

The dynamic of social capital, health and economy

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The impact of regeneration in South Yorkshire coalfield communities



Yorkshire & Humber | Regional Development Agency



Sheffield
Hallam University



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The South Yorkshire Coalfield areas of Barnsley, Doncaster and Rotherham continue to present challenges for health and sustainable economic regeneration.

The two social capital surveys undertaken within South Yorkshire represent the largest such surveys ever undertaken in England.

They assess the impact of the Health Action Zone and the Single Regeneration Budget Programme on social capital, health and people's economic prospects.

Many dedicated people, including those from the communities themselves, have put great effort into making South Yorkshire a healthier, happier, more prosperous place to live. The results of this second survey are encouraging; there are

signs of improvement in health, personal security and economic activity across the nine survey areas. There are also signs that social capital or 'community spirit' is an essential ingredient in this mix.

I encourage everyone involved in health and regeneration, from policy makers and politicians to community volunteers, to consider the conclusions of this report. Its main message suggests we are doing fairly well but that if we pay greater attention to social wellbeing we will make even faster progress.

John McIvor

Chief Executive, Rotherham Primary Care Trust

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Members of the research team all made a great contribution. Jan Gilbertson took the conceptual development forward with a review of social capital and Julie Manning was responsible for developing the nine community profiles, marshalling the database of addresses and contacting residents with the help of Emma Smith and Sarah Corker. Both Jan and Julie contributed to the survey design and questionnaire and to the analysis of the results with Mike Grimsley. As a social epidemiologist Mike brought special insights to analysing the dynamics of change.

All of us helped draft the report, working with the designer Paul Pugh to make it as accessible as possible to a wider audience in the academic and policy communities. As co-ordinator of the study, I take responsibility for any errors or omissions.

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Executive summary	
1. Rationale	1
2. Process	3
Background	
Recruitment and training of interviewers	
Survey	
3. Concept and research design	7
Links between social capital, the economy and health	
Defining the concept	
Modelling links and questionnaire design	
Final questionnaire structure and content	
4. The nine communities	13
Darfield · Barnsley	
Kendray · Barnsley	
Thurnscoe · Barnsley	
Denaby · Doncaster	
Intake · Doncaster	
Moorends · Doncaster	
Brinsworth · Rotherham	
Maltby · Rotherham	
Rawmarsh · Rotherham	
5. The big picture	35
Employment status	
Health status	
Social Capital	
Security	
6. People and place	39
Comparing communities	
Health	
Security	
Social capital	
Reciprocity	
Civic engagement and efficacy	
Trust	
7. Social capital, health and economy	47
Health, skills and work	
Social capital and health	
Social capital, security and health	
8. The impact of Area Based Initiatives	51
Attribution	
Realistic evaluation method	
Assessment	
Assessment and survey results	
9. Conclusion	55
Social capital, health and prosperity	
Reversing decline	
Balanced investment	
Synergies	
Asset or welfare: drain or sustain	
Healthy neighbourhoods, not just healthy lifestyles	
Incapacity benefit	
Community safety	
What works?	
Appendix 1: Survey questionnaire	59
Appendix 2: The ABI Assessment Form	61
Bibliography	62

1. Context

The 2004 resurvey of social capital in nine South Yorkshire coalfield communities builds on a baseline study undertaken in the year 2000. *Our Region: Our Health* and the *Objective 1 Single Programme* for South Yorkshire provides a broader policy context.

2. Rationale

The literature shows social capital – ‘community spirit’ – influences economic growth, health and sustainable development. The study tested whether public investment in Area Based Initiatives (ABIs) had increased levels of social capital and improved health.

3. Process

The survey protocols and questions were developed iteratively over a period of three months, led by a steering group drawn from the local authorities of Barnsley, Doncaster and Rotherham and partner Primary Care Trusts.

4. Communities

The Evaluation Group chose nine areas for the survey – three in each of Barnsley, Doncaster & Rotherham – to reflect a balance of ‘pit villages,’ inner urban areas and mixed communities.

5. Survey

3771 interviews were completed between September and November 2004. 1071 of these residents had also taken part in the 2000 baseline survey. In February 2005 regeneration managers assessed the impact of ABIs on social capital formation in their nine communities.

6. Benchmark results

Though the nine communities remain more deprived than the South Yorkshire Coalfield as a whole, there are signs of improvement in economic activity, health and personal security.

7. Social Capital

Though the nine communities varied in their level of social capital – on the dimensions of trust, reciprocity and empowerment – there was overall improvement between 2000 and 2004.

8. Links

Improved levels of social capital were linked to better health, higher levels of personal security and higher levels of participation in the labour market.

Nine key messages

1: Health and prosperity

Social capital contributes to health and prosperity both at a regional and neighbourhood level.

2: Resources and process

Successful regeneration is influenced by the scale of resources and the degree of community engagement.

3: Balanced investment

Investment in social capital is a vital element of any balanced regeneration programme.

4: Synergies

Investment in social capital has enhanced levels of human capital and helped people into work.

5: Asset not welfare

Social capital is an asset which must be replenished in order to promote economic regeneration and neighbourhood sustainability.

6: Healthy neighbourhoods

Empowerment and trust contribute to healthier neighbourhoods through improved mental health.

7: Labour market

Social capital encourages participation in the labour market through better mental health, a key factor behind high rates of long-term sickness.

8: Community safety

Community safety is enhanced by increased levels of social capital, reducing fear of crime and leading in turn to better mental health.

9: What works?

Further analysis is needed to properly assess how Area Based Initiatives have contributed to increasing social capital.

This second report on social capital reflects a determination by public authorities to reinvest in the ex-coalfield communities of South Yorkshire. Our earlier baseline report¹ concluded 'social capital – loosely translated as 'community spirit' – can be a powerful force for regeneration.'

We concluded also, that it is necessary to replenish this asset. In their heyday the nine communities highlighted in our studies had a super-abundance of social capital, emanating from a proud tradition of social solidarity. However just as the coalmining industry generated this social asset, so pit closures had helped undermine it. By the time of our first study in the year 2000, the coalmining legacy of trust and ties was fading fast.

