per week, based on two adults and two children (DWP, 2018). Job Seekers Allowance (JSA) is currently £3,800 annually or £73.10 per week for one adult, and for two adults living together it is £5,972 annually or £114.85 per week. Therefore, a household with two parents on JSA and two dependent children in receipt of child benefits (currently set at £34.40 per week for two children), would only receive £7,761 per year in total household income. This places all non-working families in receipt of Job Seekers Allowance below the official UK poverty line and below the deep poverty line. The Households Below Average Income (HBAI) and Social Metrics Commission (SMC) measures give slightly different estimates. When taken together they suggest that small changes in circumstances can result in people and families falling below the average living conditions accepted by society and finding themselves excluded from ordinary activities.

Those at the greatest risk of poverty are workless households, single parents and disabled people. Both measures highlight that for any household where one or two working age adults are in receipt of Job Seekers Allowance with no other household income source, they would be living in deep or persistent poverty.

The Social Metrics Commission (2019) has developed a new framework for measuring poverty which improves the way we understand the nature and experience of poverty by different families. It is still based on the idea that living in poverty is about not having the resources to meet family needs and take part in society in general, but it improves on previous measures in many ways. This includes taking account of additional resources other than income, such as savings; and additional costs, such as childcare. The framework acknowledges that more work may be needed on rural poverty issues such as transport and access to services, and fuel poverty. Under the Social Metrics Commission's new measure there are 14.3 million people in poverty in the UK, including 7 million people living in persistent poverty (in poverty for 2 of last 3 years).

Poor UK

Total UK population

66.6m*

The different levels of poverty in the UK and the value of the UK poverty line. More than one-in-five of the UK population lives in poverty - that is 14,300,000 people (21%).

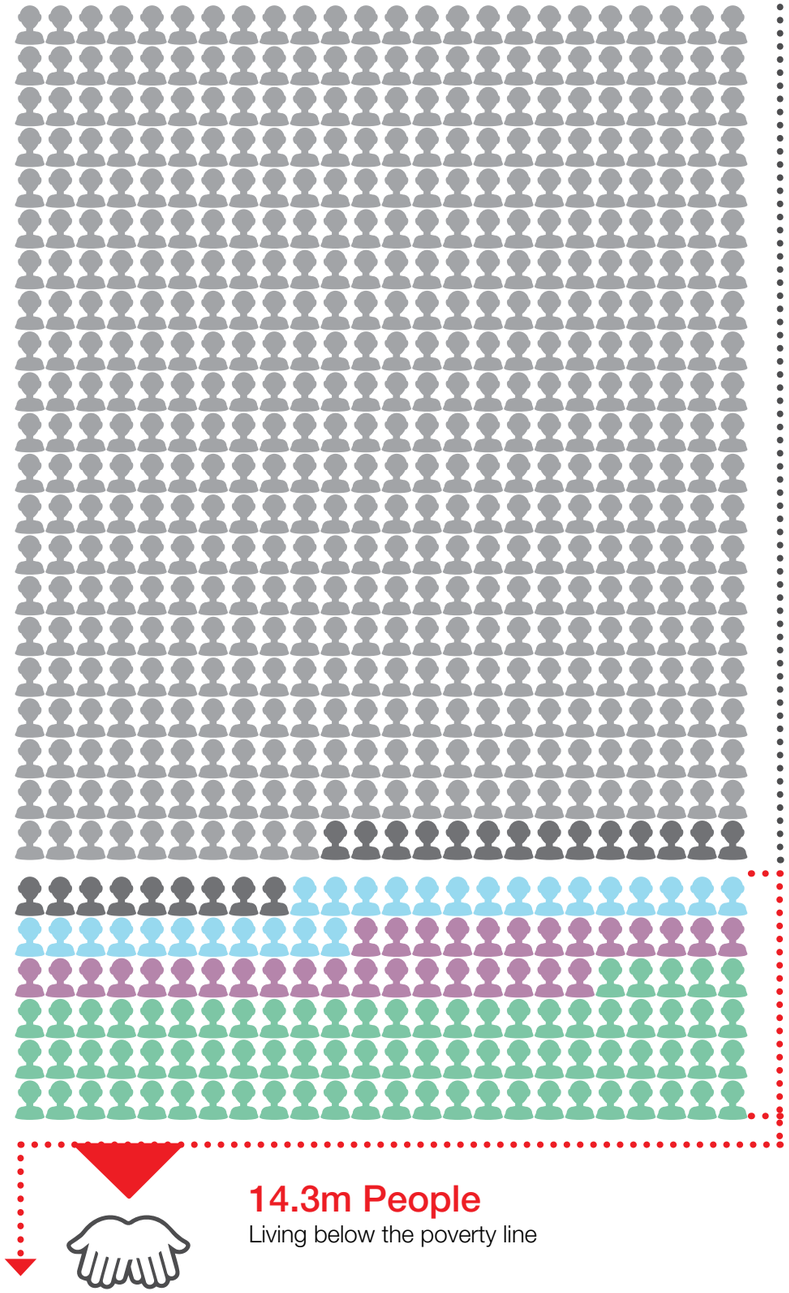
2.5m people
Living above the poverty line - within 10%.

2.6m people
Living just below the UK poverty line - within 10%

3.3m people
Living between 10% and 25% of poverty line.

8.4m people
Living in deep poverty - below 25%.

Date sources; Social Metrics Commission 2019
**UN population estimate 2018*



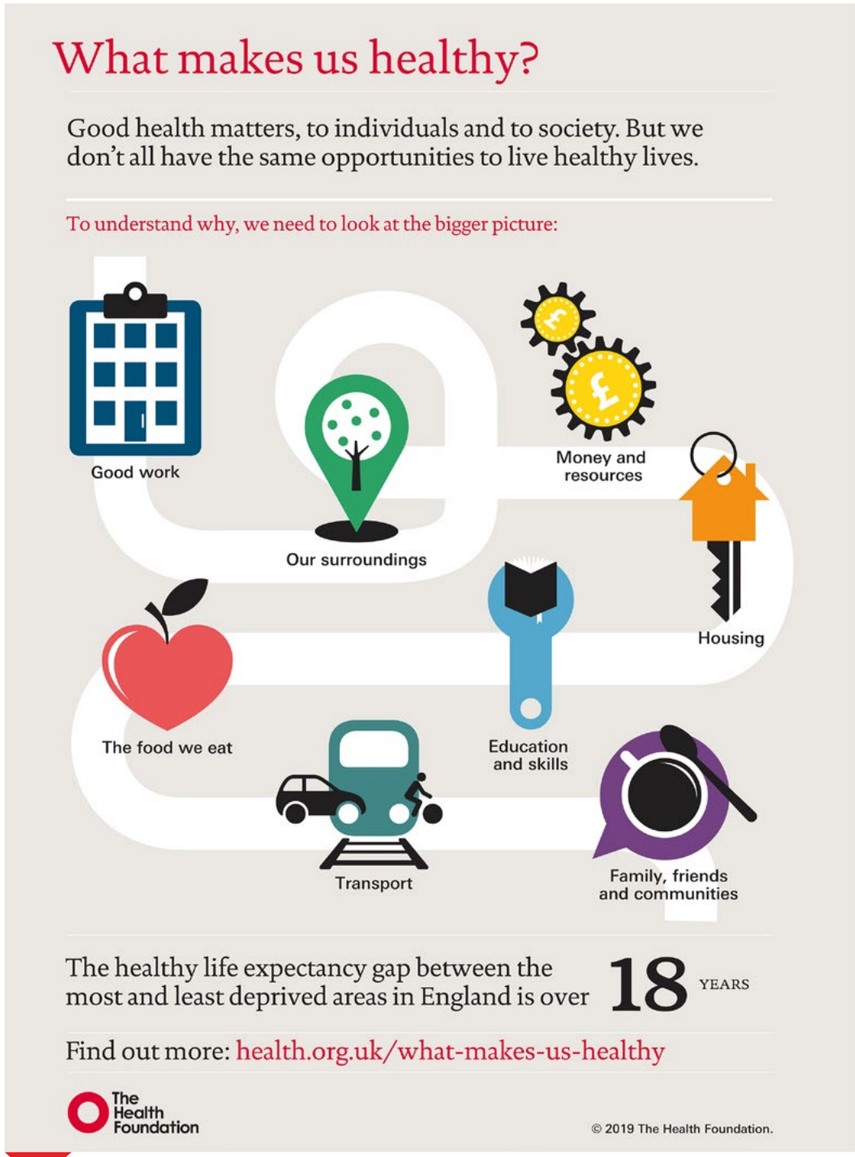
14.3m People
Living below the poverty line

How does poverty affect health?

One of the most frequently asked questions about poverty and health is 'how does poverty affect health'? Lack of money in itself does not cause someone to be poorly, but the indirect influence of poverty does have a marked effect on health.

In public health we talk about the 'wider determinants' of health. In summary, this is the relationship between where you are born, grow, live, work and age, and how these factors affect your overall health and how long you will live (life expectancy). These wider determinants of health, which include economic characteristics such as unemployment and household income, have been found to have a greater influence on population health than healthcare and lifestyle behaviours.

It is the interaction of multiple factors that matters the most and these in turn are often related to behaviours; such as consuming too much alcohol or unhealthy food; lack of exercise; or exposure to high levels of stress.

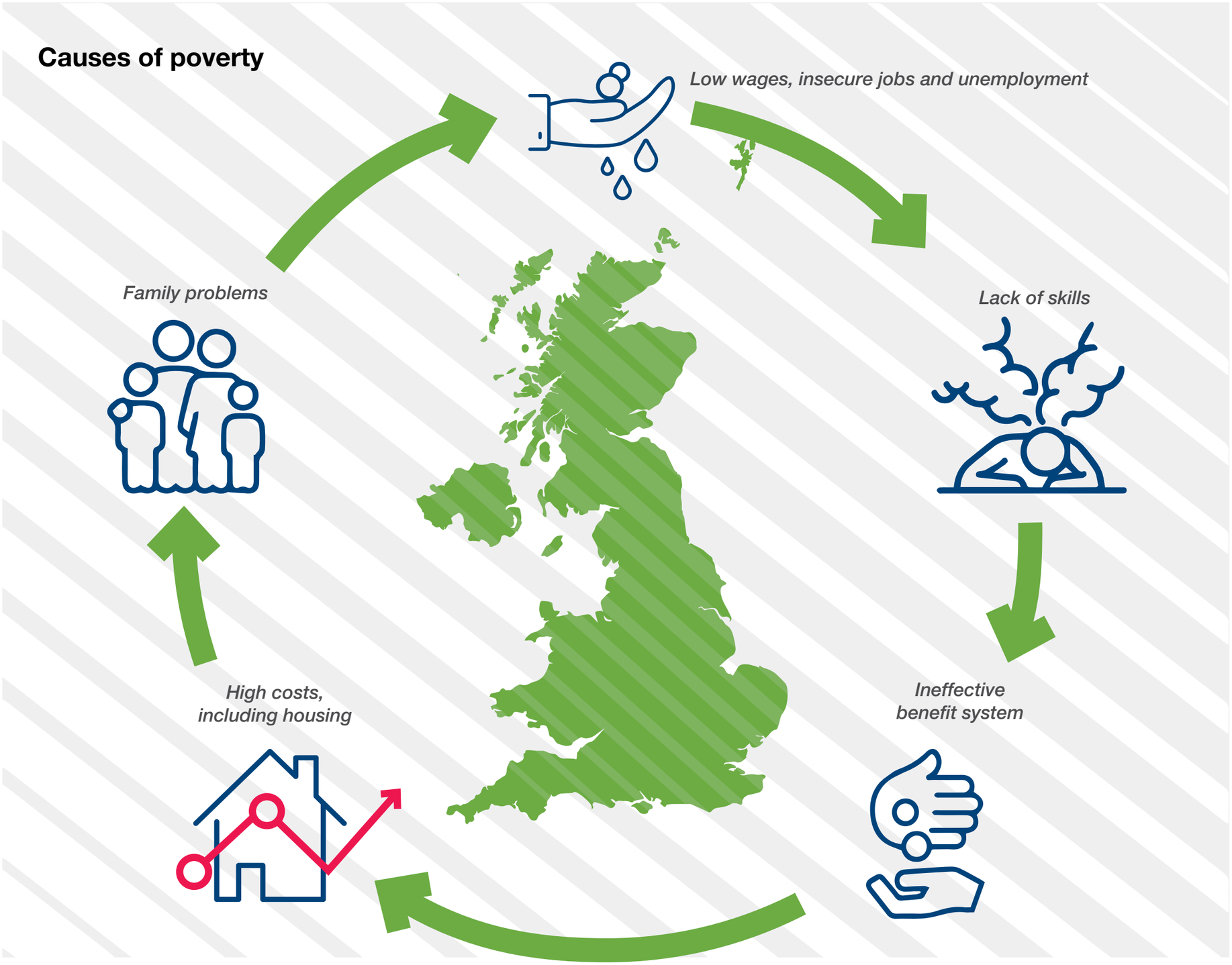


These lifestyle factors, which are inextricably linked with the wider determinants such as household income, can lead to ill health. In other words, a person's opportunity for good health is the sum of the social, political, cultural, commercial, environmental and, critically, the economic conditions they are exposed to.

Inequalities in health

Public Health England (PHE) and NHS England define health inequalities as "the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs."

We also talk about 'variations' or 'inequalities in health', which usually, but not always, result from the wider determinants of health such as material deprivation and poverty. Major government-commissioned reviews such as The Black Report (1980) and The Marmot Review: Fair Society, Healthy Lives (2010) have highlighted the strong link between outcomes for health and the wider socio-economic determinants.



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The Marmot Review

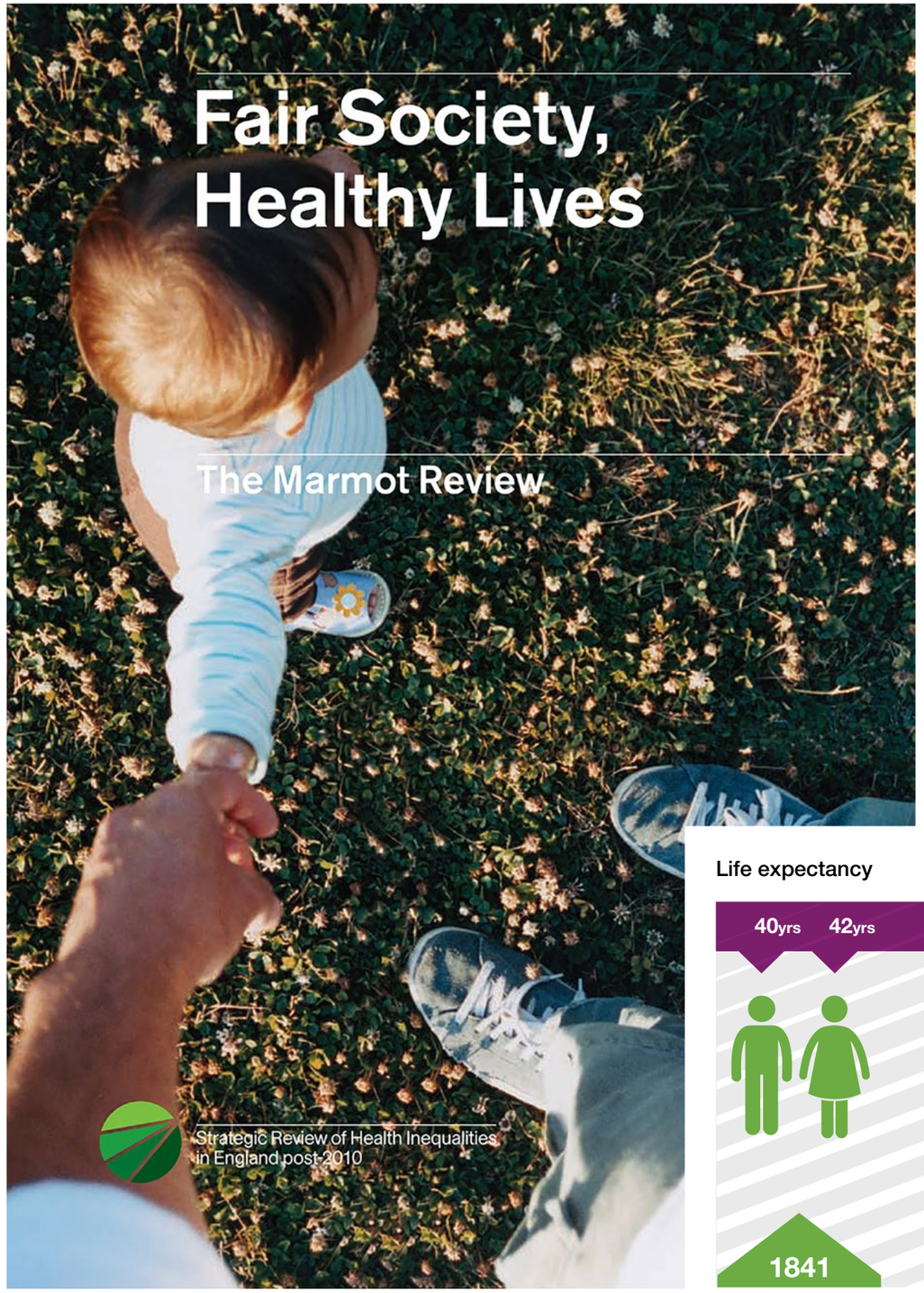
Fair Society, Healthy Lives set out the scale and distribution of health inequalities in England and the actions required to reduce them. It outlined six policy objectives for reducing health inequalities:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention.

