ITEM 9

Director of Public Health Annual Report

2014

Working with Communities: taking an asset based approach to Public Health

Health and Wellbeing Board
North Yorkshire

North Yorkshire County Council

Executive Summary

In 2014 communities across North Yorkshire welcomed the Tour de France and made the Grand Depart a resounding success. This report focusses on how we can work with communities to match that success in promoting the health and wellbeing of our residents. The strong and engaged voluntary, community and social enterprise sector (VCSE) is a particular asset for the County and is a key partner in helping to address the challenges we face in promoting and protecting the health of our people. The representatives of the sector are keen to develop and strengthen collaborations with public sector partners that will be of mutual benefit and lead to better outcomes for people across our communities.

The profile of North Yorkshire shows:

- A healthy population with higher levels of road injuries and death, excess weight in adults and smoking in pregnancy compared to the England average
- Improving life expectancy at birth with a widening gap between districts (Hambleton – highest; Scarborough – lowest)
- An ageing population with the number of people over 85 years set to increase by a third over the next decade
- Low levels of deprivation but challenges related to rurality, affordable housing and fuel poverty are present in all districts and for some population groups

The report also highlights areas where a co-ordinated approach by partners is needed. These include:

- Ensuring that each child has an active care record, supporting delivery of screening, immunisation and the Healthy Child Programme services
- Developing a mental health strategy to ensure that residents of all ages can maximise their mental health and wellbeing and access effective services when needed
- Ensuring that health and social care services are responsive to local needs and help residents to maintain their independence
- Implementing an alcohol strategy to address the harms associated with binge drinking and other risky drinking behaviours

Every community has a range of resources or assets that can be harnessed to meet local needs and challenges. The report outlines approaches communities can take to identify and make use of their individual, organisational, physical and economic assets. There must, however, be investment to make effective use of these assets and we are reminded that "voluntary action and volunteering do not come for free."

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Foreword

This report comes at a time when a lot of work, both locally and nationally, is taking place to establish joint-working arrangements between public sector bodies and organisations in the voluntary, community and social enterprise sector. This is happening against a background of continued cuts in public spending and consequent reductions in the provision of some public services, whilst an ageing population presents particular health and care demands. The focus on integrating health and care services, as required by the Better Care Fund, is welcome and our sector is keen to be involved in planning how such integration can best take place.

Putting measures in place to help to prevent poor health amongst the general public is clearly the correct priority, not as a means to saving money but because helping people to remain healthy for longer is the right thing to do.

Our sector has much to offer to help achieve this. North Yorkshire is a large County with significant variations in the health and well-being of the population. There is a myriad of community organisations offering care services, support to help people with drug or alcohol problems, or help to improve physical fitness in North Yorkshire. Community-run youth groups, lunch clubs and other activities can have significant indirect effects such as increasing the confidence of young people, or reducing social isolation for older people. Those groups tend to exist at very local levels, including in some extremely remote and rural parts of the County.

We welcome the collaborative approach promoted in this report, whilst noting that it comes with a number of challenges. There is a logistical challenge, for example, for a small number of large public bodies to work with so many small organisations.

Similarly, whilst the voluntary sector normally operates at the heart of local communities and can provide services effectively and more efficiently than statutory bodies, there are obviously costs associated with such services that need to be met. It is a mantra within the sector that voluntary action and volunteers do not come for free.

It is very pleasing that Dr Lincoln Sargeant with partners in North Yorkshire County Council and the NHS are so obviously keen to collaborate. We in the voluntary, community and social enterprise sector are keen to work with colleagues to help turn the dialogue into support for local people which further improves the profile and reach of public health across the County.

Jon Carling
Chief Executive North Yorkshire and York Forum

As local authorities take on the responsibility for public health, this provides opportunities as well as challenges for providers and commissioners. Commissioners need to know what environments and which services will help keep people out of hospital, offer value for money and provide more for less with proven benefits. Services need to be personalised, local, and user friendly.

The large rural nature of North Yorkshire with low population densities and distance between residential and commercial centres can bring challenges for local residents, especially those who are older and vulnerable, such as higher living costs, housing that is hard to heat and maintain, poor transport links and more limited social networks. Bringing services to people in sparsely populated areas requires innovative approaches which, if they are to reflect local needs and draw upon local support, depend on a thorough understanding of the way particular local communities are structured and perceive themselves.

There can be a strong sense of community spirit in our rural communities and while community action and volunteers can provide some solutions, it cannot do it all on its own, nor can this activity happen at no financial cost.

Government policy is focusing on the integration of services, and the "Better Care Fund" creates a local single pooled budget for health and local government to work more closely together around people, placing their WELLBEING as the focus of health and care services.

Community action and government policy need to go hand-in-hand, and the collaborative approach promoted in this report is welcomed. As the Voluntary Sector Representative on the North Yorkshire Health and Wellbeing Board, I feel that the sector can offer a wealth of expertise and connections which can help to inform, shape, deliver and review services and strategies around the health and wellbeing agenda. We particularly welcome the local priorities around **HEALTHY AGEING** and reducing **HEALTH INEQUALITIES**, and the focus on **PREVENTION** and early **INTERVENTION**.

Providing opportunities to participate in exercise, activities, explore and adopt a healthier lifestyle and eating regime, and valuing community based activities, are an effective tool to support physical, mental and social wellbeing.

Added benefits and value are in addressing social isolation, and through partnership approaches and volunteering opportunities, a way is provided that helps to diminish loneliness and provide a way back into the community for many people, and enable them to contribute again.

Sustainability is a major factor and investing in future capacity will be key to a successful wellbeing strategy.

Rural communities are growing and ageing faster than their urban counterparts, which means that demographic change is putting them at the forefront of tackling challenges and opportunities of an ageing society.

Both as individuals and collectively as a sector, we, in the voluntary, community and social enterprise sector, look forward to working with Dr Lincoln Sargeant and colleagues at North Yorkshire County Council, as well as the Health and Wellbeing Board to ensure people stay active, healthy and independent for as long as possible.

Alex Bird
Chief Executive Officer, Age UK North Yorkshire, and Voluntary Sector Representative on the North Yorkshire Health & Wellbeing Board

Introduction

This report has four main objectives. The first is to give an overview of the current state of health and wellbeing of the residents of North Yorkshire. This includes an assessment of the overall trends in healthy life expectancy as well as our performance with respect to variations between different communities – the two overarching measures of the public health outcomes framework (PHOF). The report focuses on a selection of issues representing the four domains of the PHOF – wider determinants, health improvement, health protection and healthcare public health that are particularly relevant at this time. In addition to a broad countywide overview, I have also highlighted issues for each of our districts. This section of the report complements the annual review of core data in the Joint Strategic Needs Assessment (JSNA) and the annual health profile produced by Public Health England for each district and the County as a whole.

There are, from time to time, topical issues that affect the health and wellbeing of our citizens which are relevant to several organisations in the County. This year, I have chosen the role of communities as promoters of health and wellbeing as a topic of special focus and the second objective of this annual report. Local communities across North Yorkshire played an active role in welcoming the world to the Grand Depart of the 2014 Tour de France and helped to ensure it was a resounding success.

As the public sector faces shrinking budgets, it looks more and more to the voluntary, community and social enterprise (VCSE) sector as partners in delivering services to residents. The importance of community resilience and community assets features increasingly in discussions about how we will ensure that the most vulnerable in our communities are supported during a period of prolonged austerity. While this interest is largely welcomed by the VCSE sector, it is recognised that there must be investment to ensure that communities have the necessary skills and resources to take on roles and functions previously delivered by public sector organisations.

There are two developing initiatives where VCSE sector contribution to the design and delivery of programmes is vital. NYCC is developing a Stronger Communities programme with the vision to foster vibrant communities in all parts of North Yorkshire. A key goal is to enable communities to effectively use their skills and assets to manage the delivery of some services that were previously operated by the Council. This will include the transfer of community assets from NYCC to community groups. The second is the Better Care Fund where VCSE bodies are involved in discussions with partners across Health and Social Care to redesign our current services to ensure that wherever possible, care is available at or close to home, to help people remain independent and to offer support when it is needed. In both cases, there needs to be on-going dialogue between the public and VCSE sector to ensure that proposals are realistic and deliverable on both sides if the aims are to be achieved.

Any definition of community includes a sense of place. A few generations ago, the place where we lived was the key factor in shaping our social contacts, perspectives and activities. Many people lived their entire lives in communities where they went to school, worked and socialised with people who shared the same basic life experience of belonging to that community and place.

The link between community and place grows weaker with each passing generation. As time goes by it will become increasingly unusual for children to be born in the same place or to go to the same schools as their parents and grandparents. We move freely around the UK and to other countries for work and our social contacts are more likely to be found in our mobile phones and computers than in our physical neighbourhoods.

These virtual communities offer new ways for people to support each other and may help to lessen the impact of social isolation for some groups.

Despite these social trends, community and place remain important. We value safety, vibrancy and community cohesion in the places where we live. Communities remain important influences on the lifestyle choices we make which in turn determine our health outcomes. We expect our communities to have a range of social amenities to enhance quality of life and we take notice when these facilities and services are lacking.

The JSNA which underpins our health and wellbeing strategy and informs our commissioning plans is based predominantly on the needs of communities with little emphasis on their assets. A focus on needs or deficits can at times dominate the way public sector organisations relate to communities. In this report, I want to put the spotlight on the inherent resilience of our communities and explore how community asset mapping combined with our traditional methods of needs assessment can help to produce a more balanced picture of our County and its communities.

The third objective is to review the main developments across the public health system in relation to the recommendations made in last year's report, as well as to highlight other significant events that have had an impact on the health and wellbeing of our residents. This year I also include a brief summary of the main activities of the Public Health Team in the first year post transition to the County Council.

The fourth and final objective is to make some recommendations to highlight key actions in the next year to promote and protect the health and wellbeing of our residents. It is my wish that this report will add to the rich discussion taking place among communities, VCSE and statutory partners about working together to make the best use of our collective assets to increase the resilience of our communities and improve the health of all residents.

I am very grateful to the many people who contributed to this report and have provided comments that have helped me to shape its contents. It has been my privilege and pleasure to work with the public health team in shaping a distinctive agenda for public health in North Yorkshire from our new home in NYCC in the last year. In this we have been supported by many colleagues in the Council and especially by the Executive Member for Public Health, Cllr Don Mackenzie. His appointment is tangible evidence of the commitment of NYCC to fulfilling its public health responsibilities and ensuring that public health features prominently in the work of the Council.

As always, I hope you find the report interesting reading and I welcome your comments and views on the issues raised.

Dr Lincoln Sargeant
Director of Public Health for North Yorkshire

Section 1: The Health of Our Communities

The conditions in which people grow, live, work and age have a powerful impact on our health. Strong communities with high levels of resilience thrive and people with good social networks live longer and have healthier lives. Recognising and understanding the enormous impact communities have on health and wellbeing is the first step we need to take in transforming the way we improve health in North Yorkshire. The social factors which influence health need to be considered alongside public health programmes and health and social care services if we are to improve the health of people in our County.

In addressing the public health issues in North Yorkshire we start by recognising the character, varying size, needs and assets of its many communities. Building on assets and fostering strong resilient communities will be key in developing a distinctive North Yorkshire public health approach.

In this section, there is a brief overview and commentary on the overarching public health outcomes showing that although residents of North Yorkshire continue to live long and healthy lives compared to the England average, there are significant variations between districts, communities and population groups.

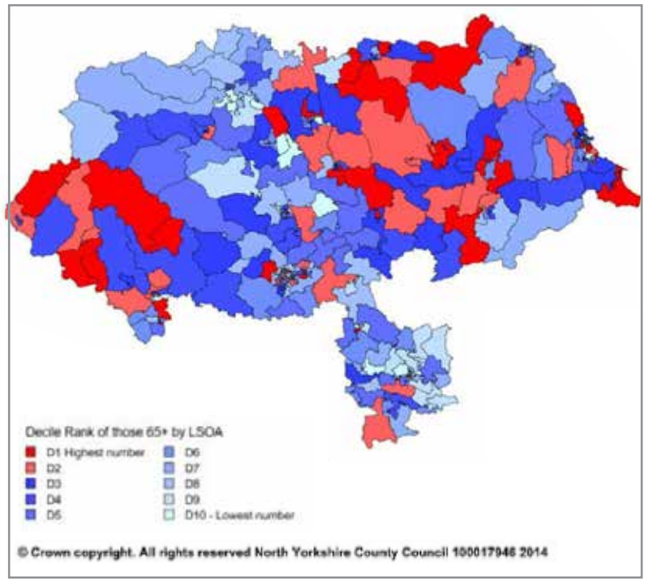
Of the 32 indicators included in the Public Health England (PHE) Health Profile for North Yorkshire in 2014 there were 20 that were significantly better than the England average and three that were significantly worse. There is a commentary on these three indicators (road injuries and deaths, smoking in pregnancy and excess weight in adults) as well as other public health issues under domains of health improvement, health protection and health and social care.

Finally, for each district there is a brief overview highlighting selected public health issues that may have particular relevance in that area.

North Yorkshire profile

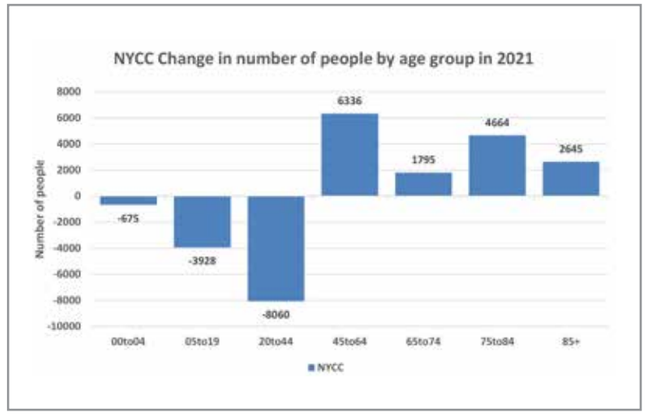
The current population of North Yorkshire is just over 600,000 and is increasing annually in size whilst the average age is rising. Within North Yorkshire geographical areas called lower layer super output areas (LSOA) with an average population of 1500 people are ranked into deciles by residence of those aged 65 and over, the red indicate the top 10 % of the LSOA that have the largest number of people of this age.

Figure 1: Population aged 65 and over for North grouped into deciles by number of residents - Source ONS 2012



The map demonstrates a challenge for the future as whilst many of these people live in or close by the major settlements in North Yorkshire, there are areas across the Dales and Moors that have a high proportion of elderly residents who may struggle as they age to access the services they need.

Figure 2: Population projections for North Yorkshire for 2011 and 2021 - Source ONS 2012



By 2021 if population trends continue the population of those living to over 85 years will grow by more than a third. This represents an increase of 2,645 people between 2011 and 2021. At the same time in North Yorkshire there is set to be a decrease in the 40-49 age group which is greater than England in magnitude. These trends mean that communities will look very different in the future.

[1]As the body ages, frailty ensues. An exact definition is difficult to agree though it is broadly agreed that frailty arises from a deterioration in the function of several physical and/or mental functions with age. The development of frailty often leads to a spiral of decline of increasing frailty and higher risk of worsening disability, falls, admission to hospital, admission to long term care and death. A Canadian study found that over 43% of those aged 85 and over could be considered frail. By this estimate for North Yorkshire 4,400 people over 85 years would be considered frail – this is the equivalent to the population of the village of Great Ayton.

Our collective challenge is maintaining the health gains for our residents in the face of a changing population profile with greater numbers of frail elderly people needing to be supported while the working age population declines in many areas of the County.

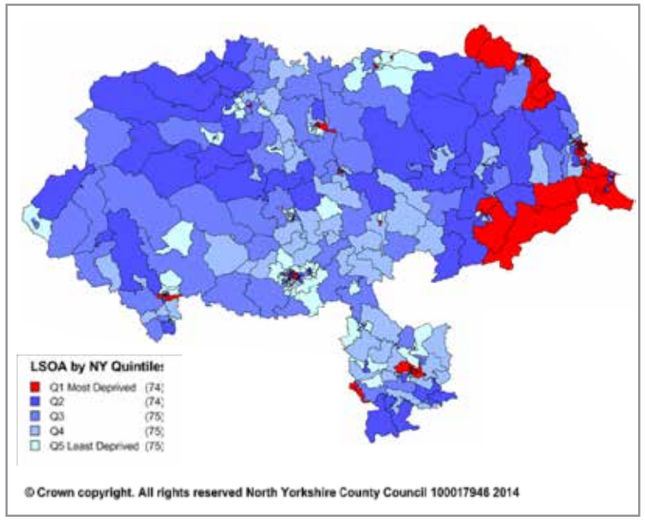
Deprivation is measured as a composite score combining data from seven domains into an index of multiple deprivation (IMD). Levels of deprivation are closely related to increased levels of need for health and care services. However, often deprivation is associated with poorer access to services and poorer health outcomes. Deprivation is significantly lower In North Yorkshire compared to the England average. Only 4.5% of people live in areas considered to be in the 20% most deprived areas in England. This may mask the impact of pockets of deprivation and issues relating to rurality, affordable housing and fuel poverty that are present in all districts and for some population groups.