The focus of this second study is the intervention by the local and health authorities to replenish social capital. Chapter 4 provides a profile of each community and lists various Area Based Initiatives (ABIs) explicitly designed to enhance social capital or having an indirect impact. Chapters 5, 6 and 7 compare the results of our second community survey in 2004 with the baseline in 2000, recording changes in social capital and links to health and economy.

A major challenge is to determine the precise relationship between these ABIs and the outcomes recorded in our survey. History and context complicate the picture. The penultimate chapter 8 of this report is therefore only a preliminary attempt at evaluation, drawing on the expertise of regeneration managers in each of the nine communities. A more rigorous evaluation, surely a priority for the public authorities, will require more time and resources.

Public health is a goal of public policy, a basic value and hallmark of a civilised society. Yet the health of a community or a region's population also makes a vital contribution to social and economic regeneration. This symbiotic relation-

ship was highlighted in our baseline study and is now an essential element of policy for the Yorkshire and Humber Region. The framework document produced by the Government Office for Yorkshire and the Humber Region, *Our Region: Our Health*² states:

'An economically strong and innovative region can make a lasting difference to the health and well-being of the people of the region; a fit and healthy workforce can drive a robust and progressive economy.'

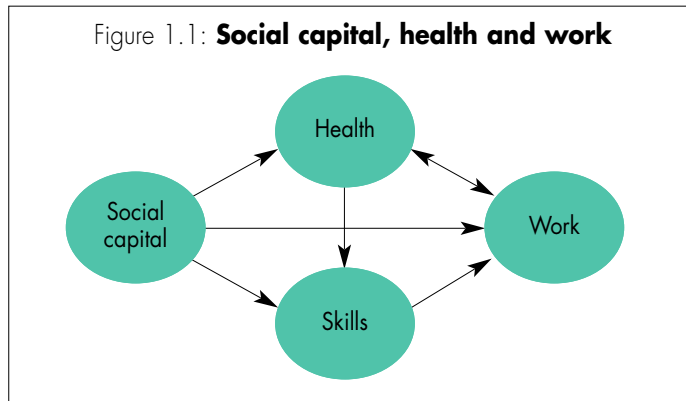
The link between health and work has political salience nationally, and especially in ex-coalfield areas which have some of the highest sickness rates in the UK. The government

is determined to reverse the upward trend of people claiming state incapacity benefit because they are classed as long-term ill and unable to work.

Fothergill and others³ maintain that a proportion of those on incapacity benefit reflect 'hidden unemployment.' They argue that a reviving economy will lead to fewer people claiming they are ill and incapacitated. But of equal importance, fewer people claiming they are ill and incapacitated will help to revive a local economy.

The focus of this report is social capital as a determinant of health and, in turn, an influence on people's social and working lives. Figure 1.1 highlights this triangular relationship and adds skills as a key human resource.

The purpose of the report is to convey our survey evidence that investing in social capital does in practice lead to better health and sustainable development in our nine communities and beyond. The signals are positive. Higher levels of social capital, encouraged by Area Based Initiatives, are clearly linked to better health. And to complete a virtuous circle, better health is linked to better qualifications and more work opportunities.



¹ Green G, Grimsley M, Suokas A. (2000) *Social capital, health and economy in South Yorkshire coalfield communities*. Centre for Regional Economic and Social Research. Sheffield Hallam University.
² Yorkshire and Humber regional Public Health Group (2004) *Our Region; Our Health: A Regional Strategic Framework for Public Health in Yorkshire and the Humber*. Government Office for Yorkshire and the Humber.
³ Beatty C. and Fothergill S. (2004) *The Diversion from 'Unemployment' to 'Sickness' across British Regions and Districts*. CRESR, Sheffield Hallam University.

2

1. Background

2. Recruitment and training of interviewers

3. Survey

In June 2004 Sheffield Hallam University was commissioned to re-examine social capital in nine communities of the South Yorkshire Coalfield. The study builds upon the baseline established in 2000 and reported in *Social Capital, Health and Economy in South Yorkshire Coalfield Communities*. A team from the Centre for Regional Economic and Social Research again managed the project, refining the conceptual base in the summer of 2004, commissioning a target of 3600 resident interviews in the autumn and analysing the results in the winter.

1. Background

The original idea for such a survey was developed by the South Yorkshire Health Action Zone (HAZ) Evaluation Group back in 1999. The steering group for the follow-up survey included representatives from the three Local Authorities in the South Yorkshire coalfields – Barnsley, Doncaster and Rotherham – and the complementary Primary Care Trusts (PCTs).

In 2000 the original Evaluation Group developed a Framework for Evaluation based at three distinct levels: project level, programme level and overall. A range of data sources was identified to contribute to evaluation at each level. The Group identified social capital as an important factor influencing health that might be expected to change as a result of HAZ activity. As social capital is not comprehensively captured by routine data sources the Group proposed a survey to obtain this information. From an early stage it was recognised that measures of social capital would also contribute to the evaluation of the SRB 5 Scheme, *Helping communities build a better future*. As a result, a HAZ/SRB Social Capital Steering Group was set up to develop a proposal for the survey and obtain funds from both partner agencies.

With great foresight, the partners decided the survey should act as a 'before and after' study to contribute to the overall evaluation of the two initiatives. It was also intended to provide information to inform the planning of local projects. During the development of the proposal members of the Social Capital Steering Group attended several national meetings on HAZ Evaluation and two meetings organised by

the Health Education Authority (then Health Development Agency) to disseminate research findings on the links between social capital and health.

2. Recruitment and training of interviewers

A primary objective of the study was to involve the local communities in the development and implementation of the surveys of residents. In 2000 Northern College, Barnsley and the Centre for Research and Evaluation (CRE), formerly SSRC, Sheffield Hallam University were responsible for recruiting and training interviewers on the project. A total of 52 interviewers were successfully recruited, briefed and trained. Particular attention was paid to employing local people from a variety of different backgrounds with a range of experience, and all interviewers (with the exception of three from Sheffield) lived in the coalfields area. All those who attended the training course gained a recognised qualification – Open College Network Level 1 Credit in 'Community Studies and Skills'. The majority of the interviewers were retained on CRE's books, with some continuing to be employed on other survey work.