The review noted that delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups, but that national policies will not work without effective local delivery systems focused on health equity in all policies.

Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

One of the best examples of inequality in health is the variation in life expectancy. There has been a continual rise in life expectancy in the UK since the 19th Century – and much of this improvement is the result of the introduction of various public health measures.



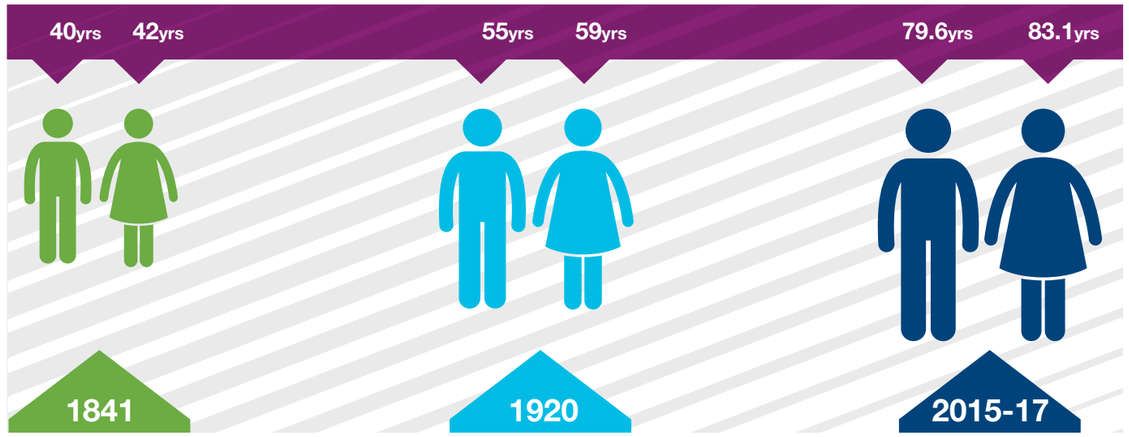
Males born in 1841 could expect to live to just 40 years, and 42 years for females, but by 1920 life expectancy at birth had increased up to 55 years for males and 59 years for females. When the Welfare State was introduced in 1948 life expectancy for males was 66 years and 70 years for females. Today, life expectancy change to for males is 79.6 years and 83.1 years for females.

Despite the improvement over time, there are significant inequalities in life expectancy between people from different socio-economic backgrounds. Poverty is associated with reduced life expectancy by almost a full decade. For example, men living in the least deprived 10 percent of areas in England can expect to live almost a full decade longer (9.3 years) than men born in the most deprived 10 percent of places – for females the gap is 7.4 years.

Research shows the strong correlation between income inequality and variations in health. In 2009 Wilkinson and Picket published The Spirit Level. It highlighted the fact that for each of eleven different health and social problems, including life expectancy, outcomes are strongly associated with, and significantly worse in, more unequal societies. New research by the same authors, (2019) also explains how income inequality affects us individually and how it shapes the way we think, feel and behave, often with marked effects on our health status.

In summary, poverty kills. It sets the context for how 1 in 5 people in the UK live and dictates the options they have relative to others in society. In this chapter, I have given an overview of the leading causes and consequences of poverty. In the next two chapters I will look at the current health profile in North Yorkshire and the local picture of poverty including how it has changed over time and its impact on the county's residents.

Life expectancy



Chapter 2:
Health in North Yorkshire today

The state of health in North Yorkshire today

North Yorkshire is England's largest county by area. It covers over 3,100 square miles (8,000 km2); is three times the size of Luxembourg; and is larger than 32 other countries.

This means that it is varied in nature, from larger towns including Harrogate and Scarborough, through to many smaller towns and villages. It has picturesque, sparsely populated upland areas in the North York Moors and Yorkshire Dales National Parks, coastal towns and rural, agricultural communities. It is also home to Western Europe's largest military garrison based in and around Catterick.

The map below shows North Yorkshire split into four groups by size of built up area. Groups A, B and D are all approximately equal in size of population, with around 135,000 residents in each of these areas.

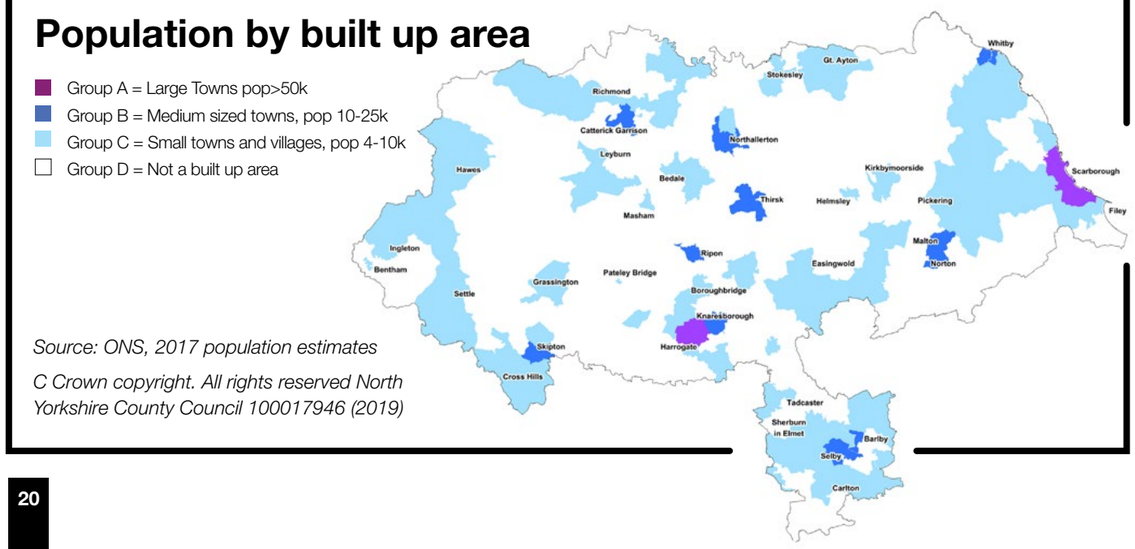
The light blue shaded areas (group C) have a combined population of 206,000, illustrating that more residents live in villages and small towns of between 4,000 and 10,000 than other types of communities. There are as many people in rural areas, shown as white as there are in the two largest towns of Harrogate and Scarborough, shaded purple.

North Yorkshire has a total population of 614,500 residents, of whom 149,000 (24.2%) are aged 65 and above. This is the 13th highest proportion and 16th highest number of this age group among England's 152 upper tier local authorities. There are also 19,600 (3.2%) residents aged 85+.

North Yorkshire is the third least densely populated upper tier local authority in England; only Northumberland and Cumbria have fewer residents per square kilometre. Amongst a set of similar areas, known as statistical neighbours, North Yorkshire has the lowest population density by a considerable margin.

Four of the seven districts within the county – Ryedale, Richmondshire, Craven and Hambleton - are in the 10 least densely populated lower tier local authority areas in England.

Population by built up area



Source: ONS, 2017 population estimates

Population density, North Yorkshire and statistical neighbours, 2017

Local authority	Population density (people per km2)
North Yorkshire	76.1
Devon	119.9
Lincolnshire	126.5
Somerset	160.9
Dorset	167.1
Suffolk	199.2
Cambridgeshire	212.8
Gloucestershire	236.8
Warwickshire	285.9
Nottinghamshire	392.3
Staffordshire	332.4
West Sussex	428.1

Source: ONS, Population estimates mid-2017

This combination of low population density with a higher than average proportion of residents beyond retirement age presents significant challenges in providing equitable access to services in local communities.

Overall, health in North Yorkshire is better than average for England. Life expectancy (LE) at birth is significantly higher for males and females, but the rate of change appears to be reducing. In five years, from 2006-08 to 2010-12, LE in North Yorkshire increased by 1.1 years for males and by 0.9 years for females. The following 5-year period (2010-12 to 2014-16) saw LE increase by 0.7 years for both males and females. Nationally, this slowdown in the rate of increase is seen and is more pronounced in deprived communities.

The charts to the right show changes in LE for North Yorkshire districts, ranked by LE in 2006-08. These show that the most recent increases have tended to be larger for the most recent time period (shaded darkest) in areas with lowest LE, to the right of each chart.

Despite this, Scarborough continues to have the lowest life expectancy in North Yorkshire, but the continued improvement in areas with low LE suggests that our work to tackle health inequality is having some impact.

Healthy life expectancy in North Yorkshire - the number of years someone can expect to live in good health from birth to death - is significantly higher than the England average for females, but not significantly different for males. Health inequality measures tend to be lower than average, but this county-level data masks differences within North Yorkshire.

With reference to the recommendations from the Marmot Review on reducing health inequalities there are some successes as well as areas for improvement.

Changes in life expectancy, male and females, North Yorkshire districts, 2006-08 to 2014-16

Getting the best start in life

The overall health and wellbeing of children in North Yorkshire is better than the England average. The infant mortality rate is significantly lower than the England average, and has halved from 2009-11 to 2015-17.

Despite continued reductions and lower than average rates of smoking in the general population, the proportion of women who smoke throughout pregnancy in North Yorkshire is significantly higher than England. However, the smoking at time of delivery figure has improved in the past two years, reducing from 14.2% in 2015/16 to 11.7% in 2017/18. The England average is 10.8%.

In 2017/18, 72.5% of local children achieved a good level of development at the end of the school reception year. This is similar to the England average (71.5%), with more than 1,600 children failing to reach a good level. However, for those children with free school meal status, only 49.4% achieved a good level of development, significantly lower than the England average (56.6%). Of the 1,600 children who did not reach a good level of development, about 250 had free school meal status.

In the 2017/18 academic year, rates of excess weight in children continued to increase. Obesity rates tend to fluctuate annually, since different children are measured each year, but there is an overall increasing trend. Over 2 in 10 (22.3%) Reception year children measured had excess weight, and more than 3 in 10 (31.6%) in Year 6.

In North Yorkshire, hospital admissions for injuries to children remain significantly higher than the England average. In 2017/18, there were nearly 1,200 hospital admissions for unintentional and deliberate injuries in children aged 0-14 years in North Yorkshire - a rate of 123 per 10,000, compared with 96 per 10,000 for England overall. Based on data for England, admissions for injury in this age group are higher in more deprived areas.

Nationally, the rate of young people being admitted to hospital as a result of self-harm is increasing, and this is also the case in North Yorkshire. In 2017/18, in North Yorkshire there were 460 hospital admissions for self-harm for those aged 10-24 years old, with a rate significantly higher than England.

The infant mortality rate in North Yorkshire (1.96 per 1,000 live births) is lower than the England average (3.92 per 1,000 live births).

Smoking whilst pregnant has reduced from 14.2% in 2015/16 to 11.7% in 2017/18.

72.5% of local children achieved a 'good' level of development at the end of Reception in 2017/18.

Over 2 in 10 (22.3%) of children in Reception and more than 3 in 10 (31.6%) of children in Year 6 had excess weight in 2017/18.

Hospital admissions for injuries in children are higher than the England average. In 2017/18 there were 1,200 hospital admissions for children in North Yorkshire for unintentional and deliberate injuries.

Maximising capabilities and having control

Performance of children who have taken GCSEs is now measured using an "Attainment 8 score". This score is calculated on the best eight GCSE scores, including English and maths with an additional weight for subjects included in the English Baccalaureate.

In 2017/18, for North Yorkshire the average Attainment 8 score was 48.5, significantly higher than England (44.5). We know that the attainment of looked after children (LAC) is often lower than their non-looked after peers, in part due to the impact of previous life experiences. For these children in care, the Attainment 8 score for North Yorkshire was 20.0 compared with 18.9 for England, highlighting the work of LAC services and the Virtual School in North Yorkshire in helping these young people to achieve their potential.

The number of fixed period exclusions from secondary schools in North Yorkshire is increasing. There were over 4,000 fixed period exclusions in 2016/17, compared with 2,500 just two years previously. The rate, expressed as 11.2% of children, is significantly higher than the England average (9.4%), but some children may have experienced more than one exclusion in a year.

In 2017, there were 730 young people aged 16 and 17 who were not in education, employment or training (NEET), or whose activity is not known, 6.5% of this age group and significantly higher than England overall (6.0%).

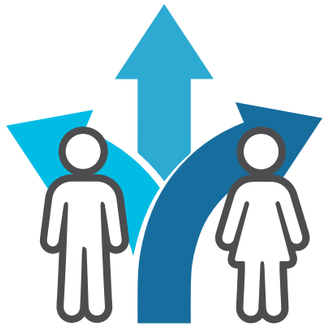
In 2017/18 there were 460 admissions to hospital for self-harm in 10-24 year olds which is higher than the England average.

In 2017/18 the average 'Attainment 8' score in North Yorkshire was 48.5 which is significantly higher than the England average (44.5).

There were 4,000 fixed period school exclusions in 2016/17 at a rate of 11.2% compared to the England average of 9.4%.

In 2017, 730 young people in North Yorkshire were not in education, employment or training.

Having opportunities for all



Employment in North Yorkshire is high. In 2018, 78.4% of people aged 16-64 were in employment, compared with 75.4% for England and 73.6% for Yorkshire and the Humber. However, full-time jobs in North Yorkshire are less common than nationally (63.1% v 67.5%) and part-time jobs are more common (36.9% v 32.5%).

The table below shows the seven highest industries for employee jobs in North Yorkshire. Compared with Great Britain, North Yorkshire has a higher rate of jobs in accommodation and food services, and manufacturing. As a rural county, North Yorkshire has about 3.6% of the workforce employed in agriculture, forestry and fishing, 4.5 times higher than England overall at the 2011 census.

Employee jobs by industry*, North Yorkshire, 2017

Industry	North Yorkshire		Great Britain
	Number of jobs	%	%
Wholesale & retail trade; repair of motor vehicles	42,000	15.7	15.2
Accommodation & food services	33,000	12.3	7.5
Manufacturing	32,000	11.9	8.2
Health & social work	30,000	11.2	13.3
Education	23,000	8.6	8.9
Professional, scientific & technical	22,000	8.2	8.4
Administrative & support services	21,000	7.8	9.1

excludes farm-based agriculture, self-employed, government-supported trainees and HM forces. Source: www.nomisweb.co.uk

In 2018 the Social Mobility Commission reviewed the latest information on social mobility for the UK, based on the analysis of the national Social Mobility Index.

In simple terms, the Index compares the life chances that a child from a poor family will do well at school and then go on to get a good job and buy a nice house to identify the best (hot-spots) and worst places (cold-spots) in England for providing opportunities for children from poor families to perform well in adult life.

For North Yorkshire, the highest performing district for social mobility in 2017 was Craven and the lowest was Scarborough district. One of the most important conclusions that can be drawn from the data for North Yorkshire is the clear east-west divide which exists across the county and the strong links with many other related issues such as child poverty, material deprivation and inequalities in health.

The North Yorkshire Coast Opportunity Area was set up to tackle issues around social mobility in the county's only overall social mobility cold-spot.

NORTH YORKSHIRE COAST
OPPORTUNITY AREA

Having healthy and sustainable places and communities

In North Yorkshire, people are living longer, healthier lives compared to England as a whole. However, there are significant variations between districts, communities and population groups.

North Yorkshire's Public Health team is addressing health inequalities through its service provision and work with partners, and also through its understanding of the wider determinants and their impact on the health and wellbeing of the local population.

Key determinants include low income, childhood factors and poor housing, which often translate into ill-health and service need through poor mental health and unhealthy behaviours.