The Index of Multiple Deprivation is a composite of indicators from seven domains of deprivation

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

[1] Rockwood K et al. Changes in relative fitness and frailty across the adult lifespan: evidence from the Canadian National Population Health Survey. CMAJ. 2011 May 17;183(8):E487-94

Figure 3: North Yorkshire LSOA IMD 2010 local Deprivation quintiles - Source ONS 2012



The majority of the most deprived LSOA across North Yorkshire are in the Scarborough district. There are densely populated deprived LSOAs in each of the major settlements across North Yorkshire. Selby has a particular concentration of deprived LSOAs along with parts of Harrogate and the southerly part of Skipton. Richmondshire has deprived LSOA around Catterick Garrison where the military families are housed.

The overall health of the population is measured by the life expectancy at birth which is the average number of years a new-born child can expect to live given current patterns in death rates within that area.

Figure 4: Male Life expectancy (in years) at birth trend data for North Yorkshire and England - Source ONS 2014

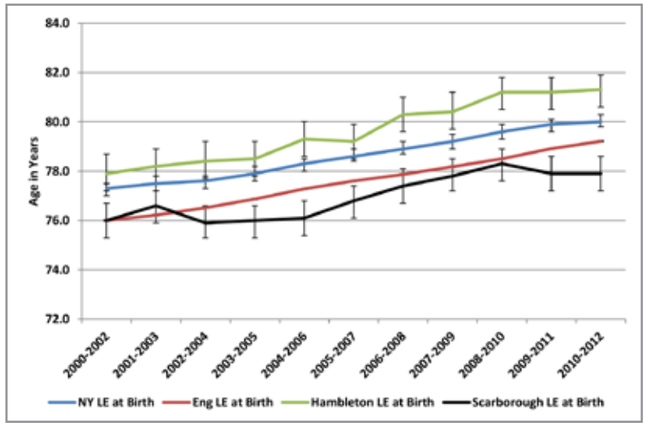
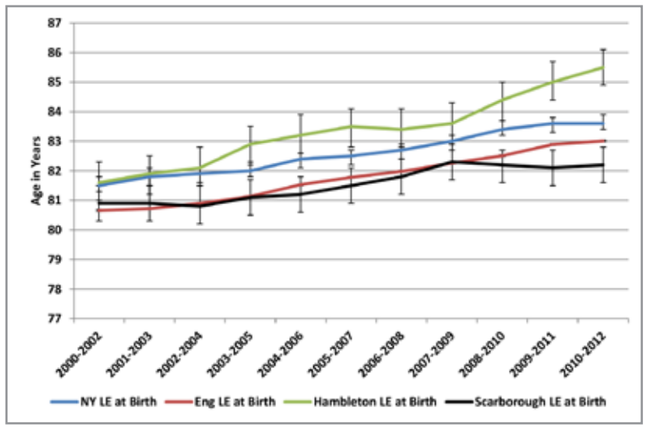


Figure 5: Female Life expectancy (in years) at birth trend data for North Yorkshire and England - Source ONS 2014

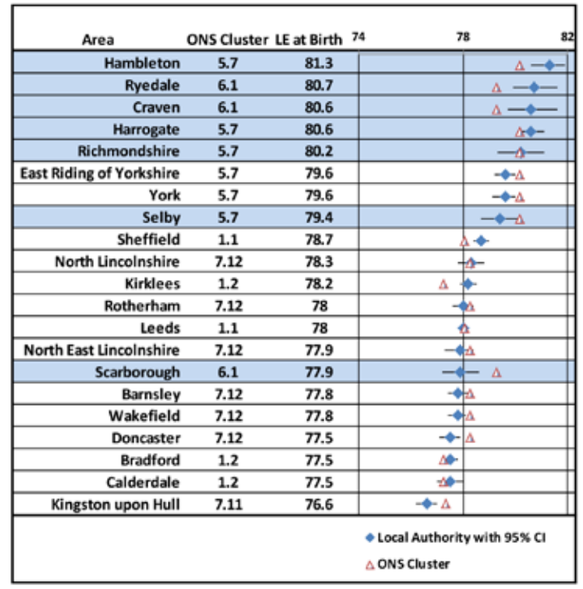


North Yorkshire has consistently had a significantly better male life expectancy when compared with the England life expectancy value. Over the last decade North Yorkshire male residents have been able to expect one year more life than the national average. This overall picture masks the difference between our districts. A boy born in Hambleton District can expect to live 2.1 years longer than the England average while one born in Scarborough Borough Council area would have 1.3 years less. The gap between these two districts has been widening over the last decade.

A similar pattern can also be seen in women. A girl born in Hambleton District is expected to live for 2.5 years longer compared to the England average. A girl born in Scarborough Borough Council area has a life expectancy that is 0.8 shorter by the same comparison, with the gap between Hambleton and Scarborough widening between 2000 and 2012.

Figure 6: Male Life expectancy (in years) at birth trend data for Yorkshire and Humber region - Source PHE 2014, ONS 2013

Area	ONS Cluster	LE at Birth
Hambleton	5.7	81.3
Ryedale	6.1	80.7
Craven	6.1	80.6
Harrogate	5.7	80.6
Richmondshire	5.7	80.2
East Riding of Yorkshire	5.7	79.6
York	5.7	79.6
Selby	5.7	79.4
Sheffield	1.1	78.7
North Lincolnshire	7.12	78.3
Kirklees	1.2	78.2
Rotherham	7.12	78
Leeds	1.1	78
North East Lincolnshire	7.12	77.9
Scarborough	6.1	77.9
Barnsley	7.12	77.8
Wakefield	7.12	77.8
Doncaster	7.12	77.5
Bradford	1.2	77.5
Calderdale	1.2	77.5
Kingston upon Hull	7.11	76.6

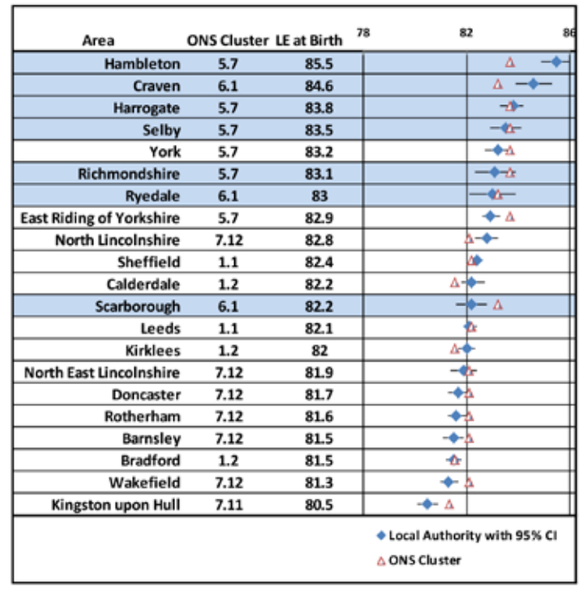


The variation in life expectancy at birth across North Yorkshire is noteworthy because the health of the population is also measured by the variation between communities for this indicator. Men in Hambleton District have the highest life expectancy in the Yorkshire and the Humber region. Life expectancy not only exceeds the England average but also that of comparator areas (Office of National Statistics (ONS) cluster of prospering towns).

By contrast Scarborough Borough Council ranks 15th of the 21 lower-tier or unitary local authorities in the Yorkshire and the Humber region having a life expectancy at birth for men that is similar to North East Lincolnshire (Grimsby) and Bradford and significantly lower than its ONS comparator cluster of coastal and countryside areas.

Figure 7: Female Life expectancy (in years) at birth trend data for Yorkshire and Humber region - Source PHE 2014, ONS 2013

Area	ONS Cluster	LE at Birth
Hambleton	5.7	85.5
Craven	6.1	84.6
Harrogate	5.7	83.8
Selby	5.7	83.5
York	5.7	83.2
Richmondshire	5.7	83.1
Ryedale	6.1	83
East Riding of Yorkshire	5.7	82.9
North Lincolnshire	7.12	82.8
Sheffield	1.1	82.4
Calderdale	1.2	82.2
Scarborough	6.1	82.2
Leeds	1.1	82.1
Kirklees	1.2	82
North East Lincolnshire	7.12	81.9
Doncaster	7.12	81.7
Rotherham	7.12	81.6
Barnsley	7.12	81.5
Bradford	1.2	81.5
Wakefield	7.12	81.3
Kingston upon Hull	7.11	80.5



The variation is similar though less marked for women. Hambleton District again ranks first in the region and Scarborough Borough Council is 12 of the 21 local authorities.

ONS Clusters

Area classifications group together geographic areas according to key characteristics common to the population in that grouping. These groupings are called clusters, and are derived using census data.

ONS 2014

Improving the Health of our communities

Figure 8: Ratio of median house price to median earnings, 2013 - Source ONS 2013

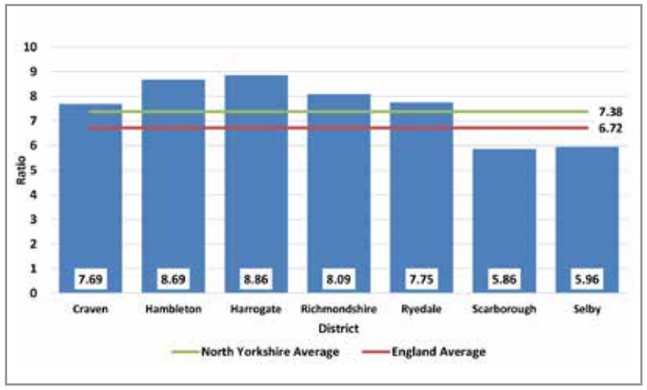
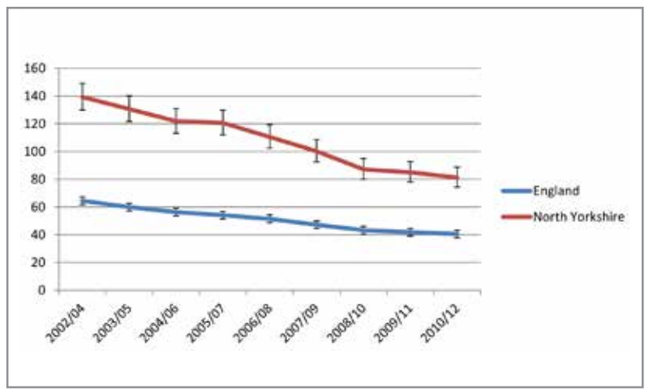


Figure 9: Killed or seriously injured on the roads in North Yorkshire (DSR/100,000) - Source HSCIC 2014



Housing

Access to housing of good quality is a major determinant of health and wellbeing. Low average levels of deprivation and low levels of homelessness and the natural beauty in North Yorkshire reflect some of the reasons why the area is such desirable place to live. A consequence of this is that the ratio of median income versus the median house price ratio has soared, making housing affordability challenging. In some rural areas, incomes are also very low or seasonal. The area is consistently higher than the national average for unaffordable homes. Five out of the seven districts are significantly higher than both the national and North Yorkshire averages.

In addition to affordability, most districts have only a very small proportion of one bedroom self-contained accommodation suitable for couples and those under 35 who cannot afford to live in the private rented sector due to recent welfare reforms and particularly vulnerable adults to live independently in their communities.

The North Yorkshire Strategic Housing Partnership, led by the Local Government North Yorkshire and York Housing Board, identifies and responds to key housing issues across the County. The current North Yorkshire Housing Strategy is due to be renewed at the end of 2014/15. A new strategy is in development for the period 2015 - 21 and will see the Housing Board working closely with the York, North Yorkshire & East Riding Local Enterprise Partnership (LEP). (http://www.northyorkshirestrategichousingpartnership.co.uk/)

Road traffic injuries

North Yorkshire performs very poorly on this indicator in comparison to the national average, although the rate has consistently been falling over time. However, more still needs to be done to understand the detail of this indicator and make improvements. There are different measures to express the impact of injuries on the roads. This indicator expresses the number of people killed or seriously injured in relation to the resident population in North Yorkshire. This does not take account of the number of miles travelled by road users or people who are resident elsewhere but are injured on our roads.

Though the 3 year moving average for road fatalities continues to decline by 3% a year, in 2013 there were 51 people killed in road collisions. This is the highest fatality number since 2007.

In contrast to the number of motorcycles on the road in any given day (1 in every 20 at peak times), close to 1 in 3 fatalities were motorcycle related. In addition to the 16 motorcycle deaths in 2013 there were:

- **25 car occupant deaths**
- **7 pedestrian deaths**
- **3 pedal cyclist deaths**

The largest majority of deaths from road collisions are male aged 40 to 49. Excluding motorcyclists, the profile is still male, though ages 20 to 29.

Over recent years there has been positive action by the 95 Alive Partnership to reduce this rate. The Partnership co-ordinates actions to improve road safety through road design and engineering measures like traffic calming where appropriate, and enforcing laws related to speed limits, seat-belts and child restraints and drink driving. This is combined with public information and education campaigns targeted at high risk groups in North Yorkshire such as young drivers, older drivers, and motorcyclists.

Visit 95 Alive, the York and North Yorkshire Road Safety Partnership at www.roadwise.co.uk

Additional funding from the Public Health grant has supported NYCC's Enhanced Pass Plus Scheme which offers newly qualified drivers the opportunity to reduce their insurance premiums whilst further developing their driving.

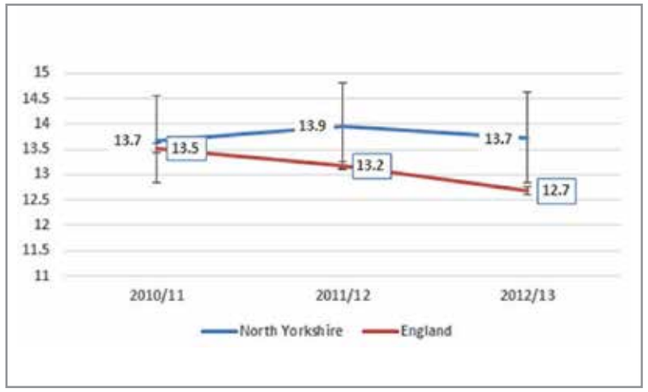
The scheme is based on the Driving Standards Agency (DSA) Pass Plus Scheme but is specifically targeted at the dangers new drivers face when on North Yorkshire's road network.

We have also supported the Partnership's programmes to help older drivers to maintain safe driving skills and to access screening to detect any problems with their eyesight and hearing that could affect their driving. These programmes help older people to maintain their independence in a rural county where many depend on their ability to drive to access services.

Road safety is an important issue for communities. People are more likely to walk and cycle if they feel there are safe routes and the risk of injury from speeding vehicles is minimised. In a report written for the British Academy ("If you could do one thing..." Nine local actions to reduce health inequalities), Professor Danny Dorling suggested that local communities might consider the introduction of 20 mile per hour (mph) zones. He projected that the potential benefits of reducing vehicle speeds through residential areas includes not only reduction in traffic related injuries, but also improved air quality, increased physical activity and improved community cohesion. However, the evidence for success for these schemes is mainly drawn from disadvantaged urban and metropolitan areas. The North Yorkshire Police area is already rated 4th lowest in the UK for its ratio of pedestrians and cyclists Killed or Seriously Injured, which suggests that the ability to reduce road casualty numbers through implementation of this measure is negligible. The potential for increasing walking and cycling as a result of 20 mph limits has yet to be established. The Department for Transport is currently undertaking a major study to identify and quantify the benefits and costs of these schemes; it is due to report its findings in 2017. NYCC will consider its position in light of these findings.

While "sign only" 20 mph speed limits are relatively easy to implement, the full benefits of a 20 mph restriction will only be achieved if vehicle speeds are reduced. In a lot of cases this requires the use of traffic calming measures such as speed humps or chicanes to make schemes self-enforcing so they do not become a drain on police resources. Traffic calming schemes are often unpopular with residents due to concerns about noise and vibration. The majority of deaths and serious injuries in North Yorkshire occur on roads that have speed limits above 40 mph, so this approach is unlikely to have a large impact on this public health indicator. Local communities considering this measure would therefore need to partner with the Police and road safety experts through the 95 Alive Road Safety Partnership Speed Management Protocol in order to find out whether there is a speed related issue in their area and then see what measures may be available to them that will make a difference. Other community solutions are currently being developed in North Yorkshire, including a scheme to hire temporary Vehicle Activated Signs and a police supported Community Speed Watch volunteer scheme, which will be able to undertake local activities to address these concerns with community based solutions.

Figure 10: Mothers Smoking at the time of Delivery in North Yorkshire - Source NHS England 2014



Smoking in Pregnancy

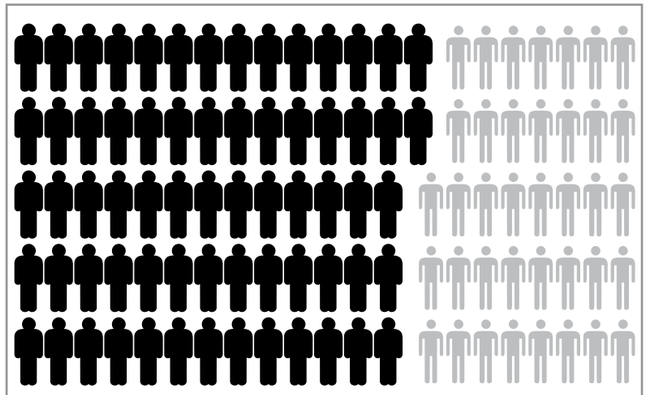
Smoking at delivery is a key indicator of the health of the mother and baby. North Yorkshire is in the lowest quartile of ONS cluster local authorities comparators. orth Yorkshire at the last published measure has become significantly worse when compared to England, for mothers who smoke at the time for delivery.