In 2004 efforts were made to re-employ the interviewers who originally worked on the baseline project. Initial contact generated 19 definite responses from interviewers who were interested in working on the project again. Inevitably, prior commitments, responsibilities and the timing of the fieldwork meant that not all of those interested could work on the project and in the event 12 interviewers from 2000 were fully recruited and briefed.

Unfortunately, attempts to recruit the same interviewers who worked on the project in 2000 did not generate sufficient capacity to fulfil the requirements of the work programme. The pool of potential interviewers was expanded and with the help of Barnsley Metropolitan Borough Council, contact was established with Darfield Community Association (DCA). The DCA are the lead body in Darfield working with the Objective 1 team on the regeneration programmes for the area. During 2003 they undertook a comprehensive Community Audit and were experienced in survey work. An additional nine contacts were made through DCA and of these one was recruited and briefed. In addition, CRE supplemented the team with seven of their own interviewing team and local contacts and networks generated a further seven interviewers.

However, by early October 2004 it became apparent that the team of interviewers would not achieve their target of

3600 interviews by the end of the month. A number of options were explored and additional capacity was sought from two specialist consultancy firms. Capacity, timing and cost were major considerations when deciding which firm to employ and in the end a team of 24 interviewers were deployed from a Hull based consultancy called Andrew Gibson Consulting. The team had appropriate experience and had worked on a similar social capital survey in Hull. CRE's target was adjusted down to around 2000 interviews with the remaining 1500 or so interviews to be achieved by the Hull consultancy. The period for the fieldwork was also extended from the end of October into November.

Figure 2.1: **Interviewer contact and recruitment figures**

Contacted:	
Total number of interviewers in 2000	56
Total contacted for 2004 via letter (completed 5 or more interviews)	53
Interested in working 2004	19
Not interested in working	31
No contact	3
Darfield Community Association contacts	9
Recruited and briefed:	
Interviewers from 2000	12
Darfield Community Association	1
Additional CRE interviewers	7
Recruited through CRE contacts	7
Additional Andrew Gibson Consultancy team	24
Total fieldwork team	51

All interviewers attended half day briefing events held by CRE. These sessions gave interviewers information on working procedures before starting work and provided opportunities for interviewers to ask questions about the research and feedback any concerns and issues to the research team. The sessions also involved running through the questionnaire with interviewers and explaining and discussing the rationale for questions with them. As the questionnaire was similar to the one used in the original survey, a number of interviewers were reasonably familiar with the questionnaire. Many talked about their experiences from the previous survey and were interested in the changes that had been made to some of the questions and the reasons behind them.

3. Survey

In 2000 the Social Capital Steering Group selected nine areas of the Coalfield for survey and a total of 4219 interviews were achieved across these areas. For the re-survey, the primary aim was to revisit as many of these residents as possible. This 'longitudinal' or 'panel' element was most important providing a robust assessment of changes in social capital and its determinants between 2000 and 2004. Within the tender specification and project budget it was planned to complete 400 interviews in each of the nine communities.

The sampling frame was all the addresses where interviews were achieved in 2000 (phase 1 addresses) plus all additional residential addresses (phase 2 addresses) within the agreed study area boundaries. In total there were 27,511 properties in the 2004 sampling frame, 1053 were empty leaving 26 458 properties in total. Of the original 4219 properties where interviews were achieved in 2000, 134 were vacant, 37 had been demolished and 1 was actually outside the boundaries of the study areas. This left 4047 phase 1 properties. A full summary of the 2004 sampling frame is provided in figure 2.2.

Once all 4047 remaining phase 1 addresses had been included, a fraction of phase 2 addresses was selected randomly. The sampling fraction for phase 2 addresses was informed by, and calculated from, regular updates provided by CRE on the progress and response rate of the phase 1 longitudinal element of the sample. Response rates for this part of the sample ran at around 50 per cent and it was estimated that an additional 3180 phase 2 addresses would be required in order to achieve around 400 completed interviews in each area. This gave an average selection of 803 properties in each area and a total of just over 7200 addresses.

After the fieldwork was completed sample figures were revised to take account of vacant and derelict properties and other unsuitable properties.

In 2000, an overall survey response rate of 46 per cent was achieved. In 2004 the response rate was 58 per cent.

Figure 2.2: **Sample statistics**

	Baseline properties 2004	Empty properties 2004	Occupied properties 2004	Number interviewed 2000	Properties in 2004 where 2000 interview	Difference vacant	Difference demolished	Outside area
Barnsley								
Darfield	3406	131	3275	487	475	11	1	0
Kendray	2176	198	1978	456	387	36	33	0
Thurnscoe	3617	183	3434	486	472	13	1	0
Doncaster								
Denaby	1918	106	1812	445	424	21	0	0
Intake	3937	75	3862	453	447	6	0	0
Moorends	2087	71	2016	444	431	13	0	0
Rotherham								
Brinsworth	4115	50	4065	471	462	8	1	0
Maltby	3679	174	3505	466	444	21	0	1
Rawmarsh	2576	65	2511	511	505	5	1	0
Total	27511	1053	26458	4219	4047	134	37	1

Figure 2.3: **Fieldwork statistics: Overall response rate**

Area	Original sample	Revised sample	Addresses not visited	Refusals	No contact	Interviews	Response rate
Brinsworth	804	793	34	66	220	473	62.3
Darfield	800	781	26	103	196	456	60.4
Denaby	802	753	50	64	231	408	58.0
Intake	803	783	52	198	161	372	50.9
Kendray	806	767	38	42	224	463	63.5
Maltby	803	775	128	101	142	404	62.4
Moorends	805	775	63	128	194	390	54.8
Rawmarsh	801	779	75	135	190	379	53.8
Thurnscoe	803	780	31	107	216	426	56.9
Total	7227	6986	497	944	1774	3771	58.1

Figure 2.4: **Fieldwork statistics: Phase 1 response showing longitudinal element**