Smokefree Places

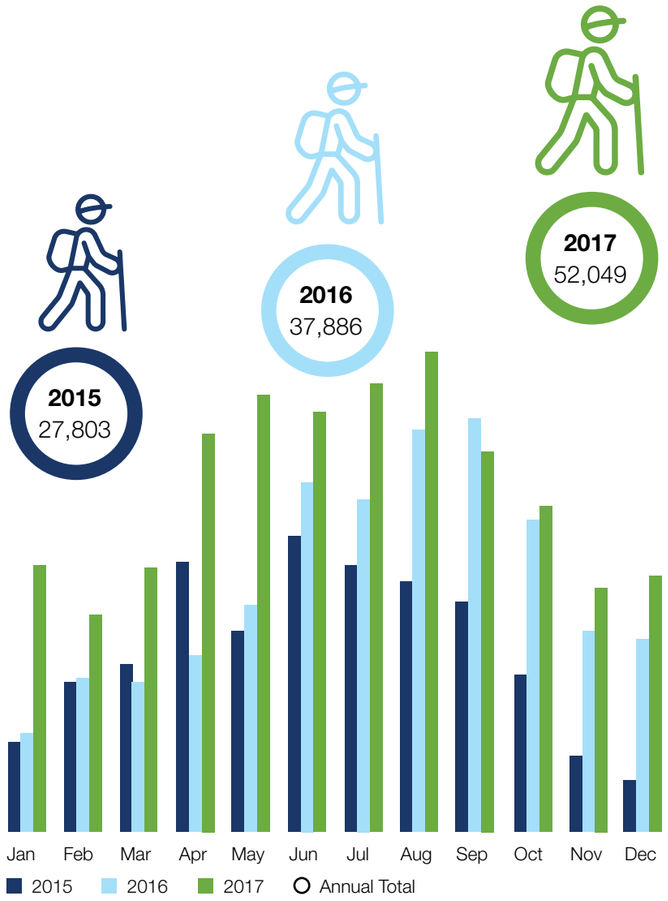
North Yorkshire boasts a wealth of natural resources including two national parks and a number of Areas of Outstanding National Beauty (AONB). As part of our aim to inspire a smokefree generation we have started a Smokefree Places grant funding scheme. This has supported smokefree play-parks in Scarborough, Harrogate and Ryedale.

Discoveries on Your Doorstep

The Scarborough and Selby Trails are a collection of walks with things to see and activities to do along the way for everyone in Scarborough and Selby. They are designed to encourage people to get outside and experience the history, nature and culture within their local area.

The project has currently been rolled out in Scarborough (Barrowcliff/ Northstead, Castle, Eastfield, and Falsgrave/Mere) and Selby (Flaxby Road and Abbots Road). The next roll out will be in Ripon with new trails identified there. Footfall counters show the increase in route use as illustrated by one of the trails in Selby after the launch in late summer 2016.

In 2017/18, 69.5% of adults in North Yorkshire were classed as physically active. The rate is significantly higher than the England average (66.3%).

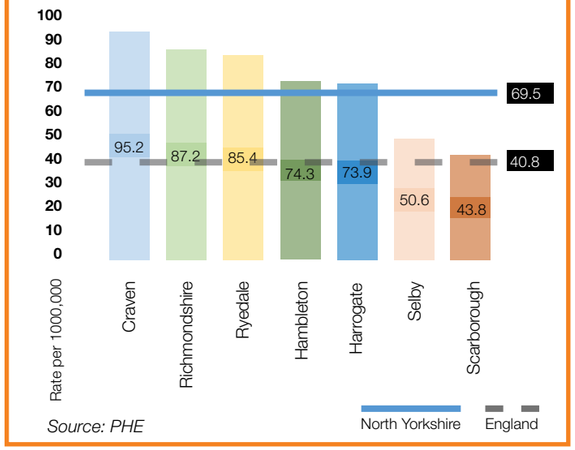


Road safety in rural North Yorkshire

The rate of people being killed and seriously injured (KSI) casualties on roads in North Yorkshire is significantly higher than the England average (70 v 41 per 100,000). There were 1,271 people KSI on North Yorkshire's roads in the three years 2105-17.

North Yorkshire no longer has the highest rate of road casualties, but this is due to the large number of road casualties killed and injured in the Westminster Bridge terror attack in March 2017. All districts within North Yorkshire, apart from Scarborough, have KSI rates which are significantly higher than England. Scarborough is not significantly different from the England average.

Killed and seriously injured casualties on the road, North Yorkshire by district, 2015-17



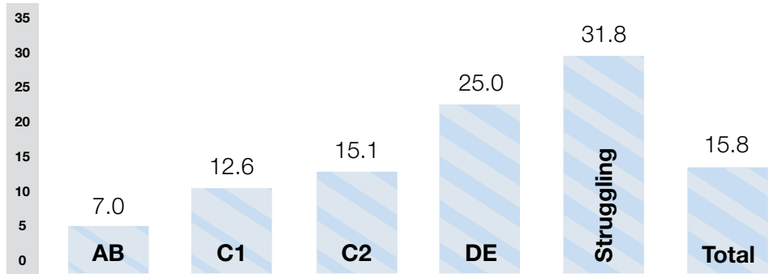
Source: PHE

Ill health prevention

North Yorkshire has a lower prevalence of adults who smoke (12.0%) than the England average (14.4%), but also lower rates of quitting (1,379 versus 2,070 per 100,000 smokers).

A 2019 survey found that people from lower socio-economic groups and those classifying themselves as struggling financially were more likely to be current smokers compared to other North Yorkshire residents. There were also higher purchases of illicit tobacco in these groups.

Current smokers by social grade, North Yorkshire, 2019



Social Group

AB	Higher & intermediate managerial, administrative, professional occupations
C1	Supervisory, clerical & junior managerial, administrative, professional occupations
C2	Skilled manual occupations
DE	Semi-skilled & unskilled manual occupations, Unemployed and lowest grade occupations

Source: Illicit Tobacco Survey, NEMS, 2019

Flu is a highly infectious disease which can sometimes lead to serious complications, particularly in people that have long-term health conditions, the over 65s, and children. The flu vaccine is the best way of protecting against flu, along with hand washing. The vaccination rate in North Yorkshire for people aged 65 and over (73.6%) is significantly higher than England (72.6%). The rate in North Yorkshire has been significantly higher than England since 2012/13, but many people still remain at risk.

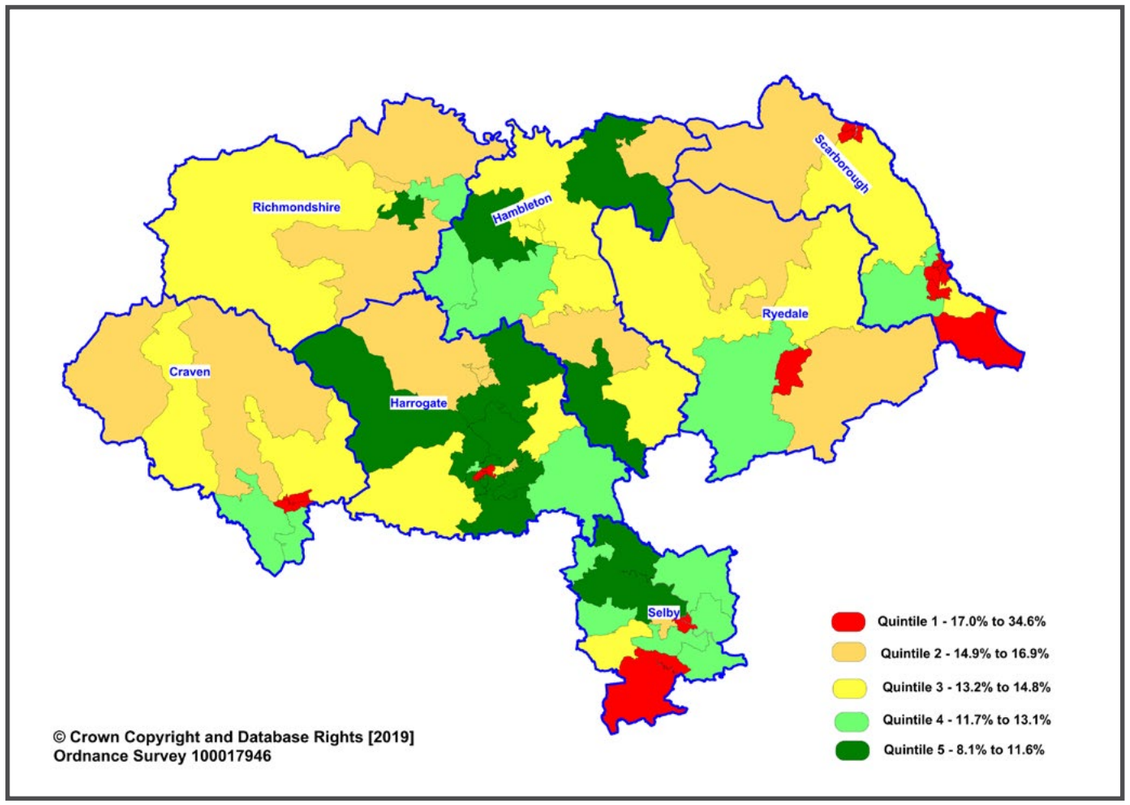
Chapter 3:
Poverty in North Yorkshire

North Yorkshire's most deprived areas

As previously described, current poverty levels are defined as people living in households with income more than 60% below the national median. Unfortunately, data are not routinely available for local authorities for this measure. The Office for National Statistics (ONS) produced experimental statistics, modelling the number of households expected to be in poverty in 2013/14.

These showed a range of between 8.1% of households in part of Harrogate to 34.6% in part of Scarborough to be living in poverty. In total, this amounts to 92,000 people in North Yorkshire in poverty, some 15% of the population, compared with 22% nationally. The uncertainty in this measure means it could be as few as 65,000 or as many as 127,000 people.

Households below 60% of median income (after housing costs), North Yorkshire MSOAs, 2013/14



The words 'poverty' and 'deprivation' are often used interchangeably. In the opening chapter of this report I explained that people can be in poverty because they have insufficient money to meet their needs - but they can also be classified as deprived due to a lack of any number of resources, not just financial. Due to the lack of robust poverty measures at a local level, I will consider deprivation, and income deprivation in particular, as proxy measures for poverty in the county.

The Index of Multiple Deprivation (IMD) is an area-based, relative measure of deprivation. It is made up of 37 indicators in seven domains of deprivation, weighted by their importance, and is calculated for every lower layer super output area (LSOA) in England.

LSOAs are neighbourhoods with a minimum population of 1,000, maximum of 3,000 but more typically with 1,500 residents when defined.

Index of Multiple Deprivation 2015, domains and weighting

Domain	Weighting
Income Deprivation	22.5%
Employment Deprivation	22.5%
Education, Skills and Training Deprivation	13.5%
Health Deprivation and Disability	13.5%
Crime	9.3%
Barriers to Housing and Services	9.3%
Living Environment Deprivation	9.3%

Source: Department for Communities and Local Government

IMD 2015 ranks LSOAs from the most deprived to the least, but does not necessarily indicate the absolute differences between areas. An LSOA with an IMD score of 40 is not 'twice as deprived' as an area with a score of 20.

As an area-based measure, IMD 2015 provides a broad indication of what is typical for an area, but this does not necessarily apply to all individuals within a particular LSOA. For example, the LSOA "Westminster 018C" is almost exactly in the middle of the distribution, ranked 16,419 of 32,844 LSOAs in England. However, this LSOA also contains Buckingham Palace, the most notable resident of which is unlikely to be considered 'averagely deprived'.

According to IMD 2015, there are 11 LSOAs, or neighbourhoods, in North Yorkshire which are amongst the most deprived 10% (decile) of areas in England. These areas are considered to have the highest and most concentrated levels of poverty in the county, although it is recognised that poverty exists throughout North Yorkshire.

Nine of the 11 LSOAs are in Scarborough Borough, and one each in Harrogate Borough and Selby District. The following table shows these 11 LSOAs with their national decile for each of the seven domains of IMD.

The eleven most deprived neighbourhoods in North Yorkshire, 2015

					Seven domains – national decile (1 is most deprived)						
LSOA Code	LSOA name (2011)	Ward containing LSOA	Rank of 42,844 LSOAs in England	Rank (NY)	Employment	Income	Health Deprivation and Disability	Education, Skills and Training	Crime	Living Environment	Barriers to Housing and Services
E01027874	Scarborough 007D	Woodlands	313	1	1	1	1	1	3	8	3
E01027819	Scarborough 012B	Eastfield	318	2	1	1	1	1	1	7	3
E01027806	Scarborough 006B	Castle	319	3	1	1	1	1	1	1	5
E01027847	Scarborough 006D	North Bay	751	4	1	1	2	1	1	1	4
E01027804	Scarborough 010A	Castle	1,005	5	1	1	1	3	1	1	5
E01027817	Scarborough 012A	Eastfield	1,714	6	1	1	1	1	3	6	4
E01027907	Selby 005C	Selby West	2,057	7	1	1	2	1	4	9	5
E01027740	Harrogate 013F	Woodfield	2,283	8	1	1	1	3	4	7	6
E01027820	Scarborough 012C	Eastfield	2,515	9	1	1	2	1	5	6	6
E01027805	Scarborough 006A	Castle	2,561	10	1	2	2	2	1	1	8
E01027869	Scarborough 001C	Whitby West Cliff	2,792	11	1	2	1	4	2	1	5

The table shows that all of the 11 LSOAs are in the most deprived decile nationally for employment deprivation. This domain is built from claimant measures for: Jobseeker's Allowance (JSA); Employment and Support Allowance (ESA); Incapacity Benefit; Severe Disablement Allowance; and Carer's Allowance, suggesting that there is much lower than average job availability and much higher than average rates of ill health preventing people from working, either due to their own ill health or caring for someone else.

Nine of the eleven LSOAs are in the most deprived 10% nationally for the Income domain, with two LSOAs in the second most deprived decile. This is probably the best measure of poverty and is based on adults and children in families in receipt of a range of benefits and allowances. One LSOA (Scarborough 007D) is ranked 99th of the 32,844 LSOAs in England, making 99.7% of the country less income deprived than this neighbourhood.

The Health Deprivation and Disability domain includes measures of years of potential life lost; comparative illness and disability ratio; acute morbidity; and mood and anxiety disorders. It is likely that poor health and disabilities can be both a cause and consequence of deprivation.

Seven of the LSOAs are in the most deprived decile for Education, Skills and Training Deprivation. One LSOA (Selby 005C) is the 73rd most deprived in England for the Children and Young People sub-domain, which includes 8 LSOAs in the most deprived decile. Five (Scarborough 007D; 012A; 012B; 012C and Selby 005C) are in the most deprived decile for Adult Skills sub-domain.

The Crime domain measures the risk of personal and material victimisation and is made up of indicators recording violent crimes, burglaries, thefts and criminal damage. The five LSOAs in the most deprived decile for this domain are all located in Scarborough Borough, with four in Scarborough town itself.

The Living Environment Deprivation Domain measures the quality of the local environment. The indicators fall into two sub-domains – 'indoors' and 'outdoors'. The indoors living environment measures the quality of housing, whilst the outdoors living environment contains measures of air quality and road traffic accidents.

The 11 LSOAs in North Yorkshire are divided into two distinct groups, with five LSOAs in the most deprived decile for the Living Environment domain, driven by the Indoors sub-domain. The measures in the indoor domain consider housing in poor condition and those without central heating. The remaining five LSOAs are in deciles six to nine nationally for this domain.

The Barriers to Housing and Services Domain measures the physical and financial accessibility of housing and local services. The indicators fall into two sub-domains: 'geographical barriers', which relate to the physical proximity of local services, and 'wider barriers' which includes issues relating to access to housing, such as affordability. Nine of the 11 LSOAs are in Scarborough Borough, and one each in Harrogate Borough and Selby District.

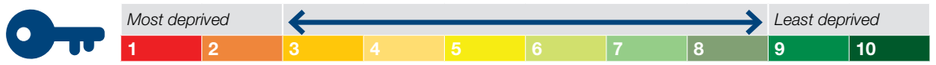
The Barriers to Housing and Services Domain deciles range from three to eight for these 11 LSOAs. The sub-domain 'geographical barriers' tends to have ranks in less deprived deciles when compared with the Wider Barriers sub-domain. This means most of these LSOAs have local services available within, or close to, the areas, but difficulties may exist with overcrowding, housing affordability and homelessness as measured in the Wider Barriers sub-domain.

The LSOAs which are closest to the most deprived 10%, but outside that range are:

LSOA name	Ward containing LSOA	IMD 2015 rank
Scarborough 010B	Ramshill	3907
Scarborough 008C	Central	5140
Scarborough 007C	Woodlands	5328
Scarborough 009B	Falsgrave Park	5334
Scarborough 004A	Colburn	5380

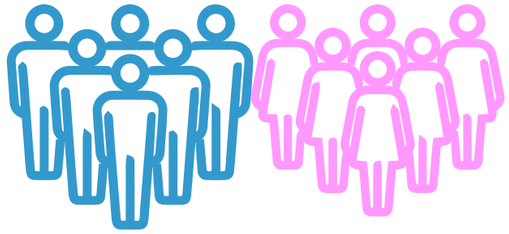
To be amongst the most deprived 10% in England, the rank would have to drop to 3,284. The LSOA Scarborough 010B is closest to that boundary, and poverty measures should be continued to be monitored to ensure these most at risk LSOAs do not become more deprived relative to other areas.