Smoking at delivery rates at Scarborough Hospital are higher than the national average. NYCC have committed additional funding from the Public Health Grant, along with funding from the local Clinical Commissioning Group (CCG) to support maternity and specialist services in Scarborough to decrease the smoking rate at delivery. NYCC have also commissioned additional social marketing in Scarborough to improve access to services and increase the proportion of women attempting to quit.

The Health Improvement Service has been commissioned to work across North Yorkshire to raise community awareness of the health and social impact of tobacco in all its forms. Through their day-to-day work professionals can link with the Smoking in Pregnancy Service and Stop Smoking Services to encourage people to take the first steps towards removing the harmful effects of tobacco from their lives to:

- Reduce the uptake of smoking.
- Encourage and support smokers to access Local Stop Smoking Services.
- Raise awareness and reduce the availability and acceptability of all forms of illicit tobacco.
- Motivate people to take necessary action to protect others from the harms of second hand tobacco smoke.

Figure 11: Ratio of adults who are categorisedas overweight or obese



Excess weight in adults

Excess weight in adults is a concern for North Yorkshire with 67.9% of the adult population being categorised as either overweight or obese. This value is greater than the England average of 63.8% and similar to areas such as Barnsley, Doncaster and Wakefield. Of note Ryedale district ranked in the top 10 districts nationally for adult obesity and there will be further comment in that district profile.

The National Institute for Health and Care Excellence (NICE) recommends that "Local authorities, working with other local service providers, clinical commissioning groups and health and wellbeing boards, should ensure there is an integrated approach to preventing and managing obesity and its associated conditions."

Prevention of obesity in adults needs to start in childhood. Effective multi-agency work has contributed to a decrease in the proportion of children with excess weight at reception over the last 5-6 years. We will ensure that our delivery of the Healthy Child Programme maintains a focus on preventing and managing childhood obesity. NYCC is working with the District Councils and local CCGs to develop an evidence-based integrated approach to weight management for adults. The first pilot was launched in Hambleton where clinicians can refer people into a structured 12-week programme to achieve weight loss and reduction of obesity associated illness.

District Councils have also taken a proactive approach to excess weight. Selby District Council has been working with their leisure provider Wigan Leisure and Culture Trust (WLCT).

Current status of Obesity Pathways in North Yorkshire

Tier 1	General information and advice about healthy eating and access to exercise is currently delivered by District Councils.
Tier 2	Structured multicomponent services are not currently available but being developed by NYCC.
Tier 3	A multi-agency specialist weight management service is not currently available but CCGs are scoping the commissioning of this service.
Tier 4	Bariatric services commissioned by CCG's (Individuals cannot access tier 4 without previously accessing tier 3 services).

Recommendation

NYCC, District Councils and CCGs should work closely to implement NICE guidance with regard to providing an integrated approach to preventing and managing obesity and its associated conditions ensuring that gaps in current services are addressed.

Move It and Lose It.

Move it and Lose it (MILI) is a two year pilot programme funded by Selby District Council. MILI is an adult weight management and physical activity programme promoting healthy eating and regular exercise and delivered in partnership with Slimming World.

During 2013/14 the programme has achieved significant outcomes in terms of participants' weight management. 42% of participants have lost at least 5% of their starting weight (a weight loss known to have significant clinical benefits) compared to a national average of around 37% in similar schemes.

Protecting the Health of our Communities

Health protection is concerned with protecting communities from health threats such as outbreaks of infectious disease or exposure to environmental hazards such as chemicals or radiation. These incidents are relatively uncommon but can be very disruptive to communities when they occur. In 2013 we had health protection incidents that affected not only whole communities but also impacting particular groups such as children, older people, military populations and work places.

Childhood immunisation programmes and Child Health Information Systems

The uptake of MMR vaccination at age five years remains a focus given previous low uptake of the vaccination. Uptake of the vaccine in North Yorkshire is currently similar to the England average but lower compared to ONS cluster group. The measles outbreak of 2012-13 uncovered gaps in the systems for data collection of childhood immunisation coverage across North Yorkshire.

The aim of Child Health Information Systems (CHIS) is to ensure that each child in England has an active care record, supporting delivery of, as a minimum, screening, immunisation and the Healthy Child Programme services. CHIS are usually provided by NHS trusts, often as part of Child Health Record Departments within those trusts that deliver some or all community child health services across the area covered by the CHIS.

It is intended that all CHIS should be able to fulfil the processing of data returns and statutory reporting requirements to support the NHS and PHE in the overall management of public health programmes, and to track progress via the indicators detailed within the Public Health Outcomes Framework and the NHS Outcomes Framework. However, due to historically different commissioning decisions and provider arrangements, nationally current CHIS vary significantly in their role and capabilities. The direction of travel is for all CHIS to be working towards meeting the requirements of the national service specification issued by NHS England and the Department of Health in April 2013, and its related information requirements.

Since April 2013, all CHIS have been commissioned by NHS England, and this will continue until at least 2020. Work is also on-going nationally to agree how CHIS will be commissioned in future, and taking into account any new learning from issues identified with the operation of CHIS across the country since April 2013.

Recommendation

NHS England should continue to work closely NHS England should continue to work closely with the provider of the Child Health Information Systems (CHIS) covering the child population of North Yorkshire to ensure there is an improvement plan to achieve delivery of the national service specification in accordance with national timescales, liaising with NYCC in respect of any current or future inter-dependencies in relation to commissioning, service provision and data or information flows.

Flu vaccination

Flu vaccination is a simple and cost effective way to prevent illness in the over 65 population as well as for people with long term conditions, thus reducing the need for health care and social care services. In the autumn/winter of 2014/2015 the annual nasal spray flu vaccine will be available for all children aged two, three and four years old as part of the NHS childhood vaccination programme.

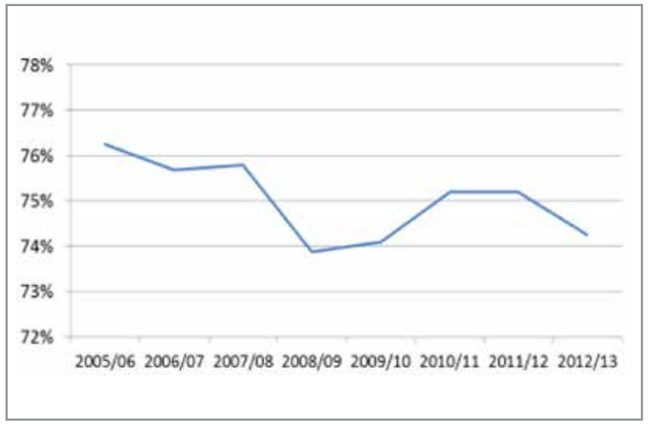
In North Yorkshire all secondary school-aged children in years seven and eight will also be offered the vaccine as part of a pilot programme.

Over time, as the programme rolls out, potentially all children between the ages of two and 16 will be offered vaccination against flu each year with the nasal spray.

Flu vaccination uptake has been declining in North Yorkshire over recent years.

There is scope for NYCC to work more closely with NHS colleagues to promote flu vaccine uptake in over 65s and at risk groups using customer service channels to raise the issue of having a flu jab. In addition, our campaigns will continue to stress the importance for frontline staff to get the vaccine in order to protect themselves and their vulnerable clients and patients from contracting flu. The flu vaccination campaign is a key measure in planning for winter health and forms an important part of a JSNA topic summary on winter health being developed with NHS and district council colleagues.

Figure 12: Population vaccination coverage in North Yorkshire – Influenza (aged 65 and over) - Source PHE 2014



Overview of outbreaks and lessons learned in 2013

Outbreaks occur because the conditions are right for an illness to spread through susceptible groups and communities. As seen with measles and flu, if vaccination rates fall consistently the risk of outbreaks from these vaccine-preventable diseases increase.

There were 125 outbreaks of infectious disease reported in North Yorkshire in 2013. The vast majority of these were outbreaks of viral gastroenteritis affecting care homes and health care settings. Viral gastroenteritis is often mild and settles by itself in a normal healthy adult but can be more distressing to an elderly population requiring care home provision. It is also disruptive to the health economy as a whole and adds more pressure to the NHS during the busy winter months in particular. Managing and reducing the numbers of infections and outbreaks is extremely difficult. The North Yorkshire and York Community Infection Control team work with care homes and other settings in North Yorkshire to educate staff, raise awareness and prevent and manage outbreaks. All health agencies work together to reduce or minimise the spread of infection, including other infections such as Clostridium difficile and MRSA.

Tyre Fire at Sherburn in Elmet

In general, people who are generally fit and well are unlikely to experience long-term health problems from temporary exposure to smoke from a fire but smoke is more likely to affect people who have existing breathing problems, lung or heart conditions (e.g. asthma, bronchitis, chronic pulmonary disease or heart disease). Some types of fires can be very difficult to put out quickly and may burn for some considerable time.

A large fire occurred at a waste recycling facility in Selby in January 2014 involving at least 2,000 tonnes of tyres. Emergency services in conjunction with local authority and public health partners ensured that messages to the public to stay indoors and shelter were given and local GPs and hospitals were contacted to monitor any increases in reported respiratory illness.

Air Quality

Since 1997 all local authorities in the UK have been carrying out a review and assessment of air quality in their area.

The aim of the review is to assist authorities in carrying out their statutory duty to work towards meeting the National Air Quality Objectives. If a local authority finds any places where the objectives are not likely to be achieved, it must declare an Air Quality Management Area there. There are currently four such areas across North Yorkshire, in Scarborough, Knaresborough, Ripon and Malton.

Tuberculosis (TB)

Tuberculosis is thought to infect approximately one third of the world population and despite the large reduction in cases throughout the post war period in the UK, the number of new cases increased between 1990 and 2005. London has the highest rate of infection within the UK and although TB does not spread rapidly in the same way as measles or flu the infectious nature of TB should not be underestimated. North Yorkshire has relatively low numbers of new cases each year and all cases require early diagnosis and treatment to ensure that these numbers remain low and that the risk of spread is minimised. Consideration is always given to whether schools, workplaces, hospitals, care homes and other settings need to be involved and if larger numbers of people need testing and follow up. This can be particularly difficult in some workplaces like factory settings where transient workers may have been at risk but have moved away. Even in North Yorkshire incidents like this are not uncommon.

Measles in 2013

From late 2012 and through 2013 the number of cases of measles reported across England increased and resulted in a national catch up campaign for 10-16 year olds being announced in April 2013. The cases mainly occurred in children of secondary school age due to a fall in MMR vaccination uptake seen between 1999 and 2005. No outbreaks were reported in secondary schools in North Yorkshire but an outbreak did occur in a prison in North Yorkshire in January 2013 that required co-operation from health providers to manage and was controlled by vaccination of remaining offenders and staff.

Outbreak of PVL infection at a military training facility

An outbreak of a particular bacterial infection called PVL (Panton Valentin Leucocidin) Staphylococcal aureus occurred in an army training facility during 2013. While this mainly causes skin infection this type of infection can be particularly severe and all cases require follow up. Outbreaks of PVL in military facilities when occurring at the same time as cases of respiratory infections such as flu can cause life threatening illness even in healthy adults. The army worked with PHE and the community infection control team to provide advice, follow up cases and prevent further infections.

Food poisoning and gastrointestinal infections

North Yorkshire has much higher rates compared to the region of some causes of gastrointestinal infections such as cryptosporidiosis and VTEC (E.coli O157) which can cause severe illness particularly in young children. This in part is most likely due to countryside, farming and animal sources of infection. Food poisoning notifications underestimate the true burden of disease and the actual number of people affected each year is likely to be much higher. Environmental Health Officers in conjunction with Public Health England follow up many cases of food poisoning each year to ensure that any common sources of infection are identified and risks minimised to reduce the risk of outbreaks occurring.

District Councils carry out proactive inspection programs to improve food safety across the County to reduce the burden of food poisoning outbreaks on health services and the economy and to maintain the reputation of tourism industry. Harrogate has the second highest number of food premises in the Country scoring 5+ on the national food hygiene rating system.

Figure 13: Confirmed and suspected outbreaks of Norovirus in North Yorkshire 2013

Confirmed and suspected outbreaks of Norovirus in North Yorkshire by Contextual Setting, 2013

Source: HPZone

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Care Home	5	7	9	8	4	3	2	3	2	4	7	4
Hospital	4	5	11	5	0	1	1	0	0	1	5	3
Nursery/School	0	0	2	0	0	0	1	0	2	1	0	6
Total	9	12	22	13	4	4	4	3	4	6	12	13

Figure 14: Incidence of Notification of Infectious Diseases – Food Poisoning Cases in 2013

Incidence of NOIDs Food Poisoning Cases in 2013

Source: NOIDs Dataset

	Cases (n)	Rate per 100,000	95% Confidence Interval
North Yorkshire	439	72.9	(66.2-80)
Yorkshire & the Humber	1985	37.3	(35.7-39)

Source: NOIDs Dataset

Health and Social Care in our communities

Ill health reduces the life span and quality of life. People with long-term conditions are more likely to need support to live independently than those without these conditions. In this section, the focus is on some of the physical and mental health conditions that lead to premature death, poor health and increased use of health and social care services. There is also mention of the Better Care Fund which is a national initiative for local authorities and the local NHS to work together to deliver improved health and social care services in local communities.

The Care Act 2014 creates a duty for local authorities to promote wellbeing when carrying out any of their care and support functions in respect of a person. In addition, it articulates a vision that the care and support system should work to actively promote wellbeing and independence, and does not just wait to respond when people reach a crisis point.

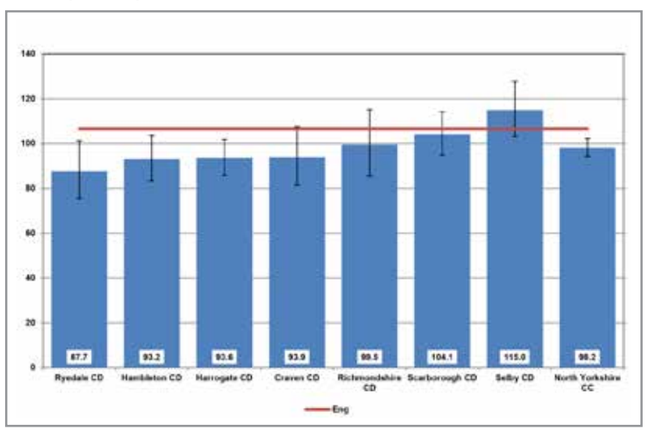
The big killers

Compared to last year North Yorkshire maintains a similar ranking for the rate of premature deaths (<75 years) within a local authority (ranked 36 out of 150 this year versus 34 last year). The pooled number of premature deaths (total under 75 deaths) for the period 2010–2012 was 5,371. The leading cause of death for those dying prematurely in North Yorkshire remains cancer, accounting for 43% of all deaths, followed by cardiovascular disease at 27%.

North Yorkshire premature mortality rankings from http://longerlives.phe.org.uk/

- **Overall premature deaths: 36 out of 150 authorities**
- **Heart disease and stokes: 44 out of 150 local authorities**
- **Lung disease: 30 out of 149 local authorities**
- **Liver disease: 24 out of 149 local authorities**
- **Cancer: 33 out of 150 authorities**

Figure 15: Premature Cancer mortality rate those aged under 75 for the pooled period 2010-12 - Source ONS HSCIC 2014



It is worth noting that the health experience of some groups may be poorer compared to the majority of residents. People with severe and enduring mental health problems often have poor physical health as do people with substance misuse issues. Some ethnic minority groups such as gypsies and travellers have lower life expectancy when compared to the general population.

In the last census in 2011 there were 588 gypsy travellers within North Yorkshire. A national study of Travellers' health status in Ireland published in 1987 showed a higher mortality rate for all causes in the Gypsy Traveller population. Life expectancy of Gypsy Traveller women was 11.9 years less and of Gypsy Traveller men 9.9 years less, than women and men in the non-Traveller population.

Barry J, Herity B, and Solan J. The Travellers' Health status Study, Vital Statistics of Travelling People, 1987. 1987. Dublin, Health Research Board.

Compared to the general population the risk of dying from all causes is increased in people with:

Substance misuse (Opioid) by a factor of	14.7
Substance misuse (Cocaine)	6.0
Substance misuse (Alcohol)	4.6
Eating disorder (Anorexia nervosa)	5.9
Learning disability (moderate to profound)	2.8
Mental illness (Schizophrenia)	2.5
Mental illness (Depression)	1.6
Heavy smoking	2.6

Chesney et al. Risks of all-cause and suicide mortality in mental disorders: a meta-review. World Psychiatry 2014;13:153–160

The health of people who are homeless is among the poorest in our communities. Being homeless means you are more likely to suffer from mental and physical ill health, and at the same time unable to access the health services you need.

The health needs of homeless people in North Yorkshire receiving a housing related support service showed that in 2010/11 that of 824 people, 33% had a support need relating to physical health, 32% mental health and 26% substance misuse.[2]

Among the most vulnerable homeless people are those with mental health and substance misuse problems who lead chaotic lives. This group represents a significant cost to all public services and therefore resourcing and commissioning specialist integrated services will be essential to reduce longer term demand and costs.