Area	Original sample	Revised sample	Addresses not visited	Refusals	No contact	Phase 1 interviews	Longitudinal element	Overall response rate
Brinsworth	462	455	0	52	131	272	151	59.8
Darfield	475	465	3	73	115	274	162	59.3
Denaby	424	393	10	49	114	220	95	57.4
Intake	447	434	4	171	66	193	78	44.9
Kendray	387	367	0	36	107	224	115	61.0
Maltby	444	418	66	82	49	221	102	62.8
Moorends	431	413	1	116	91	205	121	49.8
Rawmarsh	505	483	50	106	107	220	120	50.8
Thurnscoe	472	455	0	79	140	236	127	51.9
Total	4047	3883	134	764	920	2065	1071	55.1

3

1. Links between social capital, the economy and health

2. Defining the concept

3. Modelling links and questionnaire design

4. Final questionnaire structure and content

Most of the conceptual development for the project was undertaken prior to the survey in 2000. This chapter rehearses the basic concepts as they relate to the various ABIs operating in the nine communities. It then elaborates the essential components of the study in light of theoretical developments in social capital since 2000 and their practical application by the policy community. Most important are different forms of social capital – *bonding, bridging and linking* – which may differentially influence social, economic and health related outcomes.

1. Links between social capital, the economy and health

Social capital is increasingly recognised as an important factor in economic growth. Robert Putnam, in *Making Democracy Work*¹ demonstrated that the most economically successful regions of Italy are those with the strongest conditions of civic engagement and the highest levels of social capital. In his later book *Bowling Alone*² he specifically distinguished ‘bridging’ social capital as beneficial for finding and retaining a job. Staff at the World Bank had identified social capital as the missing link to explain why economic investment programmes have repeatedly failed in Third World economies:

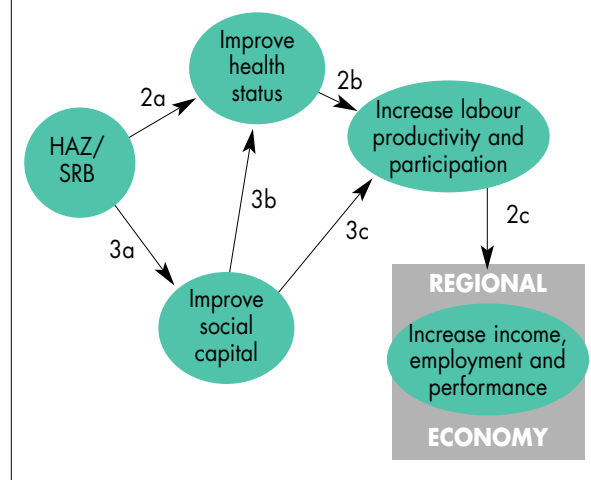
‘There is growing empirical evidence that social capital contributes significantly to sustainable development. Sustainability is to leave future generations as many, or more, opportunities as we ourselves have had. Growing opportunity requires an expanding stock of capital. The traditional composition of natural capital, physical or produced capital, and human capital, needs to be broadened to include social capital.’ Ismail Serageldin, Vice President of Environmentally and Socially Sustainable Development, World Bank.³

¹ Putnam, R.D. (1993) *Making Democracy Work: Civic Traditions in Modern Italy*, Princeton: Princeton University Press, 167.

² Putnam, R. (2000) *Bowling alone – The collapse and revival of American community*, New York: Simon and Schuster.

This evidence lends support to the SRB 5/6 and HAZ strategies of community empowerment. Figure 3.1 hypothesises the pathways to improved economic performance.

Figure 3.1: **Hypothesised impact of HAZ and SRB programmes on regional economies**



Evidence of the relationship between social capital and health (pathway 3b) came from two principle sources:

- *Population studies in North America.*
- *Research projects in the UK linked to The Social Capital Research Programme (1997-2002) funded by the Health Development Agency (HDA).*

There is a considerable amount of research on the positive relationship between health and social capital.^{4 5 6} For example, Halpern⁷ suggests that social capital may act to reduce the effects of social stress and that its presence may generate a sense of well being. Studies^{8 9 10} suggest that

3 Grootaert G (1998) *Social Capital: The Missing Link?* (PDF File) World Bank. SCI Working Paper No.3, April.

4 Cooper, H. Arber, S. Fee, L. Ginn, J. (1999) *The influence of social support and social capital on health*. Health Education Authority, London.

5 Blaxter, M. Poland, F. Curran, M. (2001) *Measuring social capital: Qualitative study of how older people relate social capital to health*, Final report to the Health Development Agency, London.

6 Coultard, M. Walker, A. Morgan A. (2001) *Assessing people's perceptions of their neighbourhood and community involvement (part 1)* Health Development Agency, London.

7 Halpern, D (1999) *Social capital: the new golden goose*. Faculty of Social and Political Sciences, Cambridge University. Unpublished report.

8 Brown, G and Harris, T (1998) *Social origins of depression*. Tavistock.

9 Wilkinson, R. (2002) *liberty, fraternity, equality – a commentary on Rodgers G.B., Income and inequality as determinants of mortality: an international cross-sectional analysis*. Population Studies, 1979, *International Journal of Epidemiology*, January.

10 Kawachi, I. Kennedy, B. Lochner, K. and Prothrow-Stith, D. (1997) 'Social capital, income inequality and mortality', *American Journal of Public Health* 87 (9) pp.1491-1498.

there are a number of effects that may be at work. These include:

- *Bonding social capital provided by close family and friends providing tangible assistance and care and creating a sense of well being.*
- *Wider social relationships may have an impact on health through impact on individuals' perceptions of their social status, their levels of stress and the strength of social affiliations.*
- *Elements of social capital such as trust, reciprocity and membership of voluntary organisations, may help to explain a proportion of life expectancy, infant mortality rate, heart disease and self rated health.*

2. Defining the concept

As a starting point in 2000 we adopted the following definition of social capital:

*"Social Capital...refers to features of social organisation, such as trust, norms, and networks that can improve the efficiency of society by facilitating coordinated actions."*¹¹

Three key features were identified as important for both the baseline and follow-up studies.