LSOA name	Ward containing LSOA	Barriers to Housing and Services	Geographical Barriers Sub-domain	Wider Barriers Sub-domain	Living Environment	Indoors Sub-domain	Outdoors Sub-domain
Scarborough 007D	Woodlands	3	5	2	8	6	9
Scarborough 012B	Eastfield	3	5	2	7	6	8
Scarborough 006B	Castle	5	9	2	1	1	4
Scarborough 006D	North Bay	4	9	2	1	1	7
Scarborough 010A	Castle	5	8	2	1	1	5
Scarborough 012A	Eastfield	4	4	3	6	6	5
Selby 005C	Selby West	5	6	3	9	7	9
Harrogate 013F	Woodfield	6	7	3	7	7	5
Scarborough 012C	Eastfield	6	7	3	6	4	8
Scarborough 006A	Castle	8	8	4	1	1	4
Scarborough 001C	Whitby West Cliff	5	8	2	1	1	6



The changing face of poverty in North Yorkshire

Population

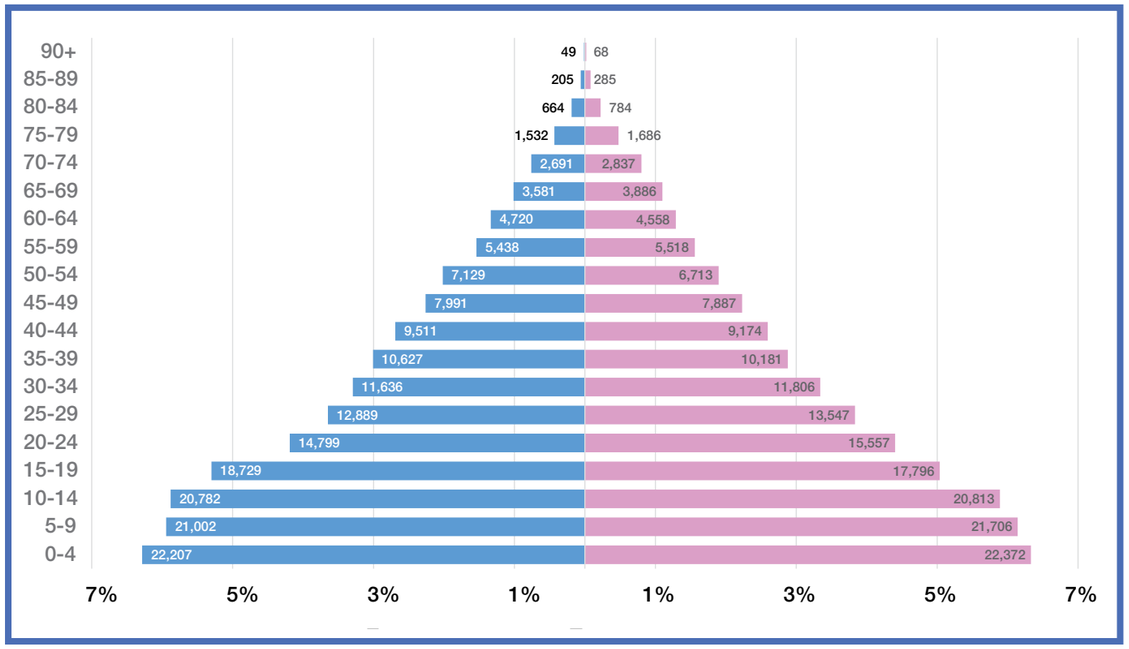


In 1891, the population of the North Riding of Yorkshire was 353,000: the latest population estimates for area covered by North Yorkshire County Council show a population of over 611,000.

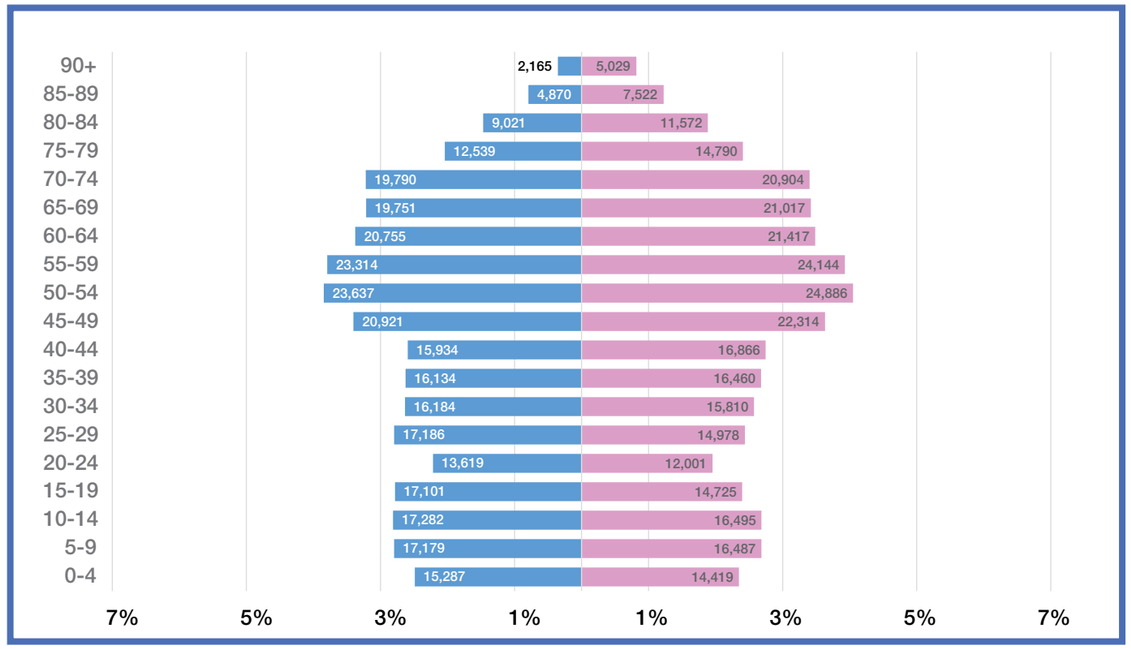
The population pyramids show the dramatic societal change over 125 years. In 1891, the population structure was much closer to a pyramid, with a wide base and narrowing towards the apex. This structure is typical of a population with a high birth rate, high infant mortality and sustained mortality rates through all age groups.

In contrast, the 2018 pyramid is top heavy, illustrative of a low birth rate, low infant mortality and low mortality rates up to age 74. There is a noticeable 'pinch' at age 20-24 as young adults move out of North Yorkshire for higher education and work.

Age profile, North Riding 1891 Census



Age profile, North Yorkshire ONS mid-year population estimates 2018



There is a challenge in comparing population over time. Despite the nation's best efforts using a census every ten years, administrative boundaries change as populations evolve. This report takes the 1891 census data and medical officer reports for North Riding of Yorkshire as an approximation of modern day North Yorkshire. They do, however, include some towns, such as Middlesbrough and Redcar, which are not part of the present day county. By the same token, Harrogate, Ripon, Skipton and Selby were historically in the West Riding but now are part of North Yorkshire.

In 1891, 36% of North Riding's population was aged under 15 but in 2017, for North Yorkshire, it was just 16%. In modern times, generally poverty falls more heavily on families with young children, who have had less time to accumulate wealth, than on pensioners.

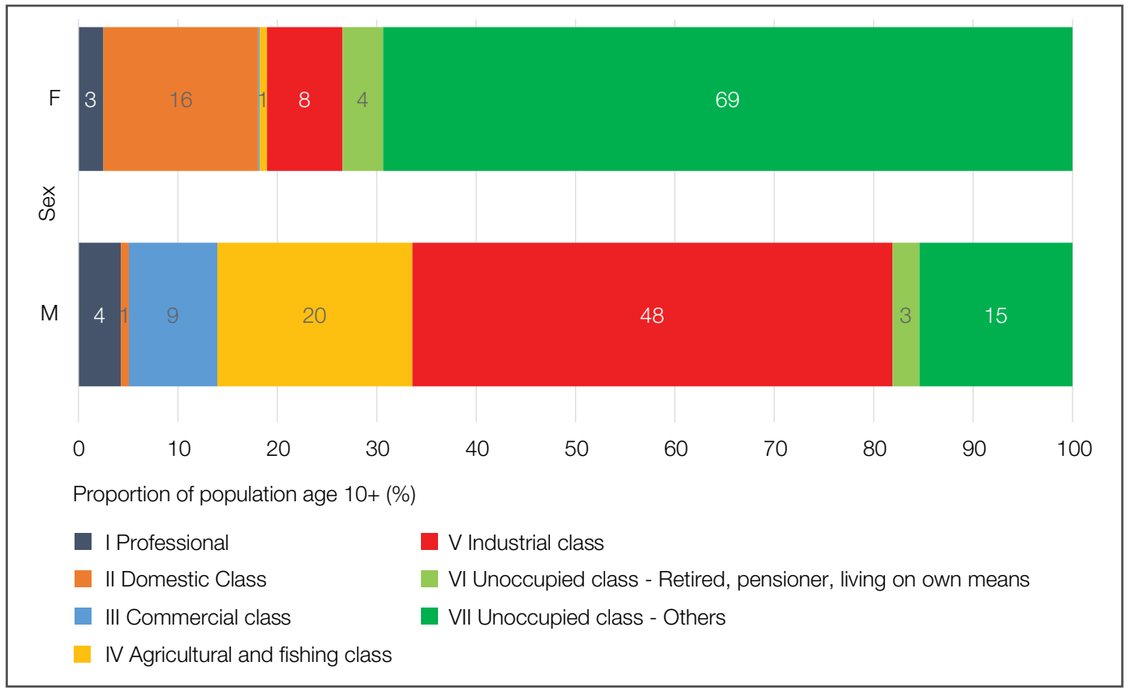
In the 21st century, increased benefits for older people and the 'triple pension lock' have, to an extent, shielded older people from the impacts of austerity policies of the past decade, so that the proportion of pensioners experiencing poverty is about half that of children, North Yorkshire JSNA County Profile 2019, p4.

Employment

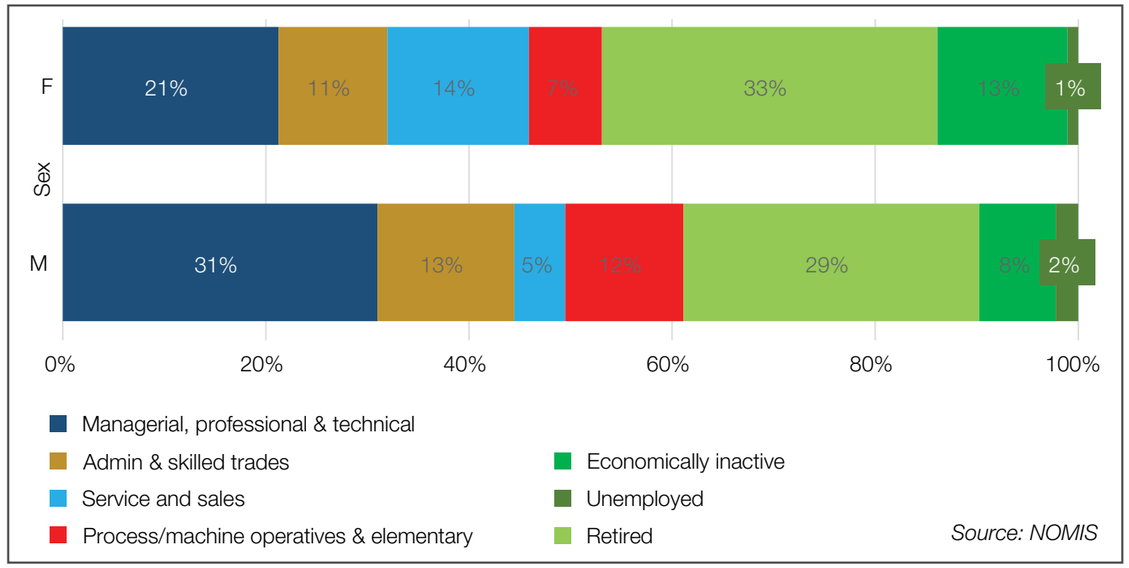
In the 19th century, there was little in the way of financial support and income largely came from employment. At that time, societal norms tended to exclude married women from the workforce and they were more often occupied at home, looking after families and domestic matters.

The 1891 census shows nearly 70% of North Riding women as 'unoccupied' and of those employed, more than half were in domestic service. For males, nearly half were employed in the "industrial class" and almost 20% in "agriculture and fishing". Only 2.7% of men are described as "retired, pensioner or living on own means" with 15% described as "unoccupied". This category may well include people without work, those in precarious work arrangements, and those unable to work due to poor health or old age. It is likely that many of the people in poverty in 1891 are drawn from this occupational group.

Occupation class by sex, age 10+, North Riding, 1891



Occupation class by sex, age 16+, North Yorkshire, 2018



In North Yorkshire today, a similar proportion of males (78.4%) but almost three times the 1891 rate of females (74.7%) aged 16-64 are in employment. Jobs are categorised using the Standard Occupational Classification (SOC) 2010.

These show that there has been a considerable shift away from industrial, agricultural and domestic work towards managerial, professional and technical employment (SOC groups 1-3), which make up the largest proportion of jobs in the county. There has been a large increase in the retired population.

In 2017/18, the unemployment rate for North Yorkshire was 3% of adults aged 16-64. This compares favourably with the 15% snapshot of unoccupied males in 1891, but is not directly comparable due to the inclusion of children aged 10-15 and older people aged 65+ in the historic figures, and the uncertain differences between unoccupied and unemployed (people actively seeking work).

Carers

In the UK approximately 22% of carers (1.2 million) live in relative poverty compared with 16% of the general population. This proportion increases the more caring people provide, with 37% of carers living in relative poverty who provide at least 20 hours of care per week. Even those who don't live in poverty report hardship, with nearly 40% of carers saying that they struggle to make ends meet (Carers UK, 2019). Families also often face lower income as caring responsibilities reduce their ability to work. According to Care UK, nearly a half of working-age carers live in a household where no one is in paid work.

Local analysis of the Survey of Adult Carers in England (SACE) conducted in October 2018 shows a similar pattern in North Yorkshire. Overall, about 40% of survey respondents experienced financial difficulties caused by their caregiving role, with 9% saying their caregiving role causes them a lot of financial difficulties. A higher proportion of females (11%) reported a lot of financial difficulties than males (5.3%). Considering hours spent caring per week, 11% of those who care for more than 50 hours per week report experiencing financial hardship, higher than those who spend less than 50 hours caring per week. Working age caregivers (aged 18-64) are statistically more likely to report experiencing financial difficulties because of caregiving compared with those aged 65+.

Poverty

In the 19th century, workhouses were the forerunners of the present day welfare state, providing food, shelter, work and education for those in most need. The 1891 census shows 1,511 "pauper inmates" of workhouses in North Riding on 5 April, census day. This gives a rate of 4.3 pauper inmates per 1,000 population.

Pauper inmates of workhouses as a proportion of the population, North Riding, 1891

Age group	Rate per 1,000
0-14	3.1
15-34	1.7
35-64	4.9
65+	25.7

Source: 1891 census

About two-thirds of pauper inmates were males (64.6%). Over 30% of the pauper inmates were aged 65 and older, highlighting the role the workhouse played in providing a safety net for people in later life, when perhaps they were less able to continue with physical labour.

More than one-quarter (26.5%) were aged under 15, but this is lower than the 36% of this age group in the total population. The lowest rate is seen in the younger working-age population: the rate is nearly three times higher in the 35-64 age group, illustrating the cumulative toll of injury and illness in the working age population. Over 400 (27.0%) were widowed (250 males and 150 females), five times the rate seen in the general population (5%).

In the 19th century, extreme poverty made residents report to workhouses. A 21st century comparison of the most extreme poverty may be food bank use. Data from the largest food bank scheme nationally shows 7,841 emergency food packages distributed in North Yorkshire in 2018/19. On average, people received two packages annually, so it is likely that 3,921 people received emergency food packages from the Trussell Trust. Independent Food Aid Network UK research show that 39.2% of food banks operate independently of the Trussell Trust, so it is likely that around 6,450 people in North Yorkshire received emergency food aid in 2018/19. This is 10.5 per 1,000 population - more than twice the rate of people in workhouses in 1891.