Rough sleeping is particularly an issue for Scarborough and Harrogate and both Borough Councils have done partnership work to improve access to services, including health, for rough sleepers.

[2] Homeless Link, 2010. The Health and Wellbeing of people who are homeless: Evidence from a national audit. Available at http://homeless.org.uk/health-needs-audit . Homeless Link. Survey of Needs and Provision (SNAP). Available at www.homeless.org.uk. The Queen's Nursing Institute Homeless Health Initiative Service User Consultation Report, February 2008. Available at www.groundswell.org.uk/documents/HomelessHealthInitiative.pdf. . The Department for Communities and Local Government. Vision to end rough sleeping: No Second Night Out. Available at www.communities.gov.uk

Mental Health

National estimates suggest that every year, one in four of us will experience a mental health problem. Public Health England estimate approximately 78,000 residents in North Yorkshire have depression. Approximately 36, 000 people in North Yorkshire accessed secondary mental health services in 2013. There are recognised gaps in provision of mental health services and all our CCGs have identified the need to increase investment to areas such as Improved Access to Psychological Therapies.

Across North Yorkshire it is estimated that at least 8,000 children aged between 5 and 16 have a mental health disorder[3]. Emotional health and wellbeing is an important issue for children and young people. Anxiety and stress relating to family environments or educational attainment and pressure to get high grades, poor body image and peer pressure in general are some of the main concerns that are not being adequately addressed. Access to specialist Child and Adolescent Mental Health (CAMH) services is not optimal and there is a lack of provision of prevention and early intervention services.

The Children and Young People's Emotional and Mental Health Strategy 2014-17 'Growing Up Happy in North Yorkshire' has now been produced. The strategy represents a commitment to ensuring that services meet needs while keeping children, young people and families at the centre of their care. It reflects the view that the emotional and mental health of children and young people is everyone's business. It sets out the intention that all children and young people will enjoy good emotional and mental health through the delivery of integrated support and targeted services, which are delivered at the earliest opportunity, in a way that is accessible and achieves positive and sustainable outcomes. The Implementation Plan for the strategy is currently being developed.

Although most people living in rural areas experience high quality of life, the risk of social isolation and loneliness is increased, especially among older people. Over a third (37 per cent) of people aged 65 and over in North Yorkshire are living alone, and nearly a half (43 per cent) have a limiting long-term illness or a hearing impairment which increases the likelihood of social isolation and loneliness. These percentages are based on projected population numbers for the County and districts, derived from Projecting Older People Population Information (POPPI) data version 8.0, www.poppi.org.uk .

NYCC is working with partners to develop a countywide mental health strategy with a proposed vision to: 'Ensure people of all ages and backgrounds receive support to attain good mental and physical health to build their resilience. And people with mental health problems are supported to achieve their goals through delivery of cost effective and integrated services'

Recommendation

Statutory and VCSE partners should continue to work together to develop a North Yorkshire Mental Health Strategy to ensure there is a co-ordinated approach to improving the mental health and wellbeing of the population of all ages, improving outcomes for people with mental health problems and combating the stigma and discrimination associated with mental illness.

[3] Source –ChiMat CAMHS Needs Assessment Data, accessible via http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=34 (accessed October 2013)

Better Care Fund

The Better Care Fund has been created, to encourage the NHS and Local Government to work together to create plans that will improve care for the elderly and vulnerable. Overall, the Government has created a £3.8bn (£39.8m locally) pooled budget for 2015/16, intended to help move care out of hospital and into the community and improve working and integration between Health and Social Care.

Up to £1 billion (£10.5m locally) of the Better Care Fund will be allocated to local areas to spend on out-of-hospital services, aimed at reducing the number of emergency admissions to hospital.

Partners across Health and Social Care are working to redesign our current services to ensure that wherever possible, care is available at or close to home, to help people remain independent and to offer support when it is needed. This will require greater investment in community services, whether 1) Primary Care such as GPs and District Nurses, 2) community health care settings such as local clinics or community hospitals or indeed 3) through social care where more support will be available to help people regain skills and confidence to remain in their own home.

All our consultations with communities and patients point in the same direction. People understand the financial climate. They say they want to be supported to live at home and use services as near to home as is possible and safe. They want to be active participants in their communities and families and only tell their story once. The Better Care Fund Plan describes how our shared investment will:

- Improve self-help and independence for North Yorkshire people;
- Invest in Primary Care and Community Services;
- Create a sustainable system by protecting Adult Social Care and by working with Secondary Care to secure the hospital, mental health and community services needed in North Yorkshire.

In North Yorkshire, the VCSE will be key partners in helping to shape and deliver some of these services working with their health and social care colleagues.

Recommendation

NYCC, district councils and NHS partners should make the most of the opportunities presented by the Better Care Fund and the shift towards integrating services to respond to community needs and maximise the use of community assets working closely with the VCSE where possible.

District profiles

Scarborough

There are 53 communities in Scarborough Borough Council ranging from the largest town of Scarborough with a population of 52,800 to small rural villages in the North Yorkshire Moors National Park like Danby (1,380). The economy is based on tourism and the level of long term unemployment is highest in North Yorkshire. The Borough has the highest crime rates in the County but these are generally low and falling.

In terms of recorded violent crimes attributable to alcohol, Scarborough again has the highest incidence in the County at a rate of 5.1 per 1,000 population which is slightly above the national average (5.03 per 1,000). However, these figures are distorted by crimes committed by people who are among the large number of visitors to the coastal towns of Filey, Scarborough and Whitby who are not included in the resident population figures for Scarborough Borough. Scarborough is part of the Home Office/Public Health England Local Alcohol Action Area (LAAA) programme to tackle the harmful effects of irresponsible drinking, particularly alcohol-related crime and disorder, and health harms.

The deprivation across the district is concentrated mainly around the large towns of Scarborough and Whitby. Some of the most deprived communities also have a significantly higher level of transience and churn which makes any approach to community resilience more challenging and both plans and resources need to reflect the rapid changes in these communities. The ethnic profile is predominantly white. Voter turn-out, trust in the public sector and volunteering levels are low compared to the County but there is interest among residents in getting involved in their local communities.

Of the 32 indicators included in the Public Health England (PHE) Health Profile for Scarborough in 2014 there were 4 that were significantly better than the England average and 9 that were significantly worse.

Figure 16: 2010 Index of Multiple Deprivation Ward Quintile Rank within Scarborough Borough

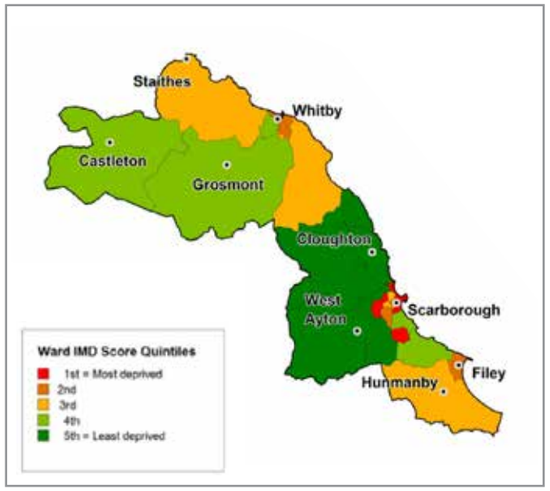
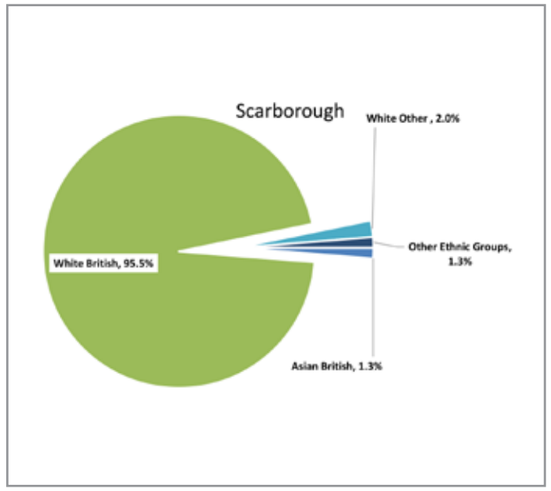


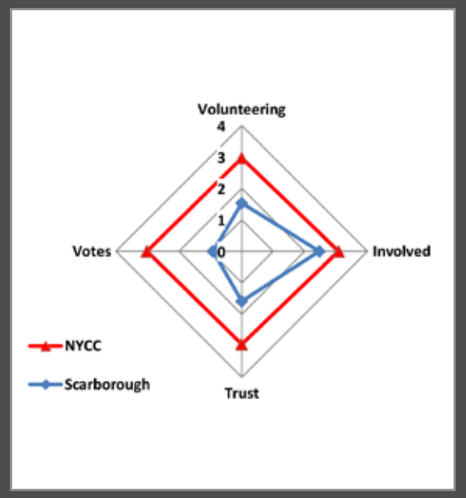
Figure 17: Ethnic groups as a % of total district population for Scarborough - Source ONS Census 2011



The chart shows z scores of the district responses to the respective domains of social capital. The higher the score the more likely the district area is to engage in that activity.

The volunteering element is the score based on the number of respondents in a NYCC survey who volunteer some of their time each week. Votes are the voter turnout at the last council election. Involved is the score based on the number of respondents who want to get involved in communities. Trust again is the score of respondents who feel public sector organisation are working for the communities best interests

Figure 18: Social Capital index for Scarborough - Source NYCC PHI Team



Premature death from heart disease and stroke is one of the indicators where the rate of mortality for those aged under 75 is significantly higher in Scarborough when compared to the national average and to North Yorkshire. Levels of physical inactivity and adult obesity are also significantly higher in the Borough compared to the national average. The estimated smoking rate in Scarborough is higher than the national average and one of the highest for North Yorkshire. These are all factors that increase the risk of heart disease. As noted violent crime related to alcohol is an issue and so is premature deaths from liver disease which is also associated with alcohol.

NYCC commissions the NHS Health Check as a mandated Public Health programme designed to reduce premature mortality by assessing people's risk of heart disease, stroke, kidney disease and diabetes and connect them to lifestyle and clinical services. The Health Check also provides the opportunity to identify issues with problem drinking. Those eligible for the programme (aged between 40 and 74 and not already on a disease register) are invited on a five year cycle. The programme is delivered by GP practices in North Yorkshire.

NYCC has been working to raise awareness of the programme especially in the Scarborough Borough area. The invitation rate for GP practices in Scarborough and Ryedale CCG was the highest in the County in 2013/14 at 18.2% compared to the North Yorkshire average of 15.3 %. Of those invited, 47.8% took up the offer in Scarborough compared to 47% for North Yorkshire and 49% nationally.

Figure 19: Male premature liver mortality rate (those aged under 75) for the pooled period 2010-12 - Source ONS HSCIC 2014

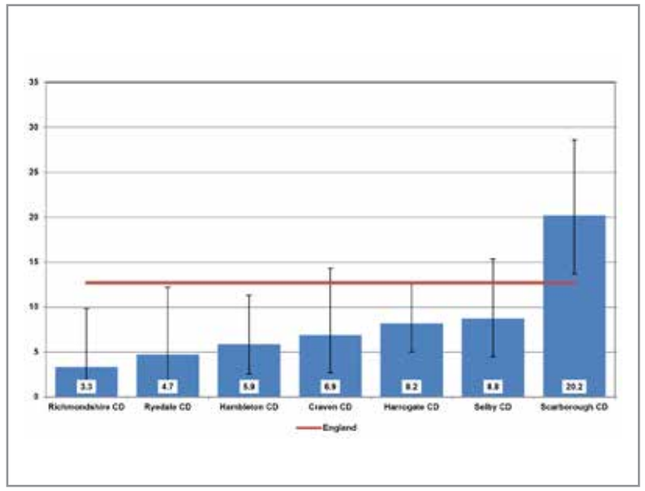


Figure 20: 2010 Index of Multiple Deprivation
Ward Quintile Rank within Ryedale District

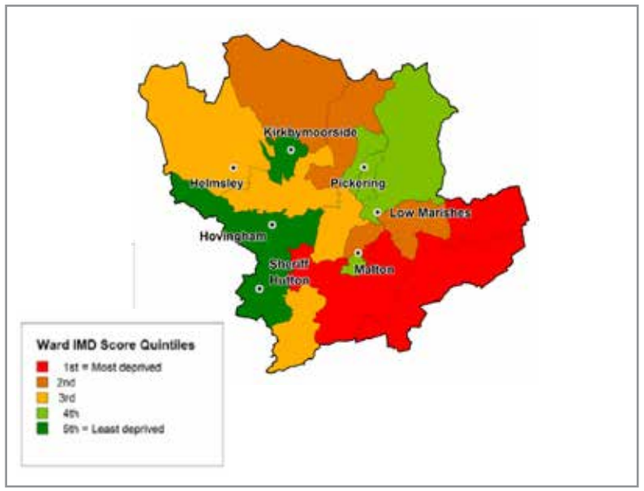


Figure 21: Ethnic groups as a % of total district population for Ryedale - Source ONS Census 2011

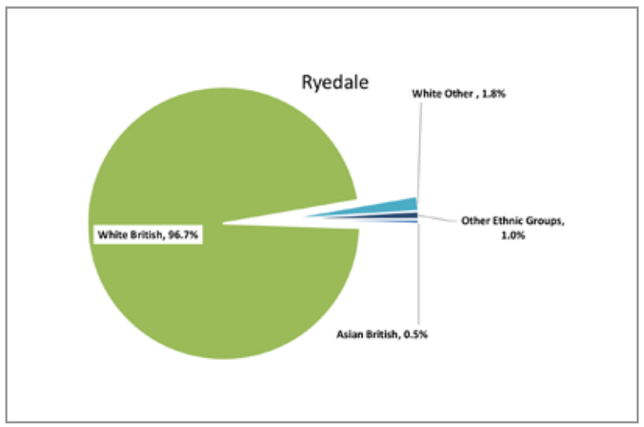
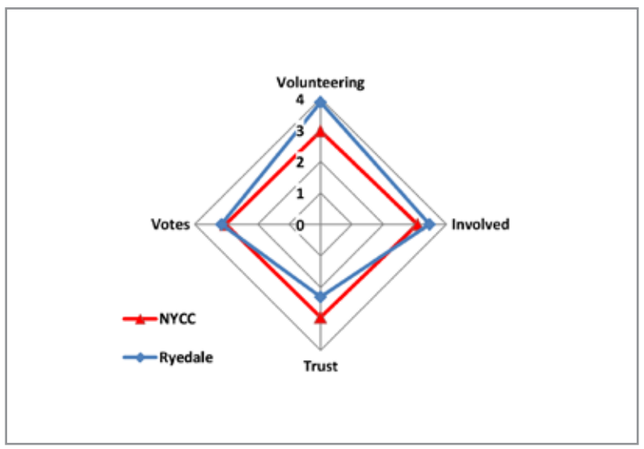


Figure 22: Social Capital index for Ryedale - Source NYCC PHI Team



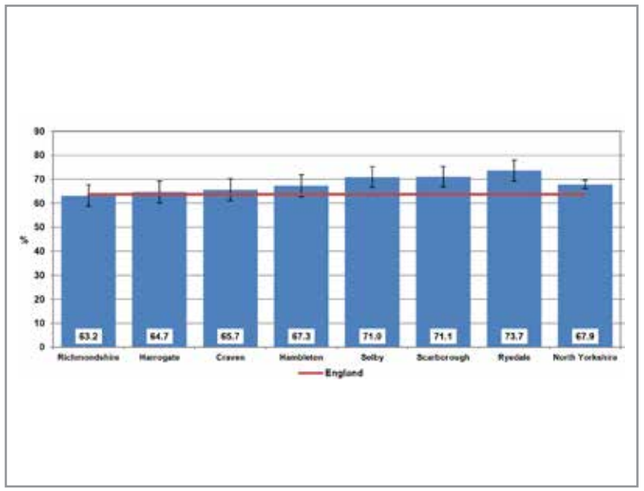
Ryedale

Ryedale is a rural district with a population density of 36 people per km2, below the North Yorkshire average of 75 and well below the national average of 401. Ryedale has 114 communities. The largest is Norton with 7530 people. Other large settlements are Pickering, Malton and Kirkbymoorside. The area has higher than national average levels of obesity along with high level of smoking and binge drinking when compared to national rates.

Rural deprivation is the key issue for the district and the ethnic profile is predominantly white. There are high scores on all domains of the social capital index.

Of the 32 indicators included in the Public Health England (PHE) Health Profile for Ryedale in 2014 there were 17 that were significantly better than the England average and 2 that were significantly worse (road injuries and deaths and excess weight in adults).

Figure 23: Excess Weight in Adults



The indicator for excess weight in adults for Ryedale was the highest in the County. The estimate was based on a survey of self-reported weight measures and was available for the first time in the 2014 PHE Health Profile. It is worth noting that this indicator was not significantly worse compared to the North Yorkshire average and that the percentage of people reported to be physically active in the district was reported at 60.9% (significantly higher than the England average of 56%). The risk of adult obesity is greater for those who are obese as children.