- *Social capital is a feature of the collective (neighbourhood, community, society) to which an individual belongs as distinct from social networks or social support that are characteristics measured on an individual level.*¹²
- *In established urban communities a large proportion of social capital, like its economic equivalent – physical assets such as factories and roads – will have been created at some time in the past, and depleted or augmented over time. Social capital is like a stock of goodwill from which benefits flow, rather than the benefits themselves.*
- *It should be possible to regenerate social capital within established communities by publicly led programmes. Such programmes might be specifically designed to induce this outcome or it may be a beneficial side effect of programmes to rebuild the physical, environmental and social infrastructure of a neighbourhood.*

These three features influenced the design of our study. The first point questions whether our proposed survey of individuals can properly distinguish the collective social characteristics of a neighbourhood from those of an individual. Is trust for example, a disposition engendered by age, sex or

economic circumstances, which most of us carry from place to place. Or is it induced by the physical and social environment of the neighbourhood. In other, more formal words, is it a compositional or contextual effect. Sally MacIntyre and Anne Ellaway have elaborated the issue.¹³

In 2000 we addressed the second, historical point, by asking focus groups of community representatives to help us understand how the past experience of coal mining might "cast long shadows forward" in terms of individual and collective action today.¹⁴ In general they mourned the erosion of community spirit, though the baseline survey did find that social capital was generally much higher in ex-pit villages than in the inner urban areas we surveyed.

The third point is addressed in this follow-up study by cross referencing the results of the survey with an assessment of the ABIs operating in the nine communities. In theory these publicly led programmes should – *inter alia* – rebuild or enhance social capital. Variations in the scope and intensity of the ABI investment may be reflected by variations in levels of social capital, always acknowledging the importance of history and context.

3. Modelling links and questionnaire design

In 2000, the South Yorkshire Health Action Zone (HAZ) Evaluation Group intended the survey questionnaire to cover elements of social capital, health and economy in such a way that any links could be identified in the final statistical analysis. They intended it to be based on a core set of questions derived from the social capital module which was at that time being piloted by the Office of National Statistics (ONS) for the next General Household Survey (GHS) and additional questions identified by the partners and communities. This was modified after community representatives suggested that the questionnaire should be relatively short so as not to alienate an already over-surveyed population. Also, our survey unit forecast that inexperienced resident interviewers would be more successful with a simple, user-friendly questionnaire.

The questions were revised again after community representatives identified problems with the core set. It was agreed where appropriate to consider alternatives including questions from the Coalfield Community Survey (CCS)¹⁵ being undertaken concurrently by the research team.

When designing the questionnaire for the follow-up survey in 2004, the most difficult trade off was deciding upon the

¹¹ Putnam, R.D. (1993) *Making Democracy Work: Civic Traditions in Modern Italy*, Princeton: Princeton University Press, 167.

¹² Kawachi, I. and Berkman L.F. (2000) *Social Cohesion, Social Capital and Health in Berkman L.F. and Kawachi, I. (eds.) Social Epidemiology*, Oxford: Oxford University Press.

¹³ MacIntyre S. & Ellaway A. (2000) *Ecological Approaches: Rediscovering the Role of the Physical and Social environment in Berkman L., & Kawachi I., (eds) Social Epidemiology*, Oxford University Press, Oxford

¹⁴ Popay, J (2000) Social Capital: the role of narrative and historical research, *Journal of Epidemiology and Community Health* 54:401

¹⁵ Green, G., Grimsley, M and Stafford GB (2001) *Capital Accounting for Neighbourhood Sustainability*, CRESR, Sheffield Hallam University.

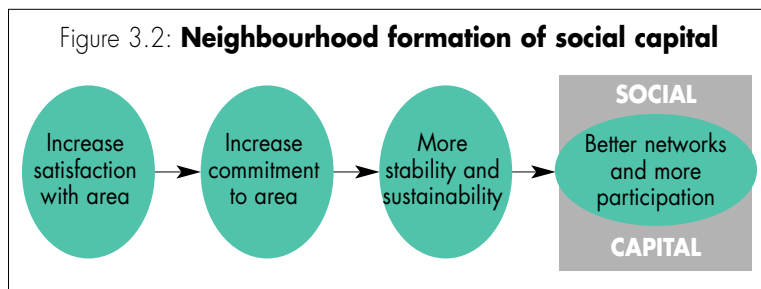
balance between questions which compared change over time and those which provided national benchmarks so that the communities could be compared to the national picture. Since 2000, the ONS Social Capital Project had provided a suggested framework for measurement of social capital in the UK which would have enabled greater comparison with government surveys.

The steering group and research team reviewed the relative advantages of (i) updating the baseline questions to allow for national comparisons, and (ii) retaining the baseline questions to facilitate local comparisons over time. It was agreed in principle that the questionnaire should be kept as close to the original as possible, unless there was a clear benefit in changing the questions.

a. Neighbourhood context

The baseline survey set out to 'explore resident's attitudes to their community'. Such attitudes may influence rather than define social capital as the schematic diagram below shows:

The questionnaire marks these pathways to social capital – measuring commitment to the area (EHS "How likely are you to stay in this area or estate?") and stability (CCS



EHS/MORI "How long have you lived in this area?"). Overall satisfaction is measured – CCS EHS/MORI by scaled responses to the question "Taking everything into account, to what extent are you satisfied with this area as a place to live?"

b. Network Geography

For many people – especially the more affluent – social networks extend beyond the neighbourhood. This is illustrated in the neighbourhood sustainability model developed in the *Capital Accounting* report referred to earlier. The Luton pilot HEA study concludes "Certain network types (diverse and geographically dispersed) might be more health-enhancing than others."¹⁶

In 2000, one ONS question was employed which specifically related to the neighbourhood – "Would you say that you know most/many/few people in your neighbourhood."

This is "local social capital" – identified as important in one of the workshops undertaken with local people.

For the follow-up survey an additional question was asked which had subsequently been adopted in the ONS harmonised question set – "To what extent do you agree or disagree that this neighbourhood is a place where people from different backgrounds get on well together?" This question relates to recent developments in the concept of social capital. Different types of social capital encompass different types of networks. An important construct is the difference between *bonding* and *bridging social capital*.

In his later work Putnam (2000)¹⁷ distinguishes the two. He defines 'bonding social capital' as taking place within and cementing homogeneous groups (this type of social capital is good for "getting by") and 'bridging social capital' as bonds of connectedness that are formed across diverse social groups (this type of social capital is crucial for "getting ahead").