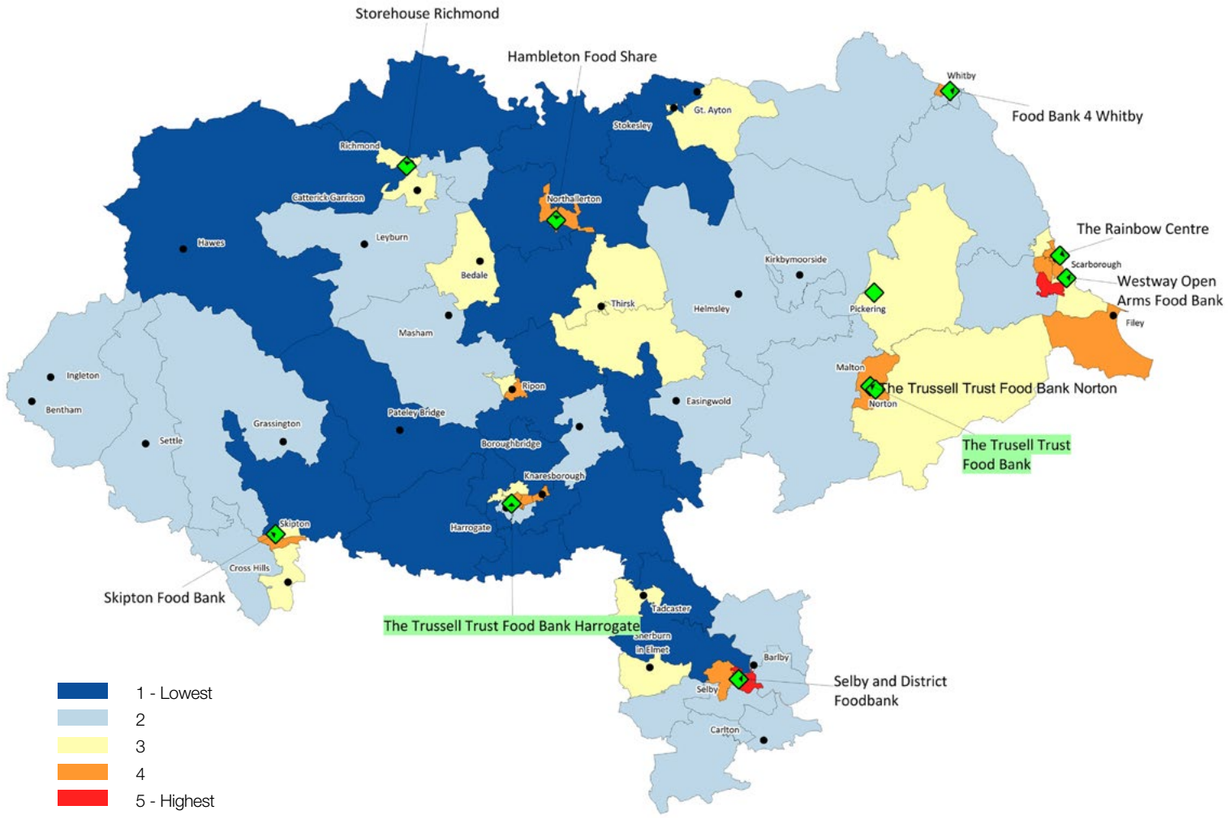
North Yorkshire Local Assistance Fund (NYLAF) is provided by North Yorkshire County Council to support vulnerable adults and help families under great financial pressure. It supports about 5,000 people annually with food vouchers: more than 80% receive a voucher for one week, with the remaining 20% receiving the maximum two vouchers in a year. This broadly aligns with estimates of food bank usage, but is difficult to say whether people in need are using both sources of support.

The census data for 1891 is, of course, a single day snapshot, compared with an annual total for food bank use, so we are comparing a moment in time measure in 1891 with an annual period measure for 2018/19. We know that children and older adults were often workhouse inmates for a year or more, but teenagers and younger adult workers tended to have shorter stays. This would have the effect of increasing the annual rate per thousand, conceivably to a similar level to current food bank use. The map below shows locations of food banks in North Yorkshire in 2018, together with an area-based measure of food insecurity, showing that higher levels of food insecurity tend to be in North Yorkshire's towns.

Food insecurity in the UK

According to a report from the House of Commons Environmental Audit Committee in January 2019: "A 2018 report by the Food and Agriculture Organisation (FAO), averaging data from 2015 to 2017, estimated that 2.2 million people in the UK were severely food insecure. This is the highest reported level in Europe and means that the UK is responsible for one in five of all severely food insecure people in Europe. In June 2017, UNICEF found that in the UK approximately 19% of children under age 15 live with an adult who is moderately or severely food insecure, of whom half are severely food insecure. The Food Foundation suggest that this makes the UK "one of, if not the, worst performing nations in the European Union".

Areas at greatest risk of food insecurity



Data source; Identifying populations and areas at greatest risk of household food insecurity in England, Applied Geography 91 (2018) (Smith, Thomson, Harland, Parker & Shelton C Crown copyright and Database Rights [2018] Ordnance Survey 100017946

Life expectancy

There is no local data available for life expectancy in 1891. For England, life expectancy for men was 44.1 years and for women it was 47.8 years. Low life expectancy in the 19th century partly resulted from the higher number of infant deaths. Surviving early childhood was a struggle, with poor sanitation, communicable diseases and lack of effective medicines. However, once a child reached five years of age, he or she was much more likely to reach a greater age.

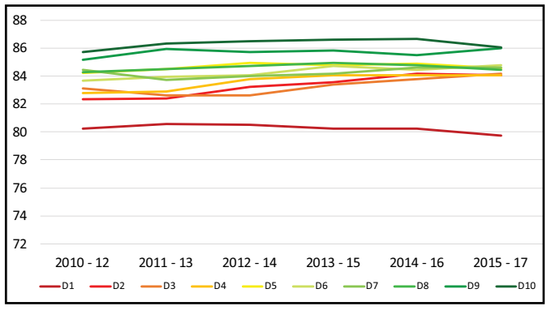
The most recent data for North Yorkshire show life expectancy of 80.6 years for males and 84.2 years for females, both significantly higher than England (79.6y and 83.1y, respectively). However, the county-level values mask some variation.

The charts below show life expectancy by deprivation deciles within North Yorkshire. The deciles are calculated using the 373 LSOAs in North Yorkshire, and there are 37 or 38 LSOAs in each decile group. The 11 LSOAs covered in this report are contained within the most deprived decile in the county, shown in dark red.

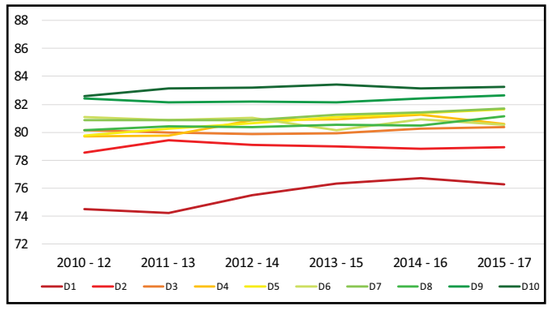
These charts show that male life expectancy is lower than female, for all levels of deprivation. They also show that, in general, life expectancy increases as deprivation decreases. However, the striking feature is that the most deprived neighbourhoods in North Yorkshire are adrift from the general distribution. They have significantly lower life expectancy than even the second-most deprived 10% of the population.

For males, the gap has narrowed somewhat since 2010-12, but statistically significant differences remain: for females, the gap is increasing. A broadly similar pattern is seen for life expectancy at 65. Residents in North Yorkshire's most deprived neighbourhoods are less likely to reach retirement and, if they do, they continue to have shorter life expectancy than their peers.

Female life expectancy at birth by deprivation decile, North Yorkshire, 2010-12 to 2015-17



Male life expectancy at birth by deprivation decile, North Yorkshire, 2010-12 to 2015-17



"Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death" *(Martin Luther King Jr. to the second convention of the Medical Committee for Human Rights in Chicago on March 25, 1966)*

Deaths in infancy

Infant deaths have a disproportionately large impact on life expectancy measures compared with deaths in later life. The 1906 Medical Officer Report for North Riding records an infant mortality rate of 127.68 per 1,000 births registered, with a total of 892 deaths of infants aged less than one year. In the three years 2015-17, there were 33 infant deaths in North Yorkshire, approximately 11 per year.

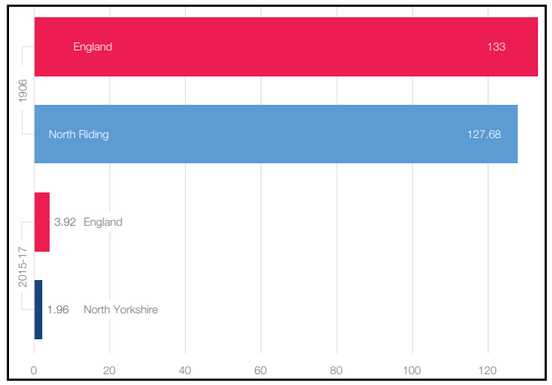
By comparing the two time periods, a dramatic reduction in infant mortality is apparent. In 1906, the North Riding infant mortality rate was 4% lower than the England rate. In 2015-17, the North Yorkshire rate was half the England rate.

Fortunately, there are too few infant deaths in North Yorkshire for meaningful analysis by deprivation status, but by observing the pattern across England, we might expect higher rates of infant mortality in the most deprived neighbourhoods in North Yorkshire. There were twice as many infant deaths in the county's 11 most deprived LSOAs during 2008-17, as would be expected if infant deaths were evenly distributed in the county. This also shows that the national distribution of infant morality is reflected in North Yorkshire.

By splitting the whole population into ten groups of equal size (deciles) according to deprivation scores, in the past 15 years, England data shows the least deprived group has experienced about half the infant mortality rate of the most deprived group.

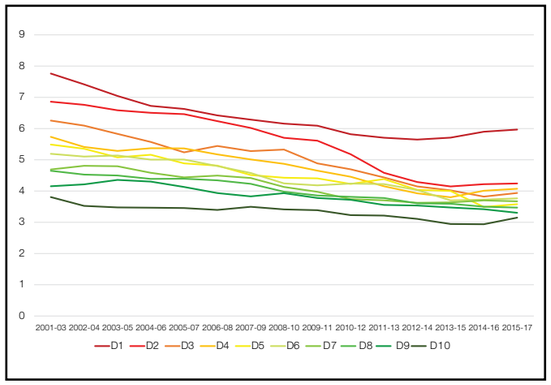
Perhaps the most striking feature of this data is the even distribution of the deciles in 2001-03, continuing up to 2008-10. However, from that point, infant mortality in deciles 2 to 10 tended to improve and cluster together, while the most deprived populations tended to diverge from the rest. For the past seven years, the most deprived 10% of communities in England have not seen improvements in infant mortality which are apparent in the other 90% of the population.

Infant mortality, North Yorkshire, North Riding and England, 1906 and 2015-17



Infant deaths per 1,000 births (registered births for 1906, live births for 2015-17)

Infant mortality by deprivation decile, England, 2001-03 to 2015-17



Housing

The analysis of IMD 2015 data showed deprivation to be more greatly affected by housing quality than access to services. The 11 most deprived LSOAs have generally low levels of home ownership (between 20% and 50%) compared with North Yorkshire (69.6%). There are two distinct groups, with six LSOAs having high proportions of socially rented houses and five with high proportions of private rented accommodation, in Castle and North Bay wards in Scarborough and Whitby West Cliff ward. The LSOA Selby 005C has 63.1% socially rented homes.

In North Yorkshire the proportion of socially rented homes (11.2%) is lower than the England average (17.7%), and of private rented homes in North Yorkshire (16.8%) is the same as the England average.

LSOA Harrogate 013F - Woodfield ward, Harrogate district - has a high proportion of one person households aged 65 and over, compared with the ten other most deprived LSOAs. LSOAs in the Scarborough borough wards of North Bay, Woodlands, Castle and Eastfield all have a rate which is lower than the averages in both North Yorkshire and England.

Eight out of the 11 most deprived LSOAs have a higher proportion of households with no central heating, compared with North Yorkshire (3.0%) and England (2.7%). All eight LSOAs are in Scarborough borough with 3 LSOAs in Eastfield ward and 3 in Castle ward. LSOAs Scarborough 006D, 010A, 006B and 001C, in North Bay,

Castle and Whitby West Cliff wards have 10% or more homes with no central heating.

Homelessness is multidimensional, with no single cause. One of the main influences for homelessness is structural factors around housing. The housing market trends and policies are influenced by changes in the labour-market and are likely to be delayed and mediated by welfare arrangements. Poverty plays a central role in shaping risk of homelessness in the UK.

Individual vulnerabilities, such as poor mental health, support needs, and “risk taking” behaviours implicated in some people’s homelessness are themselves often, though not always, also rooted in the pressures associated with poverty and disadvantage. Deteriorating economic conditions could be expected to generate more “individual” and “interpersonal” vulnerabilities to homelessness over time. Housing and welfare policies affecting low-income households have a far more profound impact on homelessness trends than general economic climate (Fitzpatrick et al, 2019).

Homelessness was a significant influence on admissions to workhouses in the 19th century. The present measure of statutory homelessness is defined as a household which has become unintentionally homeless and which must be considered to be in priority need. The measure therefore excludes some people.

The Homeless Reduction Act introduced in 2017 brought new duties to prevent and relieve homelessness. The Act extended the period in which a household could be described as

‘threatened with homelessness’ from 28 days to 56. Regardless of priority need the Act ensures a duty to prevent homelessness and relieve homelessness for all eligible applicants. Public services are also required to notify the local housing authorities if they come into contact with someone who is or may be at risk of becoming homeless under ‘duty to refer’.

In 2017/18, North Yorkshire had 323 statutorily homeless households, 1.2 per 1,000 households and ranged from 2.2 per 1,000 in Richmondshire and Scarborough to 0.3 per 1,000 in Craven. In England, the rate was 2.4 per 1,000.

People with mental health conditions are more likely to be homeless or live in unsecured housing. There are also disproportionately high rates of homelessness amongst ex-service personnel. The government’s annual count of rough sleeping showed 22 rough sleepers in North Yorkshire on the night of the survey in autumn 2018. There were 8 in Scarborough and 7 in Harrogate, with smaller numbers in other districts. Accurately counting or estimating the number of people sleeping rough within a local authority is inherently difficult given the hidden nature of rough sleeping. There are a range of factors that can impact on the number of people seen or thought to be sleeping rough on any given night. This includes the weather, where people choose to sleep (e.g. some may be in short-term accommodation or ‘sofa surfing’), the date and time chosen, and the availability of alternatives such as night shelters.

Gypsies and Irish travellers

Gypsy, Roma, Traveller and Show people (GRTS) are often absent from surveys and other data collection methods. However, there are sources which provide a partial picture of the inequalities that these communities face.

The 2011 census showed 588 people from Gypsy and Traveller communities in North Yorkshire, about 0.1% of the population. The largest numbers were in the districts of Selby (158 people), Hambleton (132 people) and Harrogate (107 people) and with smaller communities elsewhere the county. The Ministry of Housing, Communities and Local Government counts Traveller caravans every 6 months. In January 2019, there were about 390 caravans in North Yorkshire, an increase from 290 in January 2016.

Life expectancy is much shorter among the Gypsy or Irish Traveller ethnic group than for other ethnic groups, typically 10 years less than average. The group is less likely to have registered with a GP and has higher levels of infant mortality, chronic sickness, disability and poor dental health. In addition, the Gypsy or Irish Traveller ethnic group has low levels of educational attainment, economic activity (in particular for females) and there is some evidence of higher levels of domestic abuse than in the general population. The Gypsy or Irish Traveller ethnic group reported poorer general health than the overall population, both nationally and within North Yorkshire. At the 2011 census, about 5% of the county’s general population reported ‘bad/very bad’ health, but among the Gypsy or Irish Traveller ethnic group the figure was more than double that, at 12%. Similarly, in the general population, 82% reported ‘good/very good health’ while the figure was only around 74% for those in the Gypsy or Irish Traveller ethnic group.

The 2011 census also identified that there is a higher rate of lone parent families among the Gypsy or Irish Traveller ethnic group than in the overall population – around 18% in North Yorkshire compared with around 8% in the general population of the county. In Selby district, more than 1 in 4 Gypsy or Irish Traveller households are lone parent families (26% of households).

Members of GRTS communities are more likely to be caring for a dependent relative than the general population. They are also more likely to experience social exclusion.

Summary

The health of people in North Yorkshire is, in many ways, improved from the workhouse era. However, analysis of present day food bank usage and support from North Yorkshire Local Assistance Fund suggests that a similar proportion of people in 21st century North Yorkshire live their lives in a precarious position.

We can readily identify neighbourhoods in which poverty is currently more concentrated. There are drivers of poverty such as lack of access to education, employment and housing which, when combined with ill health, adversely affect health outcomes and reduce life expectancy and healthy life expectancy for some in our population. Knowing where these drivers are predominant enables us to work with communities and alongside partners using a targeted approach to reduce adverse health outcomes and tackle inequality.