As with other areas in the County a lifestyle service to deliver structured weight management interventions has been proposed in Ryedale. The district is also re-procuring its leisure services.

As part of the plan to reduce obesity in children our children's centres have built a healthy eating approach into all their activities, so for example, healthy snacks of fruit and vegetables are provided at all sessions for parents and children. Weaning sessions are run in conjunction with health visitors to support parents in making the transition to appropriate solid foods. Health visitors also attend "play, stay and weigh" sessions where children's height and weight can be monitored and advice given. Active Kid sessions are promoted and activities take place in outdoor areas, such as local parks, to normalise and encourage physical exercise. This has meant that in Ryedale there has been a drop in obesity in children from 10.8% to 8.8% from 2011-12 to 2012-13.

Figure 24: IMD 2010 Electoral Ward Quintile rank with Richmondshire District

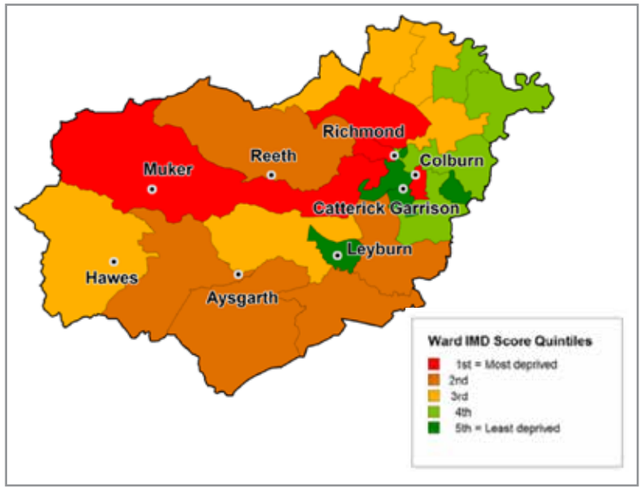


Figure 25: Ethnic groups as a % of total district population for Richmondshire - Source ONS Census 2011

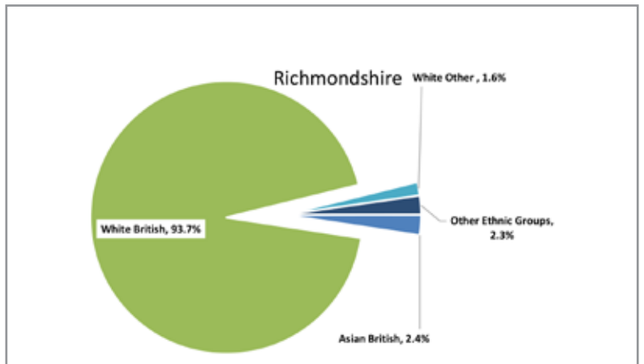
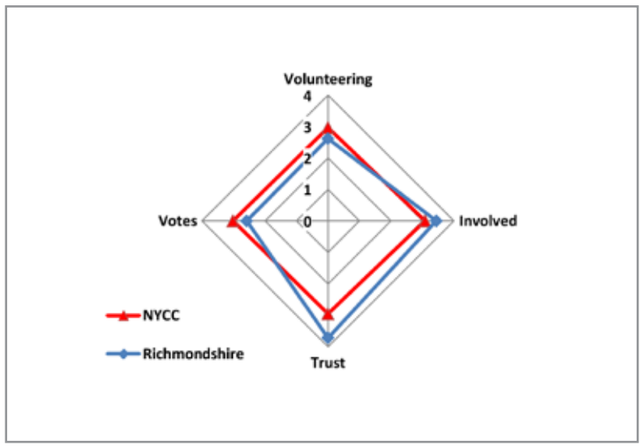


Figure 26: Social Capital index for Richmondshire - Source NYCC PHI Team



Richmondshire

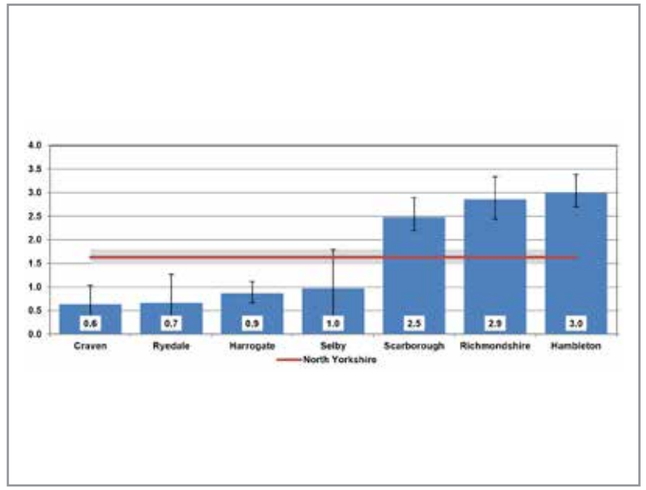
Richmondshire is a rural district with a population density of 40 people per km2, below North Yorkshire average of 75 and well below the national average of 401. Its only major town or settlement with a population over 15,000 is Catterick Garrison, home to 15,040 people. Its second largest town is Richmond, home to 8,540 people. The MOD employs 6,680 military personnel and many civilians in Richmondshire. Many private and public sector jobs exist to service the military personnel and their families and this military linked economy is important for Richmondshire. There is a thriving tourism industry within Richmondshire and this now forms the economic bedrock of the district.

Richmondshire district has a differing age structure to most of the other districts in North Yorkshire, having a large male population between 15 and 29. This is explained by the presence of Catterick Garrison which is the largest Army training base in the Country as well as housing several regiments.

Rural deprivation is the key issue for the district. There are also pockets of poverty in Colburn, an old council estate with poor housing and ex- military families. The ethnic profile is predominantly white but the presence of a large military population mean that there is greater representation of multiple ethnicities compared to other areas. There were high scores on all domains of the social capital index.

Of the 32 indicators included in the Public Health England (PHE) Health Profile for Richmondshire in 2014 there were 15 that were significantly better than the England average and 1 that was significantly worse (road injuries and deaths).

Figure 27: Statutory homeless households, crude rate per 1,000 estimated total households, 2012/13 - Source LGA 2014



Military personnel and their families have particular challenges related to separation, loss and family breakdown. Homelessness and mental health issues are therefore areas of concern for this district. Richmondshire had the second highest rate of suicide in North Yorkshire for the pooled period 2011-2013; this was 15 people in the time period.

There are well established multi-agency initiatives to prevent homelessness and to support veterans and vulnerable military families. Local schools recognise the needs of military families and offer support to children whose parents are deployed.

Figure 28: IMD 2010 Electoral Ward Quintile rank with Selby District - Source NYCC Corporate Information Systems Team

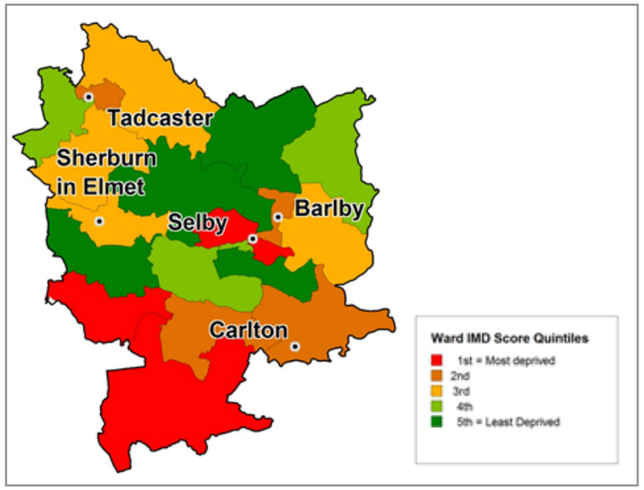


Figure 29: Ethnic groups as a % of total district population for Selby - Source ONS Census 2011

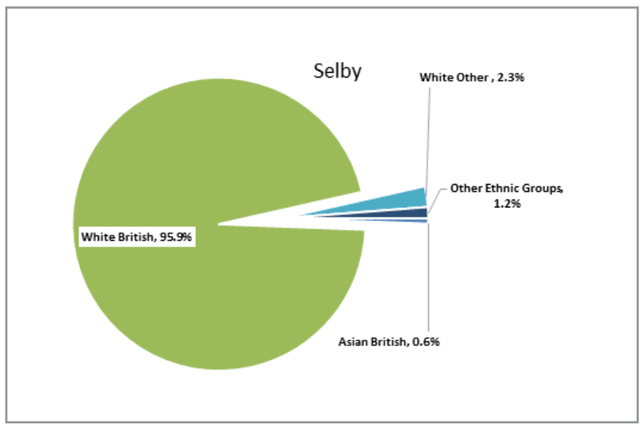
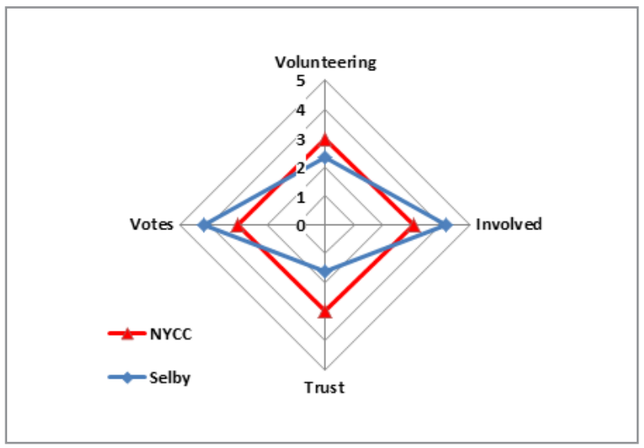


Figure 30: Social Capital index for Selby - Source NYCC PHI Team



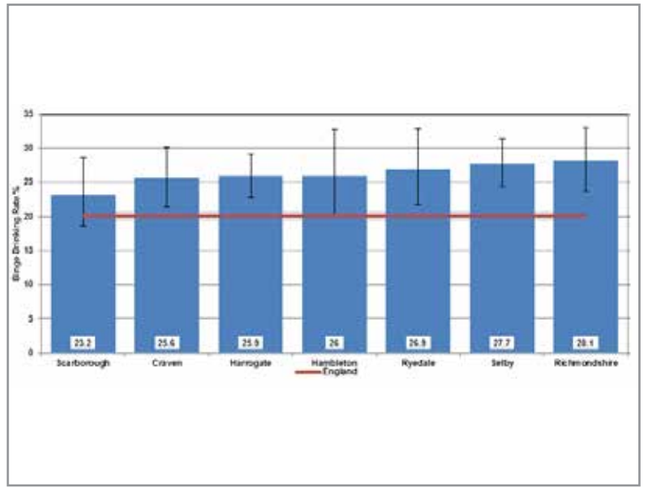
Selby

Selby has a population density of 138 people per km2, above North Yorkshire average of 75 but well below the national average of 401. Selby town, with a population of 24,680 is its only major town or settlement with a population over 15,000. Sherburn in Elmet and Tadcaster are the other large towns or settlements in the district. The rest of Selby district settlements are small rural villages such as Thorganby which has a population of around 330.

Selby town is more industrial than other areas of North Yorkshire which contrasts with the rurality of the rest of the district. Areas of deprivation are mainly in Selby town and the area around Eggborough. There is a concentration of industries and power stations, as well as road networks near the south west area of the district. Voter turn-out and willingness to get involved with the local community are high but levels of trust in the public and volunteering are lower.

Of the 32 indicators included in the Public Health England (PHE) Health Profile for Selby in 2014 there were 10 that were significantly better than the England average and two that were significantly worse (road injuries and deaths and excess weight in adults).

Figure 31: Binge Drink adult estimates by district - Source LAPE Alcohol Profiles 2013



Binge drinking is an issue for Selby as well as for other districts in the County. The drinking risk categories also show that Selby district has the largest percentage of increasing risk drinkers at 21.3 %. Selby also has a significantly higher rate of premature mortality for cancer when compared to the North Yorkshire value and ranks highest in the district.

Partners across the County including Selby District Council have agreed a countywide alcohol strategy and identified three outcome areas:

- Establish responsible and sensible drinking as the norm.
- Identify and support those who need help into treatment through recovery.
- Reduce alcohol-related crime and disorder.

A detailed action plan is being developed to ensure that there is a co-ordinated approach to reducing levels of binge drinking in Selby and across the County.

Figure 32: Index of Multiple Deprivation Ward Quintile Rank within Hambleton District

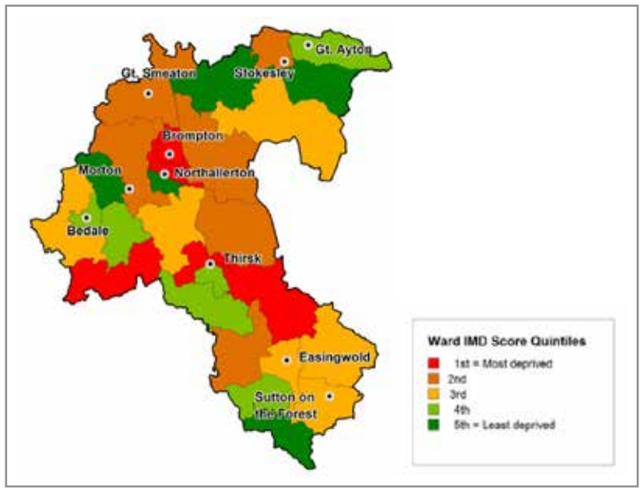


Figure 33: Ethnic groups as a % of total district population for Hambleton - Source ONS Census 2011

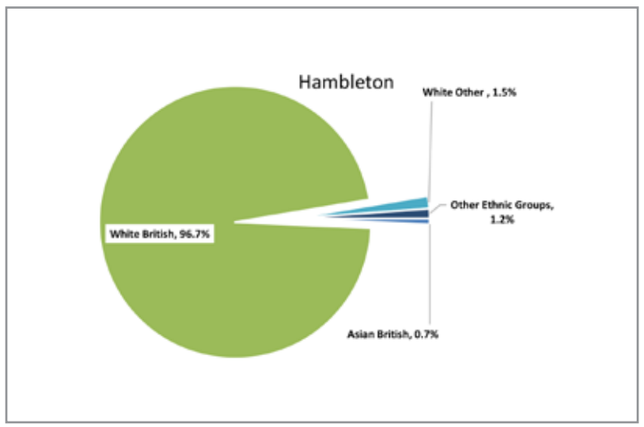
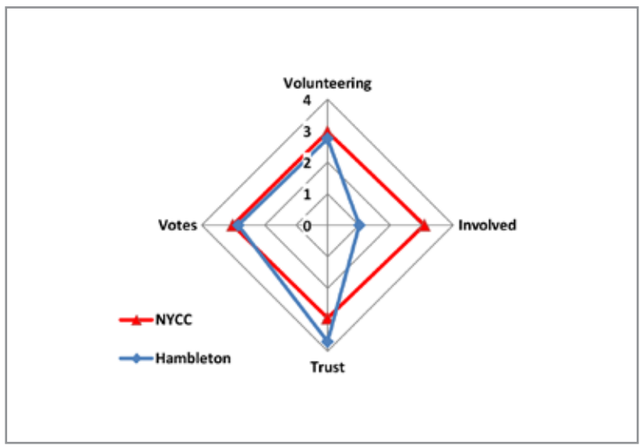


Figure 34: Social Capital index for Hambleton - Source NYCC PHI Team



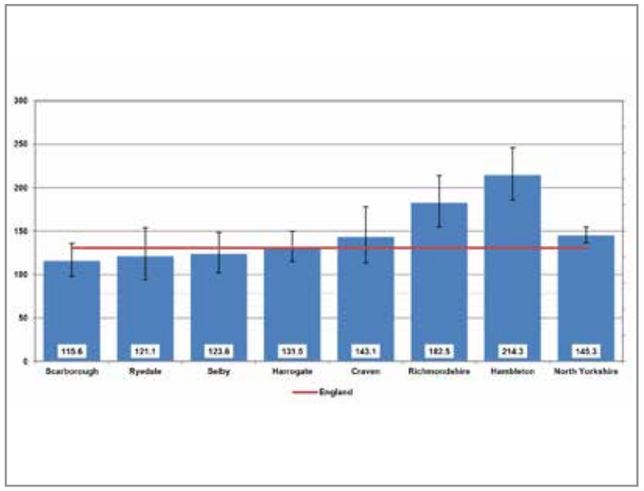
Hambleton

Hambleton is a rural district with five major centres, Northallerton being the largest of these. It is the only town with a population over 15,000 and is home to 18,730 people. The second largest town is Thirsk with a population of 9,940. Hambleton has the largest number of settlements of all the districts at 177. It is a rural district with a population density of 67 people per km2, below the North Yorkshire average of 75 and well below the national average of 401.

The economy is based around agriculture, forestry and fisheries along with manufacturing. There are areas of deprivation in some of the towns as well as rural deprivation in parts of the district. The ethnic profile is predominantly white and there were high scores on all domains of the social capital index except involvement.

Of the 32 indicators included in the Public Health England (PHE) Health Profile for Hambleton in 2014 there were 19 that were significantly better than the England average and 1 that was significantly worse (road injuries and deaths).