The new question (Q11 on the schedule at the end of the chapter) is designed to elicit *bridging social capital* which describes looser ties and is associated with more diverse relationships, sustaining generalised reciprocity and trust beyond those who are familiar or well known (for example to work colleagues, acquaintances, other communities).

The question assesses whether respondents think they have some connection or relationship with people within their neighbourhood that they view to be different from themselves. This could apply in communities which have experienced an influx of younger, employed populations who are often homeowners and

do not have traditional connections to a particular area. However such a question will have limited applicability in the communities in our study which are more homogeneous.

The distinction between different types of social capital is important. Literature suggests that the networks and contacts that make up social capital can provide highly cost-effective means for helping people find work. *Bridging social capital* (networks and contacts with acquaintances etc.) is particularly important, as a number of studies have shown that more unemployed people find employment through friends and personal contacts than through any other single route.¹⁸ Buck found that a lack of social networks of the right kind (i.e. lack of friends and acquaintances in the labour market) helped to explain why individuals who live in neighbourhoods of concentrated disadvantage are less likely to exit poverty than would be predicted by their individual characteristics.¹⁹

¹⁶ Campbell, C., Wood, R., Kelly, M. (1999) *Social Capital and Health*, Health Education Authority, 22.

¹⁷ Putnam, R. (2000) *Bowling alone – The collapse and revival of American community*, New York: Simon and Schuster.

¹⁸ Perri 6, (1997) *Escaping poverty – from safety nets to networks of opportunity*, Demos, September.

¹⁹ Buck, N. (2001) Identifying neighbourhood effects on social exclusion, *Urban Studies*, 38; 12 pp2251-2276.

As in 2000, the frequency of contact with friends, family (whether or not they lived in the area), neighbours and work colleagues was also measured. Again this question addresses both *bonding* and *bridging social capital*.

c. Reciprocal help and support

Two ONS questions – ‘favour for a neighbour’ and ‘help with a lift’ – were included in both the 2000 and 2004 questionnaires (Q14, Q15). The steering group considered alternative questions from the ONS harmonised question set which asked whether there was anyone people could call on if they were ill in bed or needed to borrow money. But these questions were felt to be rather intrusive and too sensitive, concentrating on social support rather than the reciprocal help. A small addition was also made in the 2004 questionnaire (Q15b) which distinguished the relationship with the person who could be asked for a lift. Such a distinction enabled the questionnaire to delve deeper into the type of social networks people could tap into for support and help.

d. Trust

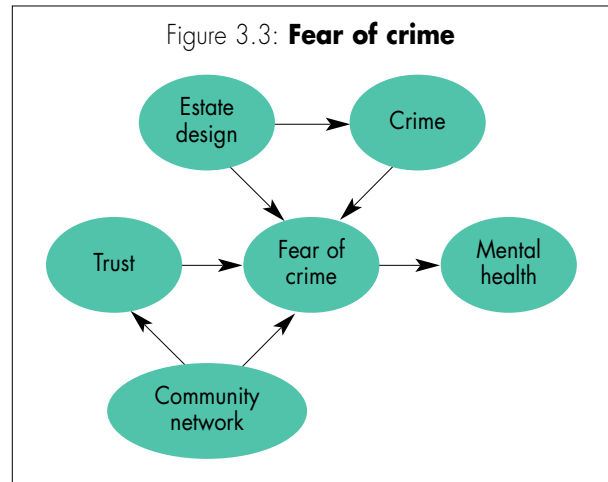
In his book *Making Democracy Work*,²⁰ Robert Putnam distinguishes *personal trust* from *social* or *system trust*. He maintains that the first leads to the second, which in turn leads to better economic performance – system trust reduces ‘transaction costs’ – the cost of negotiation. A breakdown in trust can lead – in extremis – to labour strikes. More significantly for the SRB5/6 programmes, trust in employers may help remove barriers to employment perceived by residents currently out of work or marginal to the labour market.

The questionnaire therefore covers ‘system’ as well as personal trust (Q16). ‘Trust in local employers’ was added to a set of questions on trust (in politicians and the local council) adapted from earlier CRESR surveys, and trust in local councillors, the police, courts and government were added in to the 2004 survey to take account of comparable ONS questions. The modified question 16 on trust strengthens the measurement of ‘linking’ social capital.

Linking social capital refers to the relations between individuals and groups in different social strata in a hierarchy where power, social status and wealth are accessed by different groups.²¹ For some commentators, this extends to include the capacity to leverage resources, ideas and information from formal institutions beyond the community.²²

Personal trust of family, friends and neighbours is also covered by Q16. The diagram below suggests possible links between trust (or lack of it) and feelings of personal safety (or

fear of crime). A CRESR study of Liverpool residents documented in a *European Journal of Public Health* article²³ demonstrates a further link between fear of crime and mental health.



Community safety is also an SRB5/6 objective. For these two reasons the questionnaire included two questions on personal safety from the British Crime Survey – ‘safe home alone after dark?’ and ‘safe walking alone in this area after dark?’ In 2000 we were unable to accommodate the focus group recommendation to include the ONS question on fear of walking alone in the neighbourhood during daytime. However we responded to a seminar workshop by giving priority to the ONS question which recorded victims of crime and this question was retained in the follow-up questionnaire (Q19).

e. Civic engagement and efficacy

As with trust, we can distinguish *self-efficacy* from *system efficacy*. The Luton study²⁴ defines self-efficacy as “the degree to which a person feels in control over important aspects of his or her life” and distinguishes two pathways to health. First, the greater ones sense of perceived control, the more likely one is to engage in behaviours known to affect one’s health status. Second, “Low levels of perceived self-efficacy may lead to anxiety and stress and have an impact on health through a range of health damaging stress-related behaviours and biological processes.”

The questionnaire for both surveys includes one question for each. The stress question (Q29) is taken from The Health Education Authority’s 1992 Survey of the UK Population “Looking at this card, which of these sentences best describes the amount of stress or pressure you have experienced in the past 12 months?” The self-efficacy question

²⁰ Putnam, R. (1993) *Making Democracy Work; Civic Traditions in Modern Italy*, Princeton University Press.