Poverty is also distributed throughout the county. The most recent estimates suggest about 92,000 people in North Yorkshire fall into the government's definition of poverty. At 15% of the population, this is considerably lower than the England average, but results in poverty which can be hidden from view in area-based measures where people live with the challenges of poverty amongst less disadvantaged neighbours.

Using the objectives set out by Sir Michael Marmot in *Fair Society, Healthy Lives*, we have identified indicators where North Yorkshire can improve - and those areas where success has already been achieved. The next chapter outlines the policy choices society has made in tackling poverty and the impact these have had.

Chapter 4: From the workhouse to the workplace – poverty then and now

The then – hard times indeed

Poor relief was a long-established tradition, rooted in values of compassion for the "less fortunate" and the workhouse was an acceptance of the state's responsibility to support the poor. However, life in the workhouse was harsh.

The severity of life in the workhouse was deliberate and intended to be a deterrent, so that only the truly destitute need apply, as described in my introduction. This reflected society's attitudes to poverty, which meant that the workhouse system made a basic distinction between those who were regarded as the deserving poor and those who were thought to be the undeserving poor. Life was especially harsh for those who were considered to be undeserving.

Workhouse culture mirrored the wider culture of the day, which valued status and wealth. Wealth determined power relations in society, and the well-to-do held the dominant roles - including the distribution of charity.

The poor had to submit to the benevolence of their "betters".

Today we accept that the quality of our relationships is crucial to survival, success and wellbeing, but families that entered the workhouse were segregated. Shame became the primary social emotion attached to living in the workhouse, and contributed to the terrible stigma associated with poverty.

Chief amongst the undeserving poor was the able-bodied idler (who probably never really existed). In spite of the myth of the undeserving poor, it is no exaggeration to say that daily life in the workhouse for the so-called able-bodied idler was hard, pitiless and quite pointless, all at the same time.

Employment was exclusively manual in nature and mainly consisted of exhausting, labour-intensive tasks such as breaking rocks and boulders, and crushing bones down in order to make fertiliser. One investigation about the conditions of the poor in the workhouse concluded that, "Starving paupers were reduced to fighting over rotten bones they were supposed to be grinding, to suck out the marrow" (to stay alive).

It is likely that many of the able-bodied had mental health problems and alcohol addiction. Then, as now, mental illness and addiction can be linked to poverty and debt, both as cause and effect. Healthy people maintain a balance between their individual needs for autonomy and achievement and their equally vital need for social connection and belonging.

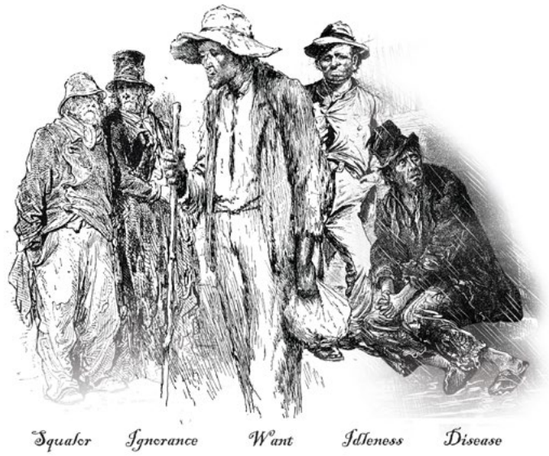
While some in the workhouse benefited from the organisation and rhythm of life it offered, for others it was traumatic. There was little recognition or treatment for mental health problems and the harsh environment took away the autonomy of inmates, provided little scope for achievement, and undermined their sense of place and status in society.

Elderly inmates undertook some work but concessions were granted according to levels of frailty. Less able-bodied inmates undertook alternative employment, such as craftwork – lace-making for example was quite common and could also generate income for the workhouse.

Successive reforms improved conditions in the workhouse over time and eventually the workhouse converted into a last refuge for the elderly and the infirm, and those who were ill, rather than the able-bodied poor. New legislation was implemented in 1929 to convert the workhouse infirmaries, which they had become, into the first municipal hospitals, run by local authorities.

The workhouse institution was abolished by law in 1930, although many continued to operate until they were truly abolished by the National Assistance Act in 1948, following the creation of the new welfare state.

Tackling the five giant evils - the transition to the Welfare State



The creation of the welfare state was the result of a national government report, published in 1942 by William Beveridge – usually referred to as the Beveridge Report. The Beveridge Report set out proposals for widespread social reform to tackle 'five giant evils' of want, disease, ignorance, idleness and squalor, through a new revolutionary system of social welfare (Fraser, 2017). This report focuses on want – poverty – and the four subsequent annual reports will consider the other giants.

The welfare state was pioneering and set out to tackle – and even try to eradicate – poverty through a large scale programme of social expenditure on health, education, housing, work and unemployment. A new system of social security was implemented to provide income security for the poorest people at times of unemployment.

Social security was funded through expansion of taxation called National Insurance. A further report by Beveridge in 1944 set out aspirations for full employment in the UK.

Overall, the welfare state was transformative and, in one way or another, it improved the lives of virtually every person in the United Kingdom, especially in the early decades when its effectiveness was rarely challenged (Esping-Anderson, 1990). It created a safety net to protect the poor and, while there were benefits that were subject to means-testing, the distinctions between the deserving and undeserving poor were less apparent. The principle was that everyone contributed through their taxes – and everyone benefited when they needed help from the state. Until the oil shocks during the 1970s, both Conservative and Labour governments attempted to follow an economic approach based on a key goal of full employment.

During the 1950s and 1960s the welfare state expanded, with extensions to unemployment, child and disability benefits; housing developments and benefits; pensions; and the extension of education and health services.

In the 1960s and 1970s, there was an increasing separation in ideology between political parties. Those on the right wanted a reduction in state expenditure and services, and preferred targeting over universalism; and the left redefined and re-identified mass poverty.

With the oil crises, high inflation and battered currency of the 1970s, the scene was set for a shift away from reducing unemployment to managing inflation and interest rates. Efforts to restrain and reduce the welfare state became more active. There was an increasing move to change from unemployment benefits towards reskilling individuals for new jobs, using coercion if necessary. However the welfare budget continued to increase – from 6% of national income post-war, to 20% in the 1970s and 25% in the 1990s.

Today, there is still substantial expenditure on the welfare state, but with a slowing of life expectancy, increasing levels of poverty and destitution and widening health inequalities, there is concern about the effectiveness of the welfare state but no clear consensus on political or economic directions of travel.

Debt and bereavement

An unexpected change in circumstances can push someone into poverty. The poorest in society are disproportionately affected by changes because they lack financial resilience. As this case study from North Yorkshire County Council's Living Well team illustrates, they may find themselves in difficult financial circumstances because of the contributions they make in unpaid work such as caring. The poor make contributions that are sometimes not recognised or valued. Like anyone, the right support at the right time can make a great difference.

Kirsty recently lost her Mum and Dad after caring for them for 20 years. She found herself alone and unable to cope with the financial implications of her parents' deaths and this affected her mental health quite severely. Kirsty was previously supported by the North Yorkshire County Council Living Well team for other reasons and returned to them due to the recent bereavement.

Kirsty required support to apply for Universal Credit and improve her financial situation. She also needed assistance with moving to a smaller property, and required support organising her Mum's funeral, and emotional support to manage the change in her circumstances.

Kirsty had bereavement counselling, saw her GP about her mental health and was advised to continue to ring the Mental Health Crisis team if or when she wasn't coping. She applied for a grant which helped towards her Mum's funeral.

The team supported her successful application for Universal Credit and helped her liaise with the Job Centre. She now sees them fortnightly and is looking forward to working in the future.

Kirsty was supported to liaise with a housing provider so she could downsize and they began to look for a smaller, more suitable property which allows dogs as this is important to her. She was helped to apply for a water meter to be installed to reduce her water bills.

She applied for Discretionary Housing Payments as she was unable to afford the rent on her own income in her parents' house. She was also awarded a grant through the Smallwood Trust charity to allow her to pay off debts and help her to pay for a removal van when the time comes.

Although Kirsty is still struggling she is in a much better place. She has improved financial circumstances and is no longer in any debt. Her mental wellbeing has begun to improve and her general mood and outlook is more positive. The Living Well team has also improved her future job opportunities by arranging support from a job coach.

The now – return to hard times?

Before the industrial revolution of the 18th and 19th centuries, Britain was a mainly rural, agrarian society with people being supported in small communities. During the industrial revolution, with increasing urbanisation and movement of people to towns and cities, and employment by industrial leaders, new means of support were needed and the workhouses emerged.

Economic depression between the World Wars resulted in high unemployment and increasing inequality. The Second World War resulted in substantial social mixing; it eliminated unemployment, brought women into the workforce, and resulted in widespread pressure for change. This led to the birth and growth of the welfare state.

Like the Industrial Revolution and the post-war era, we live in a period of major social flux characterised by an accelerating pace of technological change; globalisation; environmental crisis; large scale migration and mixing; and the uncoupling of wellbeing from economic growth. One of the defining challenges of our times is the current inequality in income between the ultra-rich and the middle income earners. Other defining challenges include climate change.

Big income differences make class and status divisions more powerful and inequalities make problems with social gradients worse. Inequality also leads to increases in anxiety about social status; heightens consumerism; affects social mixing and is associated with poorer mental health and wellbeing across the entire society (Wilkinson and Pickett, 2009).

In more unequal societies there are:

- higher crime rates;
- more imprisonment;
- lower age of criminal responsibility;
- less trust;
- lower levels of empathy; and
- poorer life expectancy.

Today, the Department for Work and Pensions (DWP) is responsible for financial assistance and support for the unemployed. Formed in 2001 from the former Department of Social Security (DSS), the DWP is the largest government department in the UK, and one of the public sector's largest employers.

One of the main duties of the DWP is the administration of working-age benefits, including Job Seekers Allowance (JSA), which is managed locally through Job Centre-Plus. JSA replaced the previous state benefits of Income Support and Supplementary Benefit. JSA is an unemployment benefit paid to people who are out of work and actively seeking employment. The Allowance is a payment which is meant to cover the costs of all living expenses of the recipient during periods of unemployment.

All claimants must state that they are actively seeking employment during this time, and must provide proof of this when they attend a Job Centre every two weeks, to 'sign-on.' If any of the conditions of the agreement are broken, without an acceptable explanation, the allowance can be reduced, or stopped, as a penalty. This is called a 'sanction'.

There is increasing evidence to show that benefit sanctioning is ineffective. There is a growing concern that certain groups are disproportionately vulnerable to sanctioning, including one-parent families (and their children); care leavers; disabled people; and those with ill health. Evidence was presented to the UN Special Rapporteur on UK Poverty to illustrate the harsh and arbitrary nature of benefit sanctions (Alston, 2018) and a recent book by Adler (2018) characterised sanctions as being cruel, inhuman and degrading. A further detailed study by Dwyer (2018) presents new evidence about the harsh consequences for vulnerable benefit claimants who are sanctioned.

The DWP also provides support to people with disability under the "Access to work" schemes (www.gov.uk/access-to-work). An employer can recover costs for any adaptations that need to be made to allow an individual to initiate work or return to work. This includes physical and mental health disabilities.

Commentators have observed that the payment and process of administering welfare benefits in the UK is neither kind nor generous – and is not intended to be so (Esping-Anderson, 1990), and this can bring shame and humiliation on the recipient (Alston, 2019). The monetary value of JSA is low and, by design, will inevitably result in all recipients being placed well below the official poverty threshold for the United Kingdom.

In 2019, a new state benefit called Universal Credit is being rolled out across the country. In March 2019 the Work and Pensions Secretary, Amber Rudd, announced that benefit claimants in Harrogate will be the first to move from old style benefits to Universal Credit. Universal Credit is replacing a number of other state benefits, including JSA, with a single payment to support the unemployed and those on low incomes. While some research suggests certain claimants do have positive experiences with Universal Credit, an increasing body of evidence makes clear that there are many instances in which Universal Credit is being implemented in ways that negatively impact on claimants' mental health, finances, and work prospects (Cheetham, et al; 2018). The Universal Credit system is designed with a five week delay between when people successfully file a claim and when they receive benefits. Further research suggests that the waiting period before benefits are paid, which can often takes up to 12 weeks, pushes many people who may already be in crisis into serious hardship – often requiring them to sacrifice food or heat (Parliamentary Report, 2018).

The pilot, rolling out in Harrogate from July 2019, aims to learn as much as possible about how to help people move onto Universal Credit.

"The switch needs to be done carefully which is why we are taking a step-by-step approach to this starting in Harrogate. I want to be sure that the switch to Universal Credit is a hassle free process for claimants and everyone receives the personalised service they deserve." – *Amber Rudd*

Alongside support with financial assistance there have been various national schemes to help the unemployed return to work – although most of these have been judged to be ineffective and have ceased. One of the most recent schemes was the national Work Programme, which required participants to undertake 30 hours of unpaid work each week. The scheme, which has ceased, was compulsory and benefit sanctions were enforced if recipients declined to take part.

Child poverty

The number of children experiencing symptoms of food insecurity, or whose family income is evidently insufficient to afford a healthy diet amounts to between 2.5 and 4 million; between 20% and 30% of all children in the UK (Stone and Hirsch, 2019). Estimates from 2017 suggest 21,290 children were living in poverty in North Yorkshire. The 2019 End Child Poverty analysis shows Northstead 41%; Ramshill 40%; Castle 40%; North Bay 40%; Eastfield 39% as the five wards with highest child poverty (after housing costs).

The Children's Future Food Inquiry report suggests that one in three children (4.1million) are living in poverty in the UK. For their families to be able to afford the Government's recommended diet, they would have to spend an estimated 35% of their income on food, once their housing costs have been taken care of.

The odds are stacked against low income households: for many a healthy diet is not affordable, and less healthy food is available everywhere and heavily marketed to parents and children alike.

In 2019, as part of the national Childhood Obesity Trailblazer Programme work was done to understand influences on childhood obesity at a school in one of the deprived areas in the county. Parents reported a willingness to improve their children's diet, but sometimes struggled with the expense of doing so.

Many teachers commented that pupil's "colour of complexions look pale and haunted" and "their food intake affects their behaviour at school negatively. You can tell when a child hasn't had tea the night before and no breakfast in the morning as they act out and have a significant negative mood".

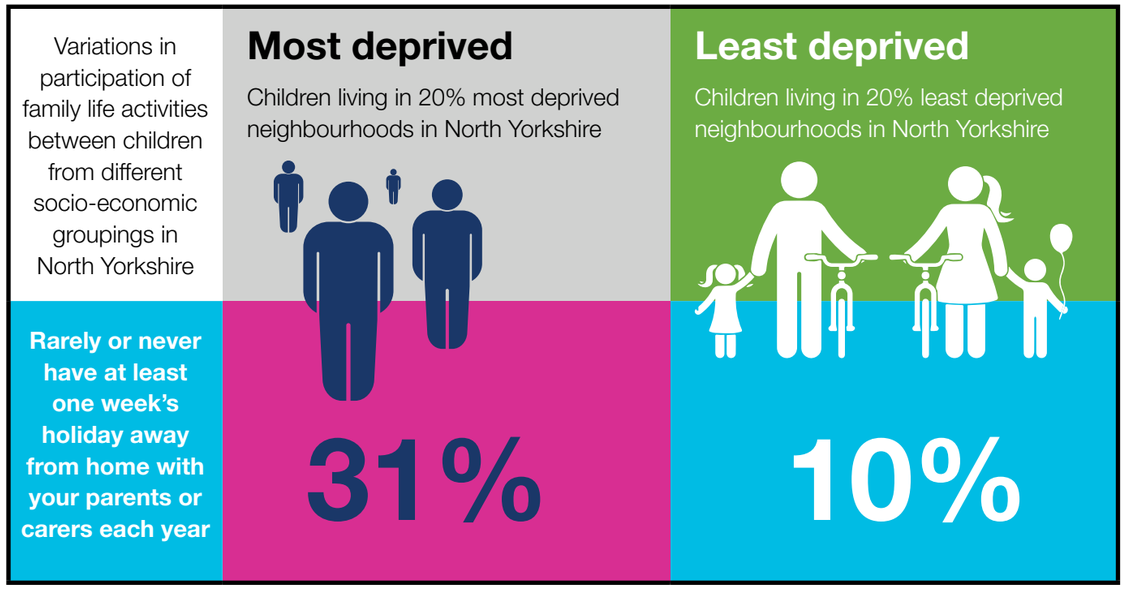
"It's easier as a low income family to fill a child on a four sausage rolls for £1 deal and know they're going to be full, rather than eating better and be starving". – *Parent in North Yorkshire*

The discovery work also highlighted that people living in the most deprived areas had fewer fresh food choices, and more convenience offers.