Figure 35: Hospital admissions caused by unintentional and deliberate injuries in young people DSR per 100,000 (aged 15-24) 2012/13 - Source NSCIC 2013



Hospital admissions for those aged under 25 has recently become an issue in Hambleton with the number of young people being admitted for unintentional and deliberate injures reaching 370 in 2012/13. The district is significantly higher when compared to the national rate and also when compared to the North Yorkshire rate. An analysis of the data suggests that the issue is with older teens and young adults (aged 15 – 24 years). Further work is needed to understand the underlying causes for this increase.

Figure 36: Index of Multiple Deprivation Ward Quintile Rank within Craven District

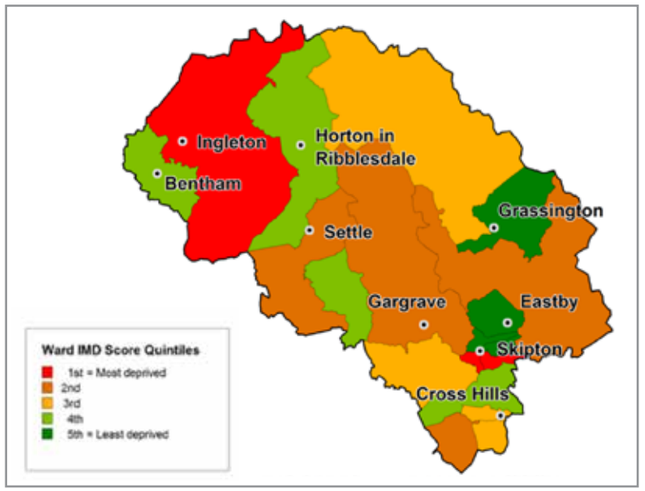


Figure 37: Ethnic groups (excluding white British) as a % of total district population for Craven - Source ONS Census 2011

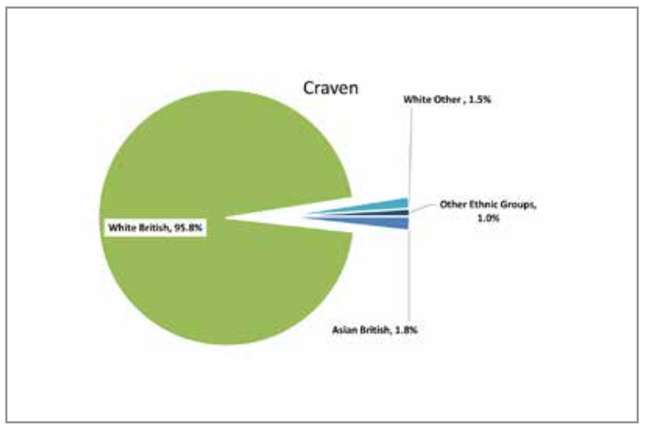
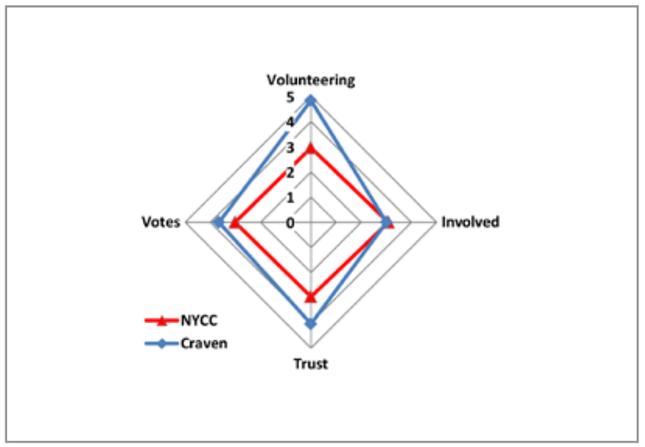


Figure 38: Social Capital index for Craven - Source NYCC PHI Team



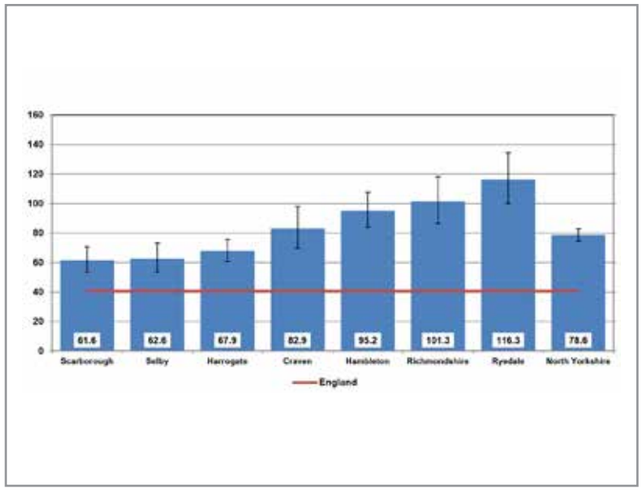
Craven

Craven is a rural district with a population density of only 47 people per km2, the third lowest in North Yorkshire and the fifth lowest in England. It has no major towns or settlement with populations over 15,000. Its largest town is Skipton with a population of 14,530. The district has 77 communities which other than Skipton are rural villages such as Airton which has only 180 residents. The economy is dominated by the distribution, hotels and restaurants sector, which reflects the importance of tourism. Another key employer is the banking, finance and insurance sector, within which Skipton Building Society is a major employer.

Rural deprivation is an issue as well as pockets of deprivation in south Skipton. The ethnic profile is predominantly white and there were high scores on all domains of the social capital index.

Of the 32 indicators included in the Public Health England (PHE) Health Profile for Craven in 2014 there were 17 that were significantly better than the England average and 1 that was significantly worse (road injuries and deaths).

Figure 39: Occurring KSI (killed or seriously injured) casualties per resident population, rate per 100,000, 2010-12 - Source: HSCIC 2014



Fuel poverty is an issue for Craven as well as for other very rural districts in the County. The rurality coupled with the housing type makes affordable heating a challenge. Many properties are far from the gas network, meaning they have to depend on more expensive fuel to heat the home and are more susceptible to fluctuating fuel prices. There is also a high prevalence of stone built housing that is difficult to insulate. The situation is exacerbated because many solid wall dwellings are in conservation areas and in the National Park which adds to the constraints of external works that can be undertaken.

NYCC is leading a joint strategic needs assessment of affordable warmth across the county to inform the approach to ameliorating the impacts on the most vulnerable households. Joint work is on-going in the district to improve housing hazards that could lead to ill health from excess cold, trips and falls and increased burden on the NHS and social care services. This work is jointly funded by Craven District Council, Airedale, Wharfedale and Craven CCG and NYCC.

As with all districts Craven has a significantly higher value for those killed or seriously injured on the roads when compared with the national value and ranks in the middle of the seven districts with respect to this indicator.

Figure 40: 2010 Index of Multiple Deprivation Ward Quintile Rank within Harrogate Borough -

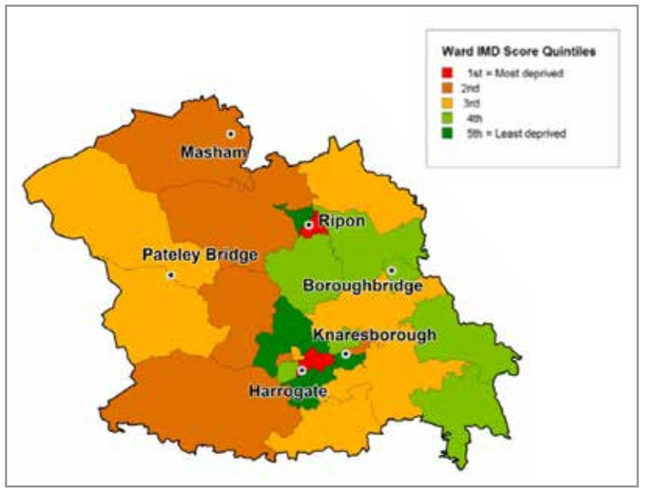


Figure 41: Ethnic groups (excluding white British) as a % of total district population for Harrogate - Source ONS Census 2011

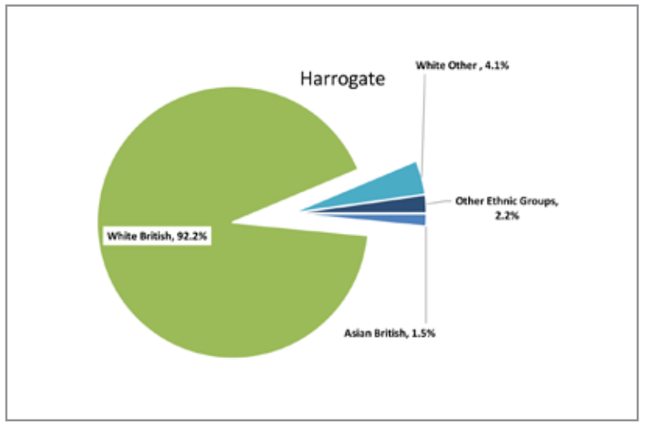
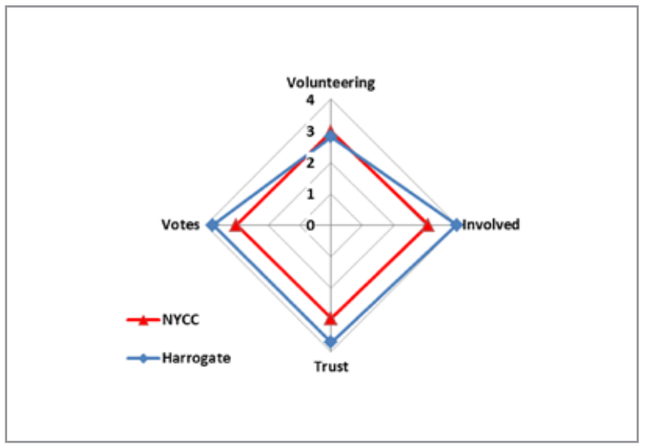


Figure 42: Social Capital index for Harrogate - Source NYCC PHI Team



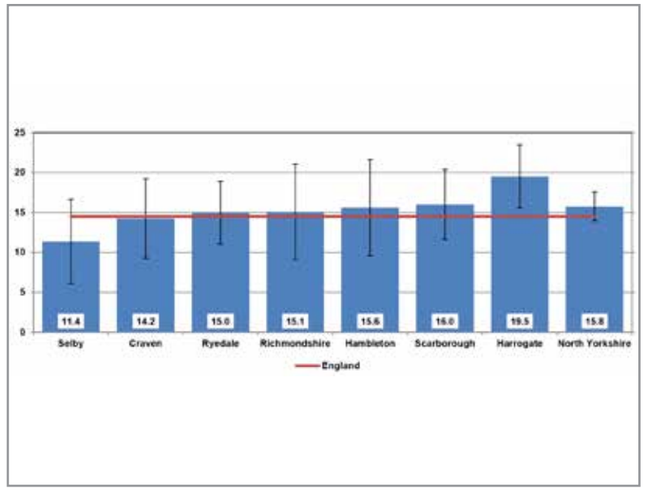
Harrogate

Harrogate district has three major towns or communities with a population over 15,000; Harrogate town, home to 74,720 people, Ripon (17,180 people) and Knaresborough (15,410 people). There are 139 communities in Harrogate district ranging in size from Harrogate town to small rural villages such as Warsil with only 30 residents. Tourism contributes 25% to the district's economy making it the key area of business for Harrogate. Harrogate International Centre hosts around 150 events per year and attracts in excess of 290,000 visitors each year, and is consistently acknowledged to be one of the UK's top event venues.

The district has a population density of 121 people per km2, above the North Yorkshire average of 75 but well below the national average of 401. Rural deprivation is an issue as well as pockets of deprivation in the towns. The ethnic profile is predominantly white and there were high scores on all domains of the social capital index.

Of the 32 indicators included in the Public Health England (PHE) Health Profile for Harrogate in 2014 there were 18 that were significantly better than the England average and 2 that were significantly worse (road injuries and deaths and incidence of malignant melanoma).

Figure 43: Incidence of malignant melanoma for all persons aged under 75, DSR (Rate per 100,000), 2008-10 - Source HSCIC 2014



Harrogate over the last five years has continued to have a high incidence of malignant melanoma and in the most recent analysis continues this trend. The incidence of malignant melanoma when compared to England is significantly higher in Harrogate. One third of cases of malignant melanoma in the County occur in Harrogate. Several factors may contribute to the trend. Sun exposure (frequent holidays abroad to sunnier climes) and sun bed use are known risk factors. Specialists have also reported a high proportion of a sub-type of malignant melanoma that occurs in older people which is in keeping with the population profile of the district. A combination of increased awareness in the population as well as an expanding catchment for dermatology services for the local hospital may also contribute to more cases being diagnosed and attributed to the district.

Difficulty of housing affordability is a particular issue for Harrogate. This has an impact on the level of homelessness and number of households living in unsuitable accommodation, in terms of size, level of amenity and condition, all of which have a potential adverse health impact. The district also has a substantial number of disabled people living in unsuitable accommodation requiring aids or adaptations to support them in their homes.

Section 2: Taking an asset based approach to improving the health of communities

In the previous section we looked at the public health profile of North Yorkshire and its seven districts. We used the Public Health Outcomes Framework and other information to highlight the health gains as well as the challenges for our communities. We sometimes focus on the health problems or deficits that need to be remedied when we are developing services or initiatives to improve the health of individuals and communities. A deficit approach can be taken by public sector providers when an unmet need is identified and a new service is commissioned to meet the need. Another approach is to ask what skills, capacity, knowledge or resources individuals or communities have that can be used to improve their health and the health of the community. This is an asset based approach.

In this section we explore the potential of using an asset based approach to improving the health of communities in North Yorkshire. We will look at some of the key assets that communities have in terms of skilled people, infrastructure, economy and organisations and groups that can be better mobilised to increase health gains. We will outline ways that communities can identify and use some of these assets to address our public health challenges.

A health asset is any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses.

A glass half-full, I&DEA 2010

Why take an asset based approach?

A growing body of evidence shows that when services begin with a focus on communities assets as opposed to what they need, a community's ability to meet its own needs increases (A glass half-full, I&DEA 2010[4]). Asset based approaches support the building of local networks that encourage mutual help, supportive friendships and the capacity for communities to act together in their shared interests.

"Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. Social networks have a larger impact on the risk of mortality than on the risk of developing disease, that is, it is not so much that social networks stop you from getting ill, but that they help you to recover when you do get ill."

Marmot (2010) Fair Society Healthy Lives Final Report[5]

Local networks can strengthen the ability of individuals and communities to act as co-producers of health rather than just consumers, thus helping to reduce demand on limited resources. However, the asset approach does not replace all investment in improving services or tackle the structural causes of variation in health outcomes. While it may help reduce demands on services in the long term and bring about more effective services, it should not purely be seen as a no-cost or a money-saving option. The aim is to achieve a better balance between traditional service delivery and community self-sufficiency by helping to build more cohesive, resilient communities. An asset based approach works best when it is driven by the community, from inception using the local skills knowledge and resources to map their community. An asset map is only useful to a community if it is made by a community and used by the community.

"Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change."

Boyne and Harris, 2009, The challenge of coproduction. How equal partnerships between professionals and the public are crucial to improving public services. (P11)

What are community assets?

What can be included as an asset of a community is very wide ranging. They can be split into four main categories[6]:

Assets of organisations and groups

The organisations that exist within a community and the potential assets that exist within the organisations, e.g. a church may, beyond being a place of worship for its members, also have a meeting space, a copier, chairs, tables, storage and a kitchen.

The type of organisations that should be considered include local authority, NHS, schools, colleges, police, fire service, libraries, churches, parish councils, local businesses, voluntary organisation, community groups and social enterprises

Physical Assets

The natural and built environment of the area such as parks, recreation areas, vacant land, cycle ways, buildings, bridges, street lights, roads, gardens, playgrounds, historical landmarks, public transport, etc. Key considerations could be:

- What natural elements exist within the community?
- What open spaces exist?
- How is land used? How would people like to see the land being used?
- What buildings or structures exist within the community?
- How are the buildings or structures used?

Economic Assets

How money is earned, spent, and invested within the community. Things that can be considered include occupations, major industries and services, community wealth, untapped economic resources, access to goods and services, and circulation of money. Key considerations could be:

- How does the community spend money on a regular basis?
- How does money stay in or leave the community?
- Does the community make their money outside or within the community?
- What forces outside the community influence its economic health?

Assets of individuals

The people who actually live and work within a community is potentially a key community asset. Among the assets that individuals may be able to bring to their community include:

- Skills they have learned at home, school, in the community, or at work.
- Hobbies or interests. What are they really good at? What could they teach others?
- Ways they have been involved in the community. How do they want to be involved in the community?
- Skills, talents, resources, materials, or supplies they have that they would be willing to share with neighbours or put towards a community effort.
- Existing (or prior) membership of groups or networks. What, if any, groups or networks would they like to be a part of or help to form?

[4] A glass half-full. How an asset based approach can improve community health and well-being. Improvement and Development Agency, 2010. http://www.local.gov.uk/c/document_library/get_file?uuid=bf034d2e-7d61-4fac-b37e-f39dc3e2f1f2&groupId=10180

[5] Fair Society, Healthy Lives. The Marmot Review, 2010. http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

[6] Development of a Method for Asset Based Working, Commissioned by NHS North West, www.nwph.net/hawa/writedir/da0dNW%20JSAA.pdf

Local example of Asset Mapping

Asset Mapping- The South Skipton Community Project in Greatwood and Horseclose

Aim: To make Greatwood and Horseclose a great place where people are proud to live and enjoy, and where everyone has the opportunity to achieve his or her fullest potential.