²¹ Cole, S and Healy, T (2001) *The well-being of nations: the role of human and social capital*, Organisation for Economic co-operation and Development, Paris.

²² Woolcock, M (2001) ‘The place of social capital in understanding social and economic outcomes’. *ISUMA Canadian Journal of Policy Research* 2 (1) pp11-17.

²³ Green, G., Gilbertson, J.M., Grimsley, M. (2002) ‘Fear of Crime & Health in residential tower blocks; A case study in Liverpool, UK’. *European Journal of Public Health* 12:1 pp10-15.

²⁴ Campbell, C, Wood, R and Kelly, M (1999) *Social Capital and Health*, Health Education Authority, 22.

(Q23), the degree to which respondents are “satisfied with the amount of control I have over decisions that affect my personal life?” is imported from the Social Action Research Project (SARP)²⁵ linked to the HDA Programme.

System efficacy is defined (in British Social Attitudes via the URBAN baseline report for Sheffield)²⁶ as ‘confidence among citizens that institutions will listen and respond to citizens’ views’ and is closely linked to civic engagement. Residents are unlikely to engage in civic affairs unless they believe they have an influence. SRB5/6 can claim that their strategy of democratic renewal and participation²⁷ should lead to better economic performance in the sub-region though it is not a formal baseline measure.

The ONS questions on civic engagement cover a broad spectrum from being informed through involvement in any local organisation to active responsibility. Both survey questionnaires included two ONS questions (Q20 & Q21) – “informed about local affairs?” and “involved in any local organisations?” In the 2004 survey a question on voting taken from the SARP questionnaire in the original survey was dropped as it had not proved particularly useful in the analysis for the original survey. Retained was an ONS questions on system efficacy (Q24) “By working together, people in my neighbourhood can influence decisions that affect the neighbourhood?”

f. Health

The health section of the questionnaire remains unchanged from 2000 and begins with limiting long term illness (Q25) which is derived from the Census and is also used in the General Household Survey. In 2000 it helped to set a baseline for the disability strategy of the HAZ. The EuroQuol EQ-5D (European Quality of Life) was included in the original survey as a succinct and robust tool to capture overall and specific dimensions of health. It includes (Q26a-e) questions ascertaining limits to mobility, self care and ‘usual activities’ and may assist in the evaluation of the SYC HAZ disability programme. The previous application across Europe provides a benchmark against which to compare health status in the coalfield communities. The five SF-36 questions (Q28a-e) which form the Mental Health Index (MHI5) were included because mental health might be more susceptible to change over the period of the study than some other indices of health.

g. Lifestyle

It has been suggested that social capital may influence health behaviour (in either a positive or negative way)

through social control or it may help by promoting health information.^{28 29} In 2004, three prevalence questions on lifestyle (smoking habits, vegetable consumption and healthy diet) have been substituted with Q30 which asks respondents to assess whether there has been any change in their health related behaviour since 2000.

h. Economy

The first Strategic Objective of SRB5/6 is to “Enhance the employment prospects, education and skills of local people.” There is emerging evidence that in deprived communities especially, residents can more easily enter formal employment via an intermediate labour market. This is where “the capacities of local communities in deprived areas are mobilised to participate actively in the development process.”³⁰

As in 2000, the follow-up survey therefore included a question on socio-economic status, or more precisely, labour market status. This question was adapted from the Census because it provided a national benchmark for comparison and excluded the sensitive question of benefits which was not especially relevant for our purposes. Also included again was a question on skills and qualifications (Q33) categorised as equivalents to National Vocational Qualifications. These equivalents had been taken from the Labour Force Survey and successfully tested in the Coalfield Community Survey.

The open ended barriers to employment question asked in the 2000 questionnaire, was dropped in 2004 as it did not prove useful in the original analysis.

4. Final questionnaire structure and content

The 2004 questionnaire design is summarised in figure 3.4 overleaf. New or modified questions are shown in red. It is largely based on the original questionnaire design and has only 34 questions in total. Questions are mainly imported from ONS including the harmonised question set devised as part of the ONS Social Capital Project. One or two are imported from SARP and most others from the complementary community study (CCS) undertaken by CRESR at the time of the first social capital survey. In turn most of these questions are adapted from national studies. Such a design ensures that we can maximise national comparisons as well as compare change over time.

²⁵ Social Action Research Project, Questionnaire (April 1999) Division of Health medicine and Epidemiology, School of Community Health Services, The University of Nottingham.

²⁶ Joint Institute for Social & Economic Research *People and Places in the North west Inner City area of Sheffield*, 1999.

²⁷ South Yorkshire Coalfield Partnership, *Helping Communities Build a Better Future: Final Bid for SRB Round 5*, 1999.

²⁸ Berkman L.F. and Glass T. (2000) ‘Social Integration, Social Networks, Social Support and Health’ in Berkman L.F. and Kawachi, I. (eds.) *Social Epidemiology*, Oxford: Oxford University Press.

²⁹ Kawachi, I. and Berkman L.F. *Social Cohesion, Social Capital and Health* in Berkman L.F. and Kawachi, I. (eds.) *Social Epidemiology*, Oxford: Oxford University Press.