Deprivation can affect activity levels, as disadvantaged students have their only hot meal of the day at school, meaning they do not have time for lunch club activities. After school clubs were not shown to be popular with the most disadvantaged students as they prioritised getting home to 'hang out' with friends. The divide in social status and wealth was found to be a concern amongst teachers as there was a perception that "you don't get involved with stuff, otherwise you will get insulted. 80% of the students don't feel like that, but 20% do, and it tends to be the disadvantaged kids".

Every two years North Yorkshire County Council undertakes a large scale, independent survey of children and young people in North Yorkshire. The survey, called Growing Up in North Yorkshire (GUNY), is one of the largest of its kind in the country.

The overall picture of family life in North Yorkshire is positive and affectionate. However, some children and young people report never having been on a family holiday (or even a day trip); being taken out as a treat for lunch or supper to a local restaurant; or celebrated a birthday with cake or a balloon.



Veterans - soldier poverty in North Yorkshire

The poor transitions of military veterans to civilian life in North Yorkshire (Shared Intelligence, NYCC, 2019).

North Yorkshire has a large - and growing - military presence across the county. There are more than 10,000 serving personnel, and more than 40,000 ex-military veterans living in North Yorkshire. Armed forces veterans account for approximately 7% of the total population.

The large majority of military veterans who live in North Yorkshire are older, retired soldiers, but there are more than 12,000 working-aged veterans, mainly but not entirely with army backgrounds, who also live in the county. Many of these veterans will go on to make successful transitions to civilian life and find work in the local labour market. However, there is strong evidence to suggest that many working-aged veterans will also be unemployed; or under-employed; or engaged in low-paid occupations that bring little job satisfaction or financial stability, after leaving their military careers (Shared Intelligence, 2019).

Recent research on the armed forces community in North Yorkshire shows large numbers of working-aged veterans concentrated in poor parts of the county. They are unemployed or at an increased risk of in-work poverty resulting from jobs in a low-paid, unskilled economy. There are particularly high numbers of younger, working-aged veterans living in places like Scarborough and Selby. Quite often, young people who grow up in these communities will join the armed forces due to the general poor job opportunities in the area, but will usually go back to their home towns after leaving the military.

The challenges faced by working-aged military veterans are varied. While ex-military officers will often go on to find rewarding work elsewhere (often combining this with a part-time reservist role), civilian life for the non-commissioned ex-soldier is usually more difficult.

Evidence shows that early service leavers in particular will be significantly more likely to experience poor transitions to civilian life. Current support for young ex-soldiers is poor, and many military veterans will be ill-prepared for the transition to their new life. Many younger veterans are discharged for medical reasons and will need to claim a range of welfare benefits after leaving the army. Many will also be in need of additional support with housing, training and health, as well as employment and welfare.

The economic uncertainty surrounding the vast majority of younger, working-age ex-soldiers can have a marked effect on their health. Younger veterans, under the age of 24 for example, are at much higher risk of mental illness and suicide. Life for the young ex-soldier in civilian society is often characterised by isolation and loneliness, resulting in risky behaviours and poor lifestyle choices.

In recognition of the social and economic challenges experienced by military veterans, the Ministry of Defence has recently set up the Defence Transition Service. It delivers specialist support for serving personnel who are most likely to face challenges as they adjust to civilian life.

Fuel poverty

In England, fuel poverty is measured using the Low Income High Costs (LIHC) indicator. Under the LIHC indicator, a household is considered to be fuel poor if their fuel costs are above average (the national median level), and if they pay that cost, they will be left with a residual income below the official poverty line. Fuel poverty occurs when a household cannot afford to keep their home adequately warm at a reasonable cost. It is often associated with older people; however 45% of fuel poor households have one or more child under the age of 16 living at home.

Fuel poverty is caused by three main factors: low income; high fuel prices; and poor energy efficiency in the home. It is estimated that 30% of winter deaths are caused by cold homes. In North Yorkshire 10.1% (26,600) of households are living in fuel poverty. Fuel poverty exists throughout North Yorkshire, but is highest in Scarborough and Ryedale.

North Yorkshire experiences particular challenges because housing tends to be older, and more difficult to make energy efficient. Many homes have solid walls so are more difficult to insulate and a large proportion of homes are off the mains gas network, meaning higher costs for heating fuels. More generally in rural areas, there is a lower take up of benefits and energy advice and grants.

Reducing fuel poverty is a priority for the North Yorkshire Winter Health Strategic Partnership, which sits under the county's Health and Wellbeing Board. There are a number of programmes in place, including the Warm and Well single point of contact which provides support to residents around fuel poverty and reducing cold homes.

Warm & Well in North Yorkshire

Steve, aged 88, lives alone in a bungalow that he owns. His wife died recently after a long illness where Steve was her carer. His income is from state pension, a private pension and an invalid pension from the Marines. In total this comes to less than £15,000 a year.

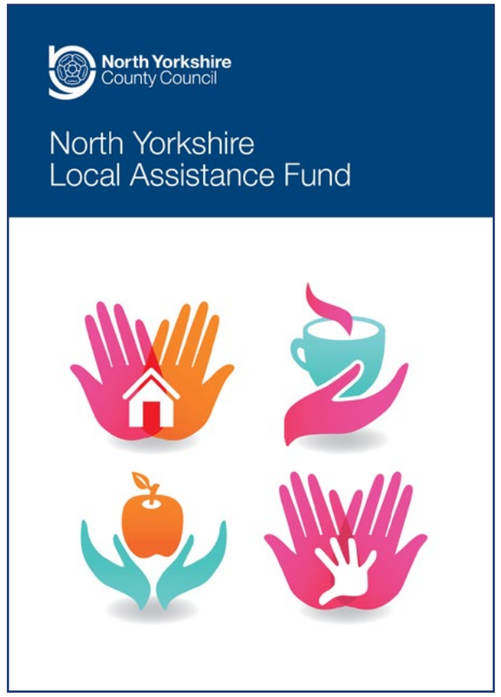
Steve has gas central heating, which is working correctly. The main issue is that his bungalow is very cold and does not retain the heat. There is no cavity wall insulation and very little in the loft. Steve's gas and electric is supplied by N-power, which has recently raised prices by £20 a month. He has never switched supplier.

Steve had already been in touch with the Ex-Forces Support project in North Yorkshire and they had started the process of pairing him up with a befriender.

After finding out about Steve's situation, the Warm & Well team referred him to Citizens Advice Hambleton to do an energy comparison; he swapped suppliers and was able to save £360 annually, which works out at £30 a month. They also taught Steve how to access his energy account online. Steve was also referred to YES Energy Solutions, a Community Interest Company dedicated to reducing CO2 and alleviating fuel poverty. They have contacted him to arrange someone to visit his property for an assessment.

North Yorkshire Local Assistance Fund (NYLAF)

When many local authorities around the country have agreed to close down their local welfare assistance programmes altogether, or significantly reduce their funding for welfare assistance, North Yorkshire County Council continues to retain its own local service and is one of very few local authorities in the country which spends the full Government recommended amount each year on welfare assistance. In the past six years the North Yorkshire Local Assistance Fund (NYLAF) has supported tens of thousands of people with awards in kind, in order to meet the costs of basic needs such as heating and food. Since 2013 the NYLAF has made more than 20,000 emergency food awards alone and has spent around three million pounds on this non-statutory service.



The Social Fund that used to provide financial support for people in times of crisis was abolished by national Government in 2012 and replaced by new Local Welfare Assistance Schemes in England. The schemes are administered by local authorities and provide the same types of emergency provision that were previously covered by the national Social Fund.

North Yorkshire's approach to the provision of welfare assistance is targeted at particular vulnerable groups, homeless people or those with mental health issues. Applications from local residents for support to buy food have increased significantly in recent years – in 2013/14, for example, there were 1,354 applications but by 2017/18 this had increased threefold to more than 4,000.

The service has been independently praised for the assistance it provides and highly acclaimed for the way in which it is discharged by the County Council:

"Part of the value of the Fund to both partners and recipients is the speed and civility of the administration, so that even when the application was rejected the applicant did not feel demeaned by the process. Not only did this allow partners to provide an emergency service but was in itself supportive to applicants, most of whom appeared to be dealing with low self-esteem and other mental health issues" *(NWA, 2018, p.7.).*

NYLAF recipient

John is 34 years of age, lives alone and has no partner or children. He left school at 16 and had been self-reliant from that time, having worked from that age until just over a year ago when he developed a physical problem that required surgical treatment. John was advised that he should not return to his usual form of work which was related to farming and was largely physical in nature. However, because he lives in a very rural area there was no other work and he had debts building up from prior to his illness (e.g. telephone and television bills, outstanding rent). He did attempt to go back to physical work however this exacerbated the medical problem and he required a further operation. He was now completely unable to return to his employment.

John continues to seek other employment. However he is in significant pain and requires pain killers and sleeping pills. This makes many types of work difficult for him.

John has a car which is old and recently required attention. In order to keep the car on the road he sold most of his possessions as without transport he felt that it would be impossible to gain employment due to a lack of public transport. He has borrowed from family and friends and feels extremely anxious about being unable to repay them. When John was changed to Universal Credit the waiting period caused him extreme difficulty as he had already exhausted his options for support although he was at pains to tell the interviewer he was grateful for the support now received from Universal Credit as it 'allowed him to keep a roof over his head'.

Although John was very reluctant to seek help or to tell people how hard he was finding it a friend told him about the North Yorkshire Local Assistance Fund. At that stage John had no money and no food.

He had received support from a foodbank but there was a limit on the number of times he could seek assistance there. In addition he said he 'felt badly' about asking for help, feeling 'stigmatised' despite the situation he was in being of no fault of his own.

John was full of praise for the help he was given from the Local Assistance Fund. Help arrived very quickly and the next day John received a £25 Tesco voucher which he described as being a 'lifeline' and 'game changer': indeed on receipt of the voucher he said that he broke down and wept. His message was that he was full of gratitude and could not thank staff enough not only for the provision of the support received but the way in which it had been delivered to him.

This chapter highlights the changes in attitudes towards poverty over time as illustrated by the workhouse and development of the welfare state. The recent approach to welfare reforms and introduction of Universal Credit are informed by austerity policies and suggest that our current response is closer to that of the workhouse era than to the 1940s when the welfare state was conceived and implemented.

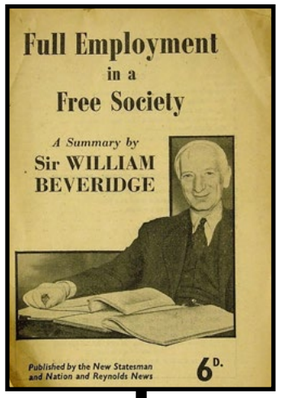
Social security and employment – the birth and growth of the welfare state

1834
Poor laws establish workhouses

1911
Limited statutory unemployment insurance introduced

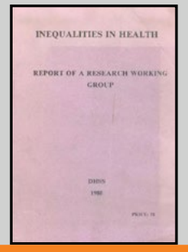
1919
'Out-of-work-donation' for the unemployed – 'dole'

1934
National assistance board takes role from local authorities



1942
Beveridge report published. The five giants were identified: Want, Disease, Ignorance, Squalor and Idleness

1965
Formation of ministry of social security

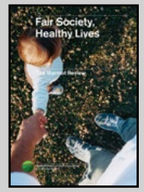


1980
Black report on health inequalities

1991
Health of the Nation links poverty and ill-health

1996
Change from Unemployment to Jobseekers Allowance

2001
Formation of the department for Work and Pensions (DWP)



2010
Marmot report published; austerity response to recession

2016
Universal credit rolled out

2019
UN Alston report on poverty in England

Chapter 5:

Review of progress on the 2018 report recommendations

The 2018 Director of Public Health for North Yorkshire's Annual Report was titled "Back to the Future". It looked back at the progress made in improving the health of North Yorkshire's residents since public health responsibilities moved to the County Council in 2013.

Three key areas of focus were recommended for priority action based on this review and feedback from stakeholders:

- Reduce health inequalities
- Improve public mental health
- Embed a public health approach

Reduce Health Inequalities

This annual report aims to broaden understanding of the principle driver of health inequalities: poverty. The significant challenge of reducing the number of Lower Level Super Output Areas (LSOAs) within the most deprived 20% of LSOAs in England as measured by the Index of Multiple Deprivation (IMD) scores, and having none in the most deprived 10% by 2025, is an ambition that is gaining traction among stakeholders across the county.

Examples of work focused on areas of deprivation include:

- The Ambition for Health Partnership aims to transform health and social care services in Scarborough, Ryedale, Filey and Bridlington by responding to the needs of residents. Local health profiles which describe inequalities have informed priorities, including a focus on children and young people linking with the North Yorkshire Coast Opportunity Area; mental health; and cardiovascular disease. The Partnership has also introduced new initiatives to tackle smoking in pregnancy.
- A commitment to reduce health inequalities runs through the Selby Health Matters action plan, which has used local data to identify priority areas for action. The Governing Body of the Vale of York Clinical Commissioning Group has also restated their commitment to helping deliver the action plan and to ensure that their commissioning of services reduces health inequalities and improves population health.
- Humber, Coast and Vale Sustainability and Transformation Partnership (STP) has identified cardiovascular disease prevention as a priority. It has formed a task group focused on delivering the national ambitions as well as key local priorities around smokefree NHS settings.

Some work has also focused on groups that have worse outcomes due to challenges in access. This may be a result of rural deprivation or disabilities.

- The Winter Health Partnership continues to deliver the Warm and Well project. The project has secured over £600,000 in grant funding during the last two years to reduce fuel poverty and excess winter deaths for people living in cold homes.
- The Learning Disability Partnership Board has worked with the Public Health team to support service improvements for people living with learning disabilities, in response to national evidence about poor health outcomes and early deaths. This has included promoting uptake of annual health checks and access to cancer screening services, as well as supporting the North Yorkshire Learning Disabilities Mortality Review (LeDeR) steering group.

In addition, there are initiatives that are aimed at improving overall population health which have been rolled out in a targeted way. These include:

- Discoveries on Your Doorstep (The Scarborough Trails and The Selby Trails) are a collection of walks with things to see and activities to do along the way. A roll out of this project is planned for Harrogate district, aligning with local policies around air quality and active travel. Improving the condition and awareness of public paths in Harrogate district has the potential to increase the number of children and young people walking to and from school, and reduce air pollution in identified air quality management areas.
- The County Council bid successfully for national Childhood Obesity Trailblazer funding to deliver a three-month 'discovery phase' that explored specific problems and drivers of childhood obesity in two target district areas, Scarborough and Selby. The overarching aim of the project is to influence the factors that contribute to childhood obesity in North Yorkshire and reduce inequalities in childhood obesity that exist within the county.

The project vision statement is to 'Inspire vibrant, progressive, inclusive environments within School Zones* in North Yorkshire which support and empower local schools and communities to lead active, healthier and positive lives.' (*the school and surrounding environment [one mile radius])

The two key elements of the project are to change the food and physical activity environments – creating environments and policies that support healthier eating and active lifestyle; and support behaviour change – providing information, tailored messages and support to young people and a broader School Zone Community.

Improve public mental health

The recommendation to improve public mental health builds on the work started in 2015, when Hope, Control and Choice – the mental health strategy for North Yorkshire - was launched.

A comprehensive Joint Strategic Needs Assessment (JSNA) deep dive investigation into the mental health needs of the population of North Yorkshire is ongoing. This includes co-producing evidence of need with specific marginalised groups, including people from the LGBT+ community. This is due to be published in Spring 2020.

North Yorkshire County Council has been awarded organic hub status by Time to Change. This initiative is a partnership between people with lived experience of mental health problems and a wide variety of stakeholders across North Yorkshire, underpinned by the values of service-user leadership. It will complement ongoing work to raise awareness and to reduce stigma and discrimination around mental health problems.

NYCC and its partners have a newly developed North Yorkshire Pathway of support for children and young people with self-harming behaviour and/or suicidal ideation. This is an online tool that contains information and guidance for parents, and professionals working with children and young people. It also provides support and advice for children and young people who identify themselves as using self-harm as a coping strategy; and/or want support as a result of disclosing self-harm, suicidal ideation and/or previous suicide attempt.

The Five Year Forward View for Mental Health set out clear recommendations on suicide prevention and reduction, and made a commitment to reduce suicides by 10% nationally by 2020/21. In 2018/19, local communities that were worst affected by suicide were given additional funding to develop suicide prevention and reduction schemes. The funding, which has been allocated to Sustainability and Transformation Partnerships (STPs) in a phased approach will help to ensure people know that high quality confidential help is available within their community. Additional money has been provided to Integrated Care Systems (ICSs) to achieve the zero suicide ambition.