Traditional consultation techniques have been extensively used and have largely only ever resulted in a small percentage of the estates contributing their views. There was a clear need to try something new.

New ways of gathering information

Film based consultation

The project has commissioned a series of films provoking conversation, interest and debate about the Greatwood and Horseclose Estate. The clips aim to raise expectation and interests in future projects, encourage a greater on-line presence in the community, and encourage greater ownership and a positive start to the South Skipton programme from the community itself.

Photo walks

The community held a photo walk where conversations were generated about living in the community and photos taken highlighting the assets and positive images of the community.

We are proud of the community itself, the resilience and personal stories of individuals on the estates and the commitment of key community activists. Film clips are a great representation of the potential that exists on the estates. Despite facing considerable personal adversity, people show remarkable capacity to respond, change and adapt. They also show a willingness to help each other which is admirable.

Harnessing the assets of individuals

> ***"Social capital can be described as the degree of social cohesion in communities. It refers to the interactions between people that lead to social network, trust, coordination and cooperation for mutual benefit"***
>
> **National Institute for Health and Care Excellence, Community Engagement PH9, 2008)**
>
> **There are three kinds of social capital described: Bonding – close ties between similar groups such as family and close friends; Bridging – looser ties with wider groups such as through social networks of colleagues and; Linking – alliances between people of different power and status**

The impact of social capital on health

The more interaction between people, the greater sense of community spirit. So having strong social networks increases your social capital.

Well known lifestyle factors such as smoking, excessive alcohol consumption and high cholesterol are powerful predicators of mortality, but social networks are an equally powerful predictor of mortality[7]. Having strong social capital reduces the likelihood that people will take lifestyle risks such as smoking[8]. This can be down to people having supportive relationships that encourage them not to smoke. Also people follow social norms so if the social networks around you are non-smokers then you are less likely to smoke. Unfortunately the most deprived communities report a lack of support with almost 50% reporting a severe lack of support[9]. This increases their risk to unhealthy risk factors and less resilience to the health effects of economic and social disadvantage.

There is strong and growing evidence that social capital and social networks can increase resilience to and recovery from illness and lifestyle risk factors. Social factors are key determinants of health and therefore can be tackled by social action. Building strong communities is core to asset based working as it increases the ability of individuals and communities to co-produce rather than solely be consumers of health and care services.

Local authorities have a role in cultivating social capital particularly now that local authorities have responsibility for public health. Beyond that, partner organisations (public, private and voluntary as well as local communities) play a vital role in creating conditions that are conducive to improving and sustaining good health and wellbeing.

Working with communities as equal partners with strengths and assets that they bring to the table, helps activate all resources in the area to improve health and wellbeing. Asset mapping, volunteering and time-banking are examples of approaches that build upon the skills of people in community.

Voluntary action has always been strong in North Yorkshire. The role of voluntary organisations is key in communities and offers something invaluable. Volunteering can improve the health and wellbeing of those who receive support from volunteers as well as the volunteers themselves. It is a key enabler of community resilience.

The term "community resilience" captures the notion of a community being able to respond to and recover from adversity, the ability to bounce back. The Carnegie UK Trust and Fiery Spirits report on "Exploring community resilience in times of rapid change" proposes four key characteristics (or dimensions) of communities that are becoming more resilient:

- **Healthy and engaged people**
- **An inclusive culture creating a positive sense of place**
- **A localising economy – towards sustainable food, energy, housing etc.**
- **Strong links to other places and communities**

[7] Pantell M, Rehkopf D, Jutt D, Syme SL, Balmes J, Adler N (2013). 'Social isolation: a predictor of mortality comparable to traditional clinical risk factors'. American Journal of Public Health, vol 103, no 11, pp 2056–62.

[8 & 9] Buck, D and Gregory, S. (2013) Improving the public's health. A resource for local authorities. The Kings Fund

Defining Volunteering

Volunteering England define volunteering as

"any activity that involves spending time, unpaid, doing something that aims to benefit the environment or someone (individuals or groups) other than, or in addition to, close relatives. Central to this definition is the fact that volunteering must be a choice freely made by each individual. This can include formal activity undertaken through public, private and voluntary organisations as well as informal community participation"

www.volunteering.org.uk/iwanttovolunteer/what-is-volunteering

We recognise the enormous value of both informal and formal volunteering. When we talk about volunteering in this report we are specifically referring to unpaid work that benefits others to whom one owes no obligation, via an organisation that supports volunteering in health and social care[10]. Although the work is unpaid it is not to say that the organisation that coordinates the work is not funded. Voluntary organisations need financial support to ensure that they can support their volunteers - if programmes are not well organised and coordinated then volunteers can become disengaged.

How many people volunteer?

Across Yorkshire and the Humber there are approximately 300,000 to 350,000 volunteers giving over 25 million hours per year (Involve Yorkshire, 2011). This equates to contributing £3.5 billion to the regional economy. There are 5,324 voluntary and community sector organisations (VCS) in North Yorkshire and York (Harrogate and Ripon CVS, 2014).

Impacts of volunteering on the recipient's health and wellbeing

Receiving support and help from a volunteer can be very beneficial and wide ranging. General benefits include:

- Increased self-esteem
- Improved disease management and acceptance
- Improved mental health.

As well as general health and wellbeing improvements, volunteers can have a direct impact on key public health agendas. Volunteers have demonstrated that they can improve breastfeeding rates. A study has shown that 15% more mothers breastfeed when they had volunteer support compared to those women who did not have any support from a volunteer[11]. Volunteering programmes can also improve the parenting skills of those they work with as well as supporting people to adopt healthy behaviours[12].

Volunteering programmes such as befriending can help reduce social isolation, exclusion and loneliness. All of these issues affect a number of people across the County, particularly those who live in rural towns and villages or along the coast where we see higher rates of deprivation.

Volunteers can support people to navigate the often complex health and social care system. Having support to do this improves access to the services that people need.

Impact of volunteering on the volunteer's health and wellbeing

Being a volunteer can have a really positive impact on health and wellbeing. Evidence suggests that being a volunteer can improve:

- Social engagement/social support
- Ability to cope with one's own illness
- Quality of life
- Sense of purpose.
- Better mental wellbeing (for older people)
- Better cognitive functions (for older people).

Younger people volunteering can often be a way in to paid employment or gaining qualifications, both of which benefit health and wellbeing.

[10] Egerton M, Mullan K (2008) "being a pretty good citizen: analysis and monetary valuation of formal and informal voluntary work by gender and educational attainment". British Journal of Sociology, vol 59,no 1, pp145-4

[11] Dennis, C. L., E. Hodnett, et al. (2002). "The effect of peer support on breast-feeding duration among primiparous women: a randomized controlled trial." CMAJ :Canadian Medical Association journal 166(1): 21-8.

[12] Mundle, C., Naylor, C., and Buck, D. (2012) Volunteering in health and care in England 2012. The Kings Fund

Touchstones Bereavement Project, Harrogate District.

Purpose: **When an older person loses their partner, not only do they lose their lifetime companion,** they also lose the person that supported them in their day to day life.

The project **supported older bereaved people to learn new skills and to share their own know how with others.**

How it works: Sessions were planned around **the needs and suggestions of the clients who attended the project and the clients' own skills and interests.**

The impact on people lives: Clients come to the group and grow in **self-confidence and self-esteem.** They have joined at probably one of the lowest points in their life, yet they have come to the sessions and actively participated and contributed. Likewise I have seen volunteers grow in confidence. Friendships have developed within the group and I am delighted that these now extend outside of the project as clients and **volunteers support each other further.**

Although the aim of the project was for clients to learn new skills and share their own knowledge, the health and wellbeing of all clients and volunteers was paramount and underpinned the project.

The opportunity to socialise each week and make new friends has greatly contributed to **reducing feelings of loneliness and isolation** often encountered by older bereaved people. In addition the project has boosted the **wellbeing** and confidence of volunteers, particularly two volunteers who came to the project having been made redundant.
For more information please contact: **Wendy Holt, Daybreak Project Co-ordinator, Age UK North Yorkshire. Tel: 01423 530628 Mobile: 0759045885**

Benefits to the wider health and social care system
Volunteering plays an important role from a broader health and social care perspective. The voluntary and community sector can respond quickly on the ground to the changing needs in the community. The VCSE also play a vital role in potentially being able to communicate with groups or communities that are seldom heard, such as people with mental health issues and learning disabilities. Volunteers give their valuable time to groups such as Advocacy Alliance in Scarborough, Whitby and Ryedale. They provide advocacy for a variety of people who need their support, enabling members of the community to understand their rights and make their voices heard on the issues that are affecting them.

Voluntary and community organisations can feed-back community issues and knowledge to inform strategic planning and service delivery. This creates greater patient and community engagement[13] and empowers communities to be involved in issues that affect them, whilst shaping services to fit the needs of the community.

Advocacy Alliance – Scarborough, Whitby, Ryedale

Aim: To provide advocacy for any person aged 18 or over with a learning disability, physical disability, sensory impairment, mental health issue, dementia, substance abuse or frailty/temporary illness.

The need for advocacy in the local community was identified in 1991 when our charity was registered. Our advocates (approximately 40) are trained volunteers or members of our trustee board. We work closely with other providers in the community and statutory services and our service is communicated by word of mouth, adverts in local press and radio, leaflets, posters in communal areas, networking at meetings.

Our feedback suggests most clients have benefited from our service. Having support to understand their rights and make their voices heard enables them to participate in the issues they bring to us, e.g. support at reviews, letter writing, visits to GPs, safeguarding meetings, child protection meetings, conflicts with carers/service providers, complaints procedures or any meeting or issue where they don't understand or don't feel listened to.

Service providers have stated they also feel that advocacy involvement can be beneficial in enabling good communication. Independent evaluation of the parents' advocacy found advocacy 'invaluable'.

We are most proud of the volunteers and the loyalty and time they give to their local community providing advocacy support. We offer regular training sessions and updates and value them very much.

For more information telephone **01723 363910, www.scarboroughadvocacy.co.uk**

[13] Paynor J (2011) Volunteering and Health: Evidence for the Impact and implications for policy and practice. London: Institute of Volunteering Research.

Help at Home Service from Harrogate Easier Living Project

Harrogate Easier Living Project helps older, disabled or vulnerable people to stay independent at home for longer by providing the following services:

- Practical support: DIY, decorating, gardening for people who are no longer able to do these tasks.
- Regular respite for carers; through short breaks and occasional holiday support.
- Transport and support: enabling people to go where they need or wish to, accompanied by a volunteer, e.g. medical appointments, social/leisure activities.

Some volunteers have gone on to use our services and some service users have become volunteers, which gives a unique insight of great value to the project.

Over the past three years, 391 people have said that our services have improved their health and wellbeing, enabling increased access to activities of their own choosing, reduced isolation and anxiety.

For more information please contact www.harcvs.org.uk/HELP 01423 813090 Frances Elliot, Project Manager

Is volunteering a good investment?
For every £1 spent on health volunteering programmes the return is between £4 to £10[14]. The return in this investment is shared between the organisation, service users, volunteers and the wider community. The key is that this investment helps to harness the talent and assets that communities and volunteers have and can result in better experiences for people accessing services, improved engagement and improved health and wellbeing for all those involved. It is not about simply saving money.

How can you volunteer?
There are enormous opportunities to volunteer across North Yorkshire. If you would like to become a volunteer or would like to know more about the services the VCS offers, there are volunteer centres across the County. Their contact details, and those of thousands of voluntary and community organisations, can be found via the sector-wide website V-hive (www.v-hive.org.uk), and there is more information on North Yorkshire County Council's website.

Opportunity to Volunteer

Please search here for local volunteering opportunities.

www.v-hive.org.uk/support/Volunteering

www.do-it.org.uk

North Yorkshire County Council – Volunteering opportunities across the County in areas ranging from countryside volunteering to Youth Justice. www.northyorks.gov.uk/article/23598/Volunteering

[14] Buck, D and Gregory, S .(2013) Improving the public's health. A resource for local authorities. The Kings Fund

Time banking

Throughout this section you will have seen the impact communities have on improving health and wellbeing. Connecting to one another increasing social capital improves health. Focusing on strengthening communities, building on assets is very much the philosophy of the distinctive North Yorkshire public health vision. Supporting the voluntary sector and developing programmes such as time banking fit with this vision. Time banking is another asset-based approach in which community members or service users support each other directly.

Time banking

Time banking is a social currency system that rewards community volunteers for their time. A participant receives one-time credit for one hour of volunteering. Credits can then be used in exchange for other services. These services could include swimming at the leisure centre or a three week language course at your local library. You might also exchange credits for other people's time – gritting the pavement, or an hour babysitting for example. Time banking is a great way to learn more about the assets in your community, whether a local volunteer group, business, or next door neighbour. It encourages people to become locally active by rewarding current volunteers and incentivising new ones.

In June 2014, the community group YorCredits began a pilot time banking scheme between the Northallerton Library and Hambleton Leisure Centre. Volunteers at the library receive stamps on a voucher card that can be spent on library and leisure centre activities.

Visit YorCredits.org.uk to see time banking in action.

People willing to share their time and skills with member of their community as well as being willing to receive from others creates a sense of community, trust and reciprocity. Co-production and reciprocity are what makes time banking a different proposition to volunteering in the traditional sense. Time banking also attracts different groups of people compared to volunteering. Time banks are successful in attracting people from low socio economic groups and marginalised groups[15]. Developing volunteering and time banks gives more people the opportunity to engage in their community. For more information on time banking please visit **www.timebanking.org**.

Employer supported volunteering

Business in the community (BITC) has developed a framework for employee wellbeing. This holistic, strategic approach is committed to building resilience in the community and in business for a sustainable future. A key component of the model is facilitating employees to volunteer in their local communities.

This approach to workplace health can have a very positive impact . For more information on this approach please visit **www.bitc.org.uk/programmes/workwell**

Recommendation

Statutory bodies should work closely with the VCSE sector to plan the development, delivery and support for health and care services which draw on volunteers

Harnessing physical and organisational assets

Vibrant communities will typically have a number of places where people meet. These meeting places can often be buildings but could also be open spaces. A community hub is a meeting place that allows different people to come together and is therefore accessible to all groups in the area. Community hubs create the environment for building bridging and linking social capital in a community by providing space for collective community activities to be developed and sustained.

[15] The NSW Office of Communities December 2013. Evaluation of the NSW Volunteering Strategy 2012-13 Final Report: Timebanking Trial

Selby Employer Sponsored Volunteering (ESV)

Selby District Volunteer Centre was involved with piloting an Employer Sponsored Volunteering Scheme during the financial year ending 31 March 2013. Our ESV pilot brought together two employers, Selby District Council and DRAX power station, 17 of their employees and several local voluntary sector groups. These groups included Alzheimer's Society, Selby Carers, Selby and District DIAL and the Wildlife HABITAT Trust based at Church Fenton.

The Volunteer Centre acted as a broker between the employees and the community groups and we brokered volunteering including supporting at Singing for the Brain sessions, admin and reception support, IT support and environmental activities. Some ESV volunteers went on to further volunteering as a result and the DVD was produced and shown at our Valuing of Volunteers EVENT November 2012.

The benefits of ESV are:

- Volunteers gain and share skills and knowledge they bring back into their workplace. They also gain an understanding of volunteering and the value of the voluntary and community groups in the Selby area.
- Employers benefit from an innovative approach to staff development that engages and inspires staff. It also increases the organisation's local credibility.
- The organisations offering the volunteering opportunities gain support that is matched to their need, this ensures they get the right volunteer to help achieve the organisations aims and promote their work. It also helps build their capacity so they can do more.

A film was produced following the pilot and can be viewed by clicking here - https://www.youtube.com/watch?v=gCwWMs1i5Qw

Following the success of the pilot, the ESV scheme is now fully live and works with public and private sector employers and a number of charities including the NSPCC, Alzheimer's Society, Selby Carers, Selby and District DIAL, Groundwork North Yorkshire and Horton Housing.

Community hubs are therefore often a physical asset as well the organisational assets that it facilitates. A building or space on its own will serve as the "heart" of a community without the organised activities that take place there. Equally communities that do not have buildings or spaces where people can meet to discuss and plan together to achieve common aims may find collective action difficult and may be less likely to achieve community cohesion.

Community Hubs in North Yorkshire supported by Rural Action Yorkshire

Over the last two years Rural Action Yorkshire have been trialling support to seven village halls to help them become community hubs providing early social care interventions. This has focussed on activities for older people to help them stay engaged and connected to their community through their village hall. The activities have been designed to help combat loneliness and isolation and help older residents stay fit and healthy. It has included new exercise classes, ping pong club, digital inclusion training, luncheon clubs, book swaps etc.

The approach is based on understanding the needs of the residents and the assets within the community and then linking the two together. During the project 82 volunteers organised activities benefitting 285 older people.

In Cold Kirby the Hub's organisers are working with the local vicar who is helping them to identify the most vulnerable residents, or anyone who is housebound and volunteers are then delivering books to their homes. In Brompton by Sawdon they have offered community meals and their newest innovation has been to send some meals out to residents who were too ill to come to the hall. They are going to investigate some 'hot boxes' or something similar to facilitate this efficiently using the small profit from the meals.