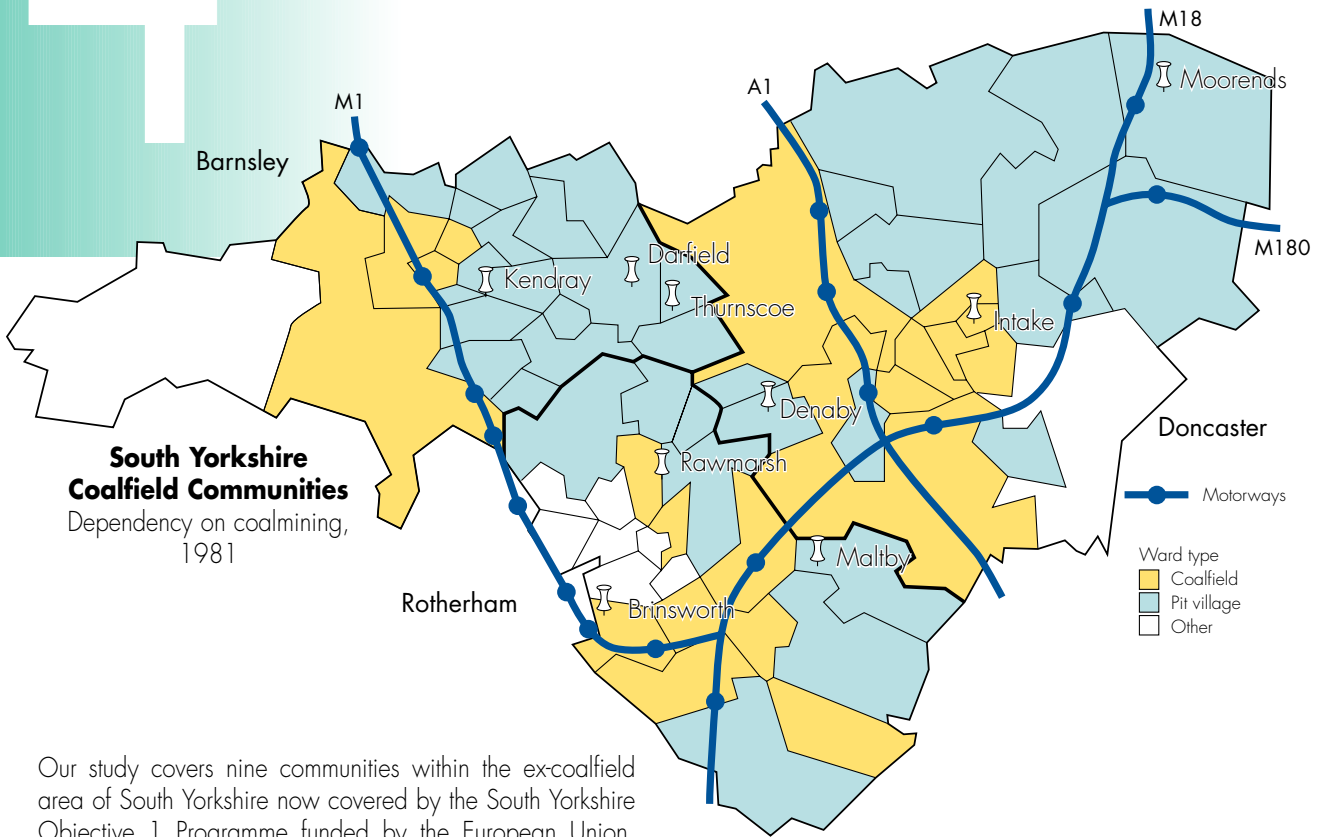
³⁰ Lloyd, P. and Ramsden, P. (1998) *Local Enterprises in Enterprising Localities: Area based Employment Initiatives in the UK*. Final report. University of Liverpool and Enterprise plc.

Figure 3.4: Follow-up questionnaire structure and content

Section	Question	Scale points	Source	No. var
Demographics	(a) Address			1
	(b) Date of Birth			1
	(c) Sex	2		1
	1. Structure of Household			6
(a) Neighbourhood	2. Tenure	7	Census+	1
	3. How long lived in area	7	CCS EHS/MORI	1
	How long lived in property	7	CCS EHS/MORI	1
	4. Satisfaction with area	5	CCS EHS/MORI	1
	5. Change in area	5	CCS EHS/MORI	1
	6. Want to stay in area	2	EHS	1
	Likely to stay in area	5	EHS	8
	7. Satisfaction with facilities?	5	CCS	1
	8. Problems with drug/alcohol	5	ONS	1
9. Problems with hooliganism	5	ONS		
(b) Networks	10. Neighbourhood Networks	4	ONS	1
	11. Different backgrounds get on	4	ONS(hq)	1
	12. Contact neighbours/friends	11	CCS +work	4
(c) Reciprocal help and support	13. Kind of neighbourhood	4	BCS	1
	14. Favour for neighbour	3	ONS	1
	15. Help with lift	3	ONS	1
	Who ask for help	1	(ONS hq)	10
(d) Trust and security	16. System and personal trust	5	ONS/CCS	9
	17. Safe at home at night	4	BCS	1
	18. Safe out at night	4	BCS	1
	19. Victim of crime	2	ONS	1
(e) Civic engagement and efficacy	20. Informed about affairs	4	ONS	1
	21. Involved in local organisation	3	ONS(hq)	1
	22. Which groups taken part in	1	ONS(hq)	13
	23. Personal efficacy	5	SARP	1
24. Working together influence	5	ONS(hq)	1	
(f) Health	25. Limiting long-term illness	2	Census/GHS	1
	26. State of health	5x3	EQ-5D	1
	27. State of health thermometer	1	EQ-5D	1
	28. Mental wellbeing	5x6	SF-36 (MHI)	5
	29. Stress	4	HEA	6
(g) Lifestyle	30. Is life healthier	2	HLS	1
	Way life is healthier	1	HLS	5
(d) Economic	31. Economic status	10	Census	1
	32. Training	2		1
	33. Skills and qualifications	6	CCS/LabForce	1

Key: Census = 1991 UK Census, CCS = Coalfield Community Survey; ONS = Office of National Statistics (hq = harmonised questions 2003) Core Social Capital questions; HEA = 1992 Health Survey, HLS = Health and Lifestyle Survey undertaken by the then Social and Community Planning Research. The research was conducted by the Department of Community Medicine at the University of Cambridge in 1984/5 and 1991/2 and sponsored by the Health Promotion Trust. EQ-5D=Euroqual. SF-36 = Short Form 36. Note: Total 33Questions, 95 Variables.

4



Our study covers nine communities within the ex-coalfield area of South Yorkshire now covered by the South Yorkshire Objective 1 Programme funded by the European Union. Now only four mines are working. Twenty years ago there were 39 pits and the map shows how the mining communities were distributed across the 65 electoral wards included in the three Metropolitan Boroughs of Barnsley, Rotherham and Doncaster at the time.

Following a convention developed at Sheffield Hallam University¹ and adopted by the UK Government Task Force², 'pit village' defines a ward where over 25% of males worked in mining. It was highest in Thurnscoe – one of our study areas – where two-thirds of resident men worked in the mines. 'Coalfield communities' defines a