The North Yorkshire Suicide Prevention lead is working with STPs/ICSs to ensure the funding available through NHS England is aligned to the North Yorkshire Suicide Prevention Plan priorities including delivery of mental health and suicide prevention training and grass roots funding for local community projects. In 2018/2019 phase one funding was allocated in the HRW CCG area, with phase 2 funding allocated to Humber Coast and Vale and West Yorkshire areas in 2019/2020.

Additional money has been given to develop a postvention offer across the ICS footprint. Postvention is an intervention conducted after a suicide, largely taking the form of support for the bereaved (family, friends, professionals and peers). Family and friends affected by a suicide may be at increased risk of suicide themselves.

Promoting improved physical health in people with mental illness is key. Living Well Smokefree, the new stop smoking service for North Yorkshire, has a key focus on people with mental health problems. Tees, Esk and Wear Valleys Foundation NHS Trust, the main mental health service provider in North Yorkshire, is working to become smoke free.

There are many actions that are not labelled "mental health" but contribute to improving population mental health including:

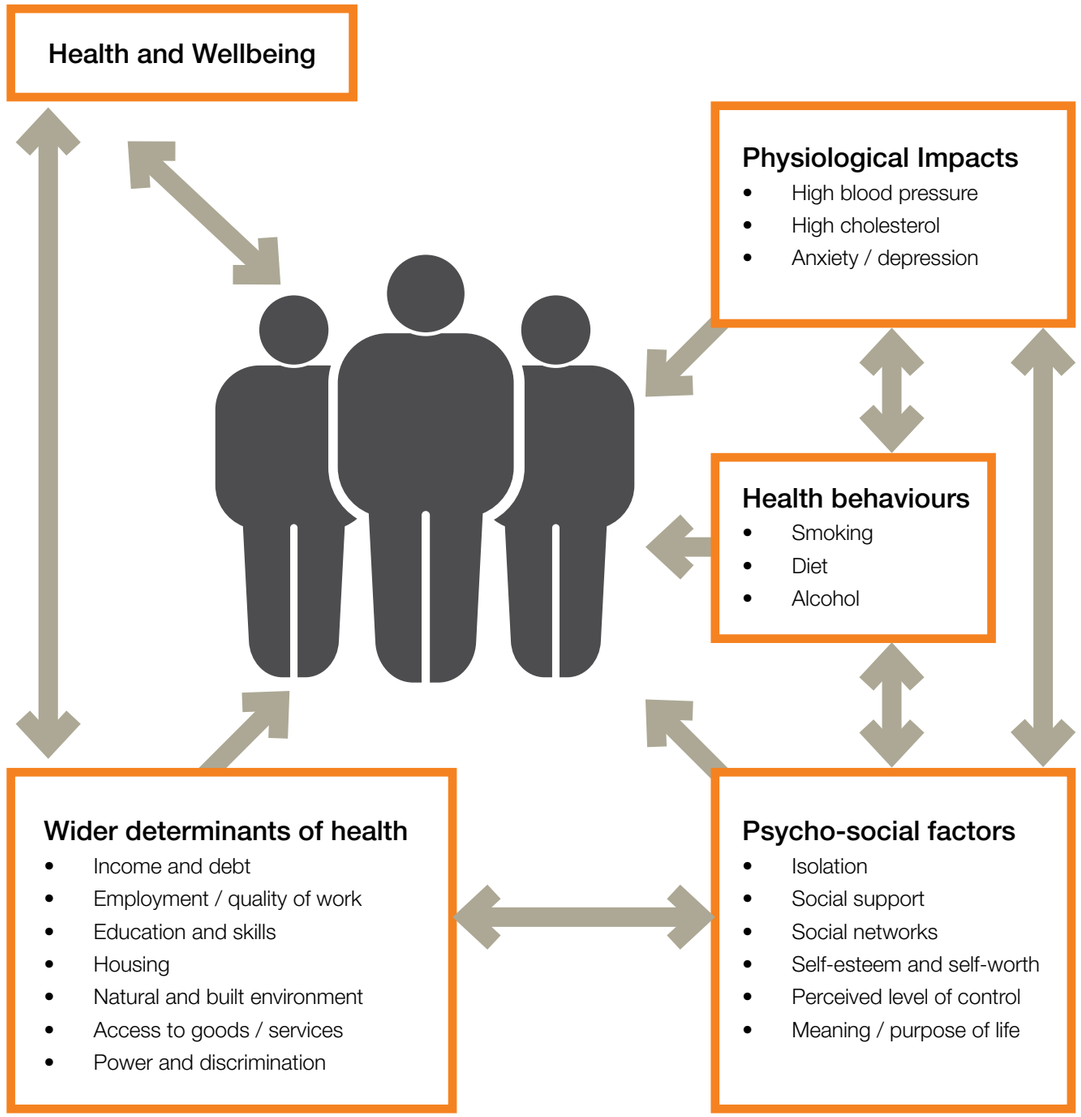
- Exploring the impact of Adverse Childhood Experiences and how all partners develop "trauma informed" practice
- The North Yorkshire Workplace Wellbeing Charter includes mental health promotion
- Securing "Age Friendly" status for North Yorkshire, which aims to make changes to ensure North Yorkshire is a great place to grow old in
- The NYCC Stronger Communities Investment Prospectus delivers a range of projects aimed at promoting mental health

Embed a public health approach

Some examples of how partners are embedding a public health approach to their work include:

- Population profiles for CCGs and Districts are used by partners to inform priority setting and actions to meet need
- Renewed emphasis on population health management by NHS partners
- Partners delivering the North Yorkshire Growth Plan taking account of the impact of population health and health inequalities in future planned developments
- District and borough councils developing plans to ensure localities are healthy places to live and work
- NYCC Public Health team working with colleagues in primary care to identify opportunities and approaches to promote population health through primary care
- Partners signing up to Making Every Contact Count (MECC) approach
- A virtual network of partners established to co-ordinate public health campaigns and other communications
- Focused review of Non Elective Admissions highlighting the role of social care in reducing unplanned admissions
- Facilitating all social care staff to receive a flu vaccine with increased uptake compared to previous years
- Evaluation workshop for partners working in Scarborough communities

System map of the causes of health inequalities



Source: Place-based approaches for reducing health inequalities, Public Health England, 2019

Chapter 6:
Conclusion and recommendations

Poverty reduces both quality and length of life. The fact that poverty affects some people and places disproportionately more than others is unfair. Furthermore, poverty defines the social context into which some children are born, which means they start life at a disadvantage. While individual triumphs over adversity are possible, the “rags-to-riches” story tends to be rare and exceptional. It is only right that every child should have the same chances irrespective of the circumstances of their birth.

The rise of food banks in recent years indicates a re-emergence of destitution where people lack sufficient income to meet their basic needs. Data shows that some of those who find themselves needing to rely on the compassion of others are in full time employment. They are hard-working, conscientious citizens who nevertheless find that they cannot make ends meet despite their best efforts. They do not want handouts. They want instead an economy that is fair and does not trap people in poverty through low paid, unstable work and a rising cost of living that outpaces wages. They want to know that if they face difficulty they will have access to benefits that will help them to overcome the challenges with dignity.

We have looked at two responses to poverty – the workhouse and the welfare state. The former focused on the individual and took little account of the economy and social context that was causing worklessness and poverty. The result was a system that punished the able-bodied poor. The welfare state was founded on very different principles. The Beveridge report recommended three key measures: a national health service, universal children’s allowances and the full use of the state’s powers to maintain employment and reduce unemployment.

A key conclusion of Marmot’s review was that health inequalities result from social inequalities. Evidence shows that focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. Actions need to be universal but with a scale and intensity that is proportionate to the level of disadvantage. Marmot was clear that national policies were needed to reshape the way the economy works to reduce poverty. However, national policies have to be underpinned by local delivery that is informed by empowered communities and citizens. These principles inform my recommendations for action.

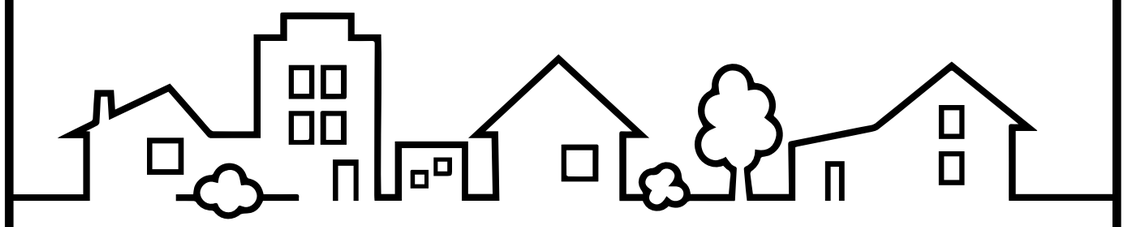
Recommendation - support deprived areas

There are 11 Lower Level Super Output Areas (LSOA), out of 373 in the county, with Index of Multiple Deprivation scores (IMD 2015) amongst the most deprived 10% in England and a further 12 LSOA amongst the more deprived 10-20% in England. Many of these are located in the coastal town of Scarborough but they exist in other places as well.

The evidence indicates that interventions to increase income in these LSOAs will help to lift these away from the most deprived group. These might include supporting people into employment and better paid, more stable jobs; improving opportunities for in-work progression through skills training, and increasing uptake of benefits to which people are entitled. The changing face of work due to increased digitalisation, artificial intelligence and technology advances needs to be monitored to prevent adverse impacts on employment opportunities in the county.

Recommendation

North Yorkshire County Council, the Borough and District Councils should lead coordinated plans focused on areas of deprivation through collaboration with local communities and residents to reflect their priorities for reducing poverty and shaping healthy places.



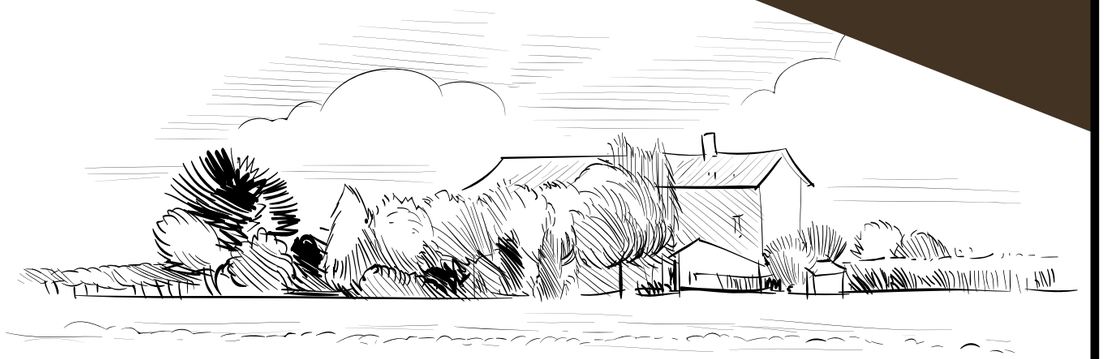
Recommendation - tackle rural poverty

Rural locations are associated with transport issues, decreased access to services and opportunities, and fuel poverty. These concerns are especially challenging in a county with a high proportion of older residents. 43% of the North Yorkshire population live either in the countryside or in small villages with less than 4,000 residents. This compares with 6% of the population of Teesside or West Yorkshire. Rural poverty may often be hidden in the statistics. The integral links between the rural economy of North Yorkshire and that of neighbouring city regions of Teesside and West Yorkshire needs greater emphasis.

Recommendation

Local authorities in North Yorkshire should continue to advocate for an inclusive, vibrant and sustainable rural economy as integral to the local industrial strategies being developed by Local Enterprise Partnerships and City Region deals.

North Yorkshire County Council, the Borough and District Councils should consider developing a coordinated Rural Strategy that highlights rural-specific needs including employment, connectivity and affordable housing



Recommendation - reduce childhood inequalities

The impacts of prolonged austerity and cuts to welfare benefits have driven an increase in levels of childhood poverty. Children in workless families are especially at risk but many poor children are in families where parents work. Single parent families are particularly hit by welfare cuts.

Recommendation

All agencies working with children and families should be alert to the risk and impact of childhood poverty and ensure they take account of hidden and indirect costs that may hinder a child's full participation in the services they offer. Plans that are drawn up to support children and families should reflect this assessment and should include actions to mitigate the impact of poverty identified.

Actions may include support for managing household budgets, facilitating access to employment and training opportunities including provision for childcare, and signposting and making referrals to debt and benefits advice to maximise income where appropriate.

As part of the Joint Strategic Needs Assessment, North Yorkshire County Council and Clinical Commissioning Groups in North Yorkshire should undertake specific investigation into child poverty to provide an updated picture of the scale and distribution of child poverty across North Yorkshire to inform strategies and service delivery.

Recommendation - work with military families and veterans

Catterick Garrison is the largest military base in Western Europe, housing 6,500 service personnel in 2019. It is scheduled to expand to 9,000 service personnel from 2023. There are over 50,000 veterans in North Yorkshire. Lack of opportunities for spousal employment and the transition from military to civilian life can increase the risk of poverty. This is identified in the recent armed forces and veterans needs assessment. The new Ministry of Defence (MODs) Defence Transition Service (DTS) aims to support ex-armed service veterans as they transition into civilian life in North Yorkshire.

Recommendation

Military and related agencies should ensure that service and veteran-specific issues identified in the needs assessment are addressed.

All agencies should identify and train military service champions within their organisations to ensure that military veterans are not disadvantaged when accessing local services such as health and housing in keeping with the commitments of the Armed Forces Covenant.

Recommendation - create safe environments for high-risk groups

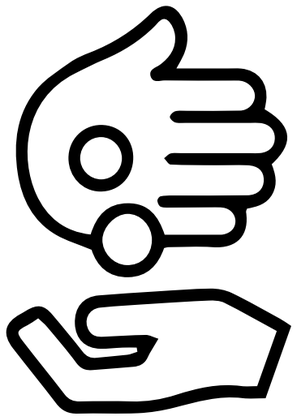
Deprivation and inequality can be concentrated in particular groups of people – such as those who are addicted to drugs; are homeless; have a disability; or experiencing mental ill health. Often these factors co-exist and place individuals at high risk for poverty and its negative consequences. Some families and individuals may have multiple interventions by different services which are not coordinated. Safe and stable housing is often a prerequisite for the targeted and individualised approaches that may be more beneficial for these groups compared to universal services which may not be sensitive to their multiple complex needs.

Recommendation

All agencies working with people with multiple health and social problems should consider a 'housing first' approach that provides a safe and stable environment which is sensitive and flexible to the needs and individual circumstances of the person.

Recommendation - develop priorities to mitigate the impact of changes to the benefit system

Navigating the benefits system is often challenging for people who are vulnerable. There are elements of how the system works including sanctions which causes loss of income at a time of greatest need. These sanctions appear to disproportionately target single parents, those with long-term health conditions or disabilities and keep people locked in poverty. The way in which the benefits system is operated at times has more in common with the workhouse than with the aspiration of Beveridge, that benefits should support people to live dignified lives. There appears little real evidence to support the notion that a harsh benefits regime will motivate people out of poverty. In fact, it appears to be having the opposite effect.



Recommendation

As part of the Joint Strategic Needs Assessment, North Yorkshire County Council and Clinical Commissioning Groups in North Yorkshire should undertake specific investigation to understand the impact of changes to the benefit system, cuts and sanctions on people, in terms of their mental and physical health and the use of services to set new strategic priorities in local plans to mitigate these impacts.

Recommendation - improve community engagement

Working with people and communities to create a shared future is more effective than doing things for them or to them. This principle is supported by a growing body of evidence that community participation leads to sustainable poverty reduction, especially where attention is given to training and building capacity in the community.

Poverty can undermine social networks and approaches that seek to build social capital in communities can increase the resources available to people to tackle the problems they face. The aspiration of working with communities is to design, reshape and deliver services equally with those who use them to create better outcomes.

Co-production	**Doing with** in an equal and reciprocal partnership
Co-design	
Engagement	**Doing for** engaging and involving people
Consultation	
Informing	
Educating	**Doing to** trying to fix people who are passive recipients of service
Coercion	

Recommendation

North Yorkshire County Council, the Borough and District Councils should work with voluntary and community sector partners to strengthen the involvement of local communities in shaping plans for reducing the impact of poverty in areas of deprivation.

Actions may include identifying influential community members reflecting different perspectives; providing training and support for communities to develop local plans; and facilitating communities to work with relevant agencies to co-produce plans and services.

All agencies should identify or appoint community champions and senior sponsors to promote a culture of community engagement in their organisations.

DPHAR 2019

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The full report can be found at www.nypartnerships.org.uk/DPHAR

Contact us

Dr Lincoln Sargeant, Director of Public Health for North Yorkshire, County Hall, Northallerton DL7 8DD

Tel: **01609 532476** Email: **nypublichealth@northyorks.gov.uk**
Web: **hub.datanorthyorkshire.org/group/dphar** Twitter **@nyorkshealth**

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