This work is now being extended to more potential hubs through funding by Hambleton, Richmondshire and Whitby CCG.

The Digital Age has also introduced new possibilities for thinking about communities that is less about place and more about shared interest. We can "meet" people on-line and build social networks without needing to be in the same physical space. Communities of interest can organise quickly and effectively through various social media. As with any innovation, the results can be positive or negative.

In a rural county such as North Yorkshire, social media can provide another option for combatting the effects of social isolation and loneliness if the potential can be positively tapped.

Virtual hubs through new technologies offer a way for people to connect with each other. These virtual communities often facilitated through social media allow people to talk and offer support regardless of where they are physically located in the County. These networks have the potential to offer huge potential for support. The working age generation and the younger generation are so accustomed to connecting with people virtually via their mobile device or computer. That is not to say that virtual hubs and community don't extend across generations. More and more older people are using social media to connect with people, such as family members who have moved away from where they grew up. Of course a virtual hub is no replacement for face to face contact, but it does allow for people to keep in touch and offer support in a way that might not have happened before or in instances where contact may have been lost.

Social media adds another dimension to the traditional understanding of community. The growth of social networks that are aided by social media are the preferred way to keep in touch for many of our residents. Understanding and utilising this is essential if we want to connect with communities today and in the future. Below is an example of the value a Facebook network has had on an individual.

A virtual community hub - a service user story

I joined Facebook to keep in contact with younger members of my family. I then discovered that many of my friends who I didn't see much were also Facebook users. I have an enduring mental illness but function well enough not to be able to access specialist services. My family/ carers are in Sussex. I belong to the Acorn Centre, Mind in Harrogate District. They support a large number of us "functionally" well Service Users. However, there have been a number of changes in how we can access services provided at the Centre. For me it means I don't see so many people. Joining Facebook meant that I was able to reconnect to these people. The network of service users is nebulous and ill-defined but it allows us to virtually keep an eye on each other. There are no joining requirements - just befriended by a Centre member. When I had a rough time earlier this year friends got in touch to check on me. I am no longer alone.

How to do Asset mapping

Asset mapping is often a necessary first step for a community to tackle the issues that are important to residents. It is a process that communities must own and is only useful if it serves a purpose that is meaningful to the community. It can be formal or informal and the level of detail will be determined by the specific context. It is not done to a community. It is done by and with the community to serve the needs of the community.

For a community to make full use of its assets it needs to identify and understand what they are. Performing an asset mapping is a way of meeting this requirement.

Although there is no standard way of carrying out an asset mapping project there are some key stages that should followed:

Stage 1: Project definition, objectives and identification areas too be mapped

However, the first stage must be to agree the basic objectives of the mapping exercise by discussing and agreeing a common understanding of what is meant and expected from asset mapping. The following key questions should be answered:

- **What definition of community assets will be used?** A clear understanding of what assets will be included in each of the four main asset categories.
- **What is the intended purpose of having a community asset map?** What will it be used for? Who will use it? How will they use it?

Two options could be considered:

Option 1: A static description of a community; an in-depth community profile or "Story of Place". It would be published (printed and/or as a PDF) as a text based description of the community including brief descriptions of organisations and other assets. It would not contain detailed information about assets of individuals other than as a summary of some of the underlying features of the community.

It could be used by organisations and individuals when developing ways to improve a community's health and wellbeing or by an individual to help support them in improving their own health and wellbeing. It could also be used as the starting point for producing a community development plan.

Option 2: A more dynamic/interactive, data based approach that can be used by people and organisations when needing help, support or during the development of solutions to meet community requirements. The asset map would be updated regularly.

Details of the assets of individuals could also be made available, although most probably using a trusted local group to act as an intermediary between enquirer and "asset".

These options represent two extremes. In practice an asset mapping exercise is likely to be aimed at meeting objectives positioned somewhere between the two extremes.

- **What resources will be available to perform the mapping?** To produce a fully detailed community asset map requires a significant amount of community engagement. Even carrying out less detailed mapping exercises would need a significant understanding of the local area. How easy this will be depends largely on what community networks exist that can be used as both a source of local information and to actively contribute to the mapping process. It is likely this will vary from place to place.

  The availability of required resources can therefore influence choice of area to be mapped and the level of detail to be mapped.

- **What area is to be mapped?** A key decision that must be made is to decide what is meant by the local community. It is important that when a community area is defined it is based on its population's identification of what they considered to be their community. (People might feel that they belong to several communities designated by size and expectations of services and facilities, e.g. ward/village, local town, district, county).

  A small urban or rural community could be mapped down to assets of individuals with a degree of detail that would be difficult or impossible, and most probably inappropriate, for larger areas.

  The size of communities to be mapped can therefore be used to determine the detail of asset mapping to be carried out or, conversely, the detail of asset mapping wanted can be used to determine the size of areas is to be mapped.

Stage 2: Identifying and securing the resources

An asset mapping exercise will only be practical by utilisation of existing community networks/groups, both for their local knowledge and to provide the "feet on the ground" needed to carry out effective engagement with the community being mapped.

Stage 3: Research and engagement

The actual identification of assets, importantly including what the community itself sees as its assets.

Stage 4: Mapping and understanding the community assets

Bringing everything together either as a snapshot of the community as a onetime event or as the starting point of a continual engagement and updating exercise, including publication of the asset map in whatever previously agreed format.

Stage 5: Changing/developing commissioning plans and priorities

Linkage of the asset mapping exercise into the JSNA, JHWS and other organisations strategic plans and/or meet any other agreed asset mapping objectives.

2020 North Yorkshire - Stronger communities

The purpose of the stronger communities programme is to empower communities across North Yorkshire to use their skills and assets to work with the Council and others to coproduce a range of local support and services that maximise the wellbeing of local people of all ages. The Council's core focus, at least initially, for developing local support and services will be:

- **libraries**
- **transport**
- **youth provision**
- **adult social care/prevention.**

Recommendations

Organisations working with local communities should promote an asset based approach to understanding and responding to the issues that are important to those communities.

Any assessment of need such as Joint Strategic Needs Assessments should include an assessment of the available assets that are already available to address the needs identified.

Section 3: Looking Back 2013

3.1 Progress on 2012 Report Recommendations.

Below are examples of progress made in the last year on the key recommendations published in 2013.

Reduce the inequalities in health that are apparent across the County between the most affluent communities and those that suffer from high levels of social and economic deprivation.

- The NYCC wider partnership conference was held in November 2013 under the theme 'Public health in North Yorkshire - Creating a whole-county approach to reducing health inequalities' (http://www.nypartnerships.org.uk/index.aspx?articleid=16837)
- The North Yorkshire Community Plan (2014-17) now has reducing health inequalities across North Yorkshire as one of the three priorities. This is an excellent development in support of continued and concerted co-ordination of efforts to reduce unwarranted variations in outcomes. (http://www.nypartnerships.org.uk/index.aspx?articleid=16841)

Focus on happy and healthy ageing, helping people to maintain their health and independence as they grow older and move into retirement.

- The Health and Wellbeing Board partners continue to make good progress on facing the challenge of an ageing population, with all Clinical Commissioning Group plans and the plans of NYCC Health and Adult Services reflecting the needs of the population and the importance of prevention over cure. This preventative approach is also clearly reflected in North Yorkshire's submission to the Better Care Fund which includes support on healthy lifestyles and physical activity to prevent falls.
- The third round of NYCC Innovation Fund was launched in June 2014. Through the this fund the VCSE sector has an opportunity to develop services that enable individuals to become less reliant on Council services, by providing early intervention and prevention and reducing the need for referral to statutory agencies. (http://www.northyorks.gov.uk/article/26256/Voluntary-sector–innovation-fund)

Continue to support Sir Michael Marmot's principle of giving every child the best start in life, and also consider how we can ensure that our young people can move from education into employment in the County.

'The best possible health underpins a child's or young person's ability to flourish, stay safe and achieve as they grow up.' (Healthy Child Programme [HCP] from 5-19 years old. DH October 2009)

- Young and Yorkshire: The Plan for all Children, Young People and their Families Living in North Yorkshire 2014 was approved by NYCC in July 2014. The plan has three overarching priorities: ensuring that education is our greatest liberator, with a higher proportion of pupils attending a good or outstanding school; helping all children to enjoy a happy family life, with a safe reduction in the care population; and ensuring a healthy start to life, with more children and young people leading healthy lifestyles.
- NYCC Public Health Team and Children and Young People's Services (CYPS) are currently leading the commissioning of the 5-19 years aspects of the Healthy Child Programme, with the service due to commence on 1 April 2015. The comprehensive engagement exercise has been a significant success and the findings have shaped the service and the outcomes it is working to achieve.
- NYCC is also working with colleagues from NHSE area team to seek an integrated commissioning arrangement for the delivery of immunisation and vaccinations and in making transition arrangements for the transfer of the 0-5 Healthy Child Programme (which includes the contract for Health Visitors) to the Local Authority in October 2015.

Have the public's health and wellbeing as a central consideration in the decision making of all of the organisations and agencies within North Yorkshire; particularly North Yorkshire County Council, the clinical commissioning groups and the district councils, recognising that public health is about the big picture in our society not just individual choice and behaviour.

- The major statutory public sector bodies in North Yorkshire continue to show considerable leadership and support on improving the health and wellbeing of the population. The district and borough councils, Clinical Commissioning Groups, and NYCC recognise the importance of and their role in, improving health for everyone in plans and strategies.
- The North Yorkshire Community Plan (2014-17) takes this a step further and has an action to "support organisations in North Yorkshire to promote a whole-organisation approach to health and wellbeing, including healthy work places and training for workers." This action provides support and acknowledgement to the existing good work of employers in North Yorkshire, but also recognises that we can take that work further, sharing good practice and expertise.
- Public Health Intelligence has access to hospital activity data for the County. This will aid delivery of the Better Care Fund, support the CCGs through the core offer and help the Health and Wellbeing Board monitor progress against its strategy.

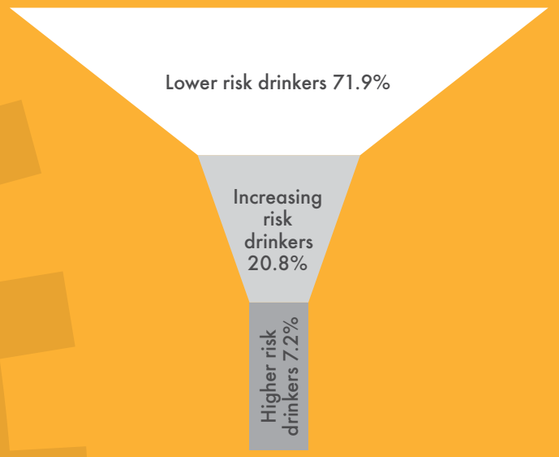
Harness the enthusiasm and sense of wellbeing that has been created by hosting the Grand Départ of the 2014 Le Tour de France, with the aim of creating a social and physical activity legacy in the County.

- NYCC is supporting the Sustrans 'Slow Tour of Yorkshire', a project inspired by the Grand Départ that aims to highlight family friendly cycle routes in the area. The slow tour of Yorkshire project has produced a package of maps, useful information, and competitions to enable people to enjoy some of the best of Yorkshire's cycling at their own pace www.sustrans.org.uk/ncn/map/themed-routes/slow-tour-yorkshire).
- North Yorkshire Sport took the lead on coordinating Tour de France legacy initiatives regionally. The first annual School Games with coaches from British Cycling saw winners from each district compete on a closed circuit at the University of York.
- A workplace challenge scheme was established to encourage friendly competition between employees and departments around the area.
- You can even download a "Ride the Yorkshire Routes" smartphone app created by the City of York with contributions from North Yorkshire County Council that provides information on how to ride the Tour routes safely.
- As part of the Harrogate and Knaresborough Local Sustainable Transport Fund project being delivered by Highways and Transportation Services, a new smart phone app has been created which enables users to find their way around Harrogate by bicycle or on foot www.openharrogate.co.uk.
- Both our National Parks (North York Moors and Yorkshire Dales) are active partners in promoting the legacy through initiatives to increase access to the parks for people of all ages and abilities and through the provision of a range of volunteering opportunities

Prevent the health and social harms caused by high levels of alcohol consumption and lack of awareness of the dangers of increased drinking, not just in our town centres but in our homes.

- Partners across North Yorkshire have now agreed an Alcohol Strategy 2014-19 with the vision: 'Working together to reduce the harm caused by alcohol to individuals, families, communities and businesses in North Yorkshire while ensuring that people are able to enjoy alcohol responsibly'. The implementation plan is being developed and agreed between NYCC, District Councils, Police, Probation Services and the Office of the Police and Crime Commissioner.
- NYCC has now awarded contracts for an adult, recovery focussed substance misuse service across North Yorkshire. The new service will open on 1st October 2014 and will be available to support anyone over 18 who misuses drugs and/ or who is a harmful or dependent drinker. It will ensure that we are better placed to address the unmet needs for treatment and support for those problem drinking.

Figure 44: Proportion of drinking risk status for North Yorkshire



3.2 Transition of the Public Health Team into NYCC

The Public Health Team (along with around 70 service contracts) transferred from NHS North Yorkshire and York to North Yorkshire County Council on 1 April 2013. The process of preparing for the transfer and the subsequent management of the transfer has been complicated, but successful. The team now sits as part of the Health and Adult Services Directorate but with key links across the other NYCC directorates, the district councils and the clinical commissioning groups.

In the last year there has been a process of building the team from seven individuals (four whole time and three part time) who had been members of the old NHS NYY Public Health Directorate in 2012 to 14 staff (not all full time) in the Public Health Team with four additional staff in support functions or secondments working with the team.

The main service priorities of the Public Health Team are to:

- Provide leadership and support to achieve public health outcomes across health improvement, health protection, and health and social care.
- To ensure effective commissioning of public health services.

In 2013-14 the team along with colleagues in NYCC:

- Started on an ambitious programme of commissioning of public health services including sexual health, substance misuse, tobacco control and the 5-19 Healthy Child Programme. Existing services have been reviewed to ensure they are tailored to the distinctive context of North Yorkshire and offer best outcomes and value for money.
- Developed a Public Health Communications Strategy leading to 15 campaigns supported, including sun safety, lung cancer, winter health and alcohol awareness. This includes continuation of the Public Health Fact sheet series which are published on the NYCC website www.northyorks.gov.uk/stayinghealthy - 6 factsheets were produced and marketed in 2013/14. The fact sheets are in demand and have led to interest in the press.
- Worked with colleagues in Craven and Selby District Councils to support community development projects in deprived wards through community needs assessment and asset mapping approaches to ensure projects have public health information and intelligence to target their actions on priority areas for their population.
- Secured increased capacity for smoking in pregnancy services in Scarborough working with the Acute Trust, SRCCG and East Riding Council.
- Reviewed the 2012 Joint Strategic Needs Assessment (JSNA). A structure is now in place for future versions of the JSNA. A JSNA Editorial Group has been established to oversee the production of the JSNA. The membership of the group includes district councils, clinical commissioning groups, the voluntary sector, CYPS, Central Services, the police, and NHS providers. This group will help to ensure that issues raised in the DPH report and other key documents are factored in to the JSNA process.
- In 2013/14 the NHS Health Checks programme invited 30,613 people aged 40-74 years, and delivered 14,319 health checks leading to 1,031 people being identified as being at high of cardiovascular disease (CVD) or being diagnosed with high blood pressure, diabetes or chronic kidney disease (CKD).

Areas for public health activity in 2014-15 include:

- Increasing breast feeding initiation and maintenance as part of giving every child the best start in life,
- Implementation of the county-wide alcohol strategy,
- Develop and finalise a county-wide mental health strategy,
- Develop falls prevention work in the community as part of integrated approach between health, social care, leisure and housing to reduce unnecessary hospital and care admissions.

Work is continuing on developing a "distinctive public health" agenda for North Yorkshire that represents the key assets and needs of the County. "

Section 4: Recommendations

1. NYCC, district councils and CCGs should work closely to implement NICE guidance with regard to providing an integrated approach to preventing and managing obesity and its associated conditions ensuring that gaps in current services are addressed.

2. NHS England should continue to work closely with the provider of the Child Health Information Systems (CHIS) covering the child population of North Yorkshire to ensure there is an improvement plan to achieve delivery of the national service specification in accordance with national timescales, liaising with NYCC in respect of any current or future inter-dependencies in relation to commissioning, service provision and data or information flows.

3. Statutory and VCSE partners should continue to work together to develop a North Yorkshire Mental Health Strategy to ensure there is a co-ordinated approach to improving the mental health and wellbeing of the population of all ages, improving outcomes for people with mental health problems and combating the stigma and discrimination associated with mental illness.

4. NYCC, district councils and NHS partners should make the most of the opportunities presented by the Better Care Fund and the shift towards integrating services to respond to community needs and maximise the use of community assets working closely with the VCSE where possible.

5. Statutory bodies should work closely with the VCSE sector to plan the development, delivery and support for health and care services which draw on volunteers

6. Organisations working with local communities should promote an asset based approach to understanding and responding to the issues that are important to those communities.

7. Any assessment of need such as Joint Strategic Needs Assessments should include an assessment of the available assets that are already available to address the needs identified.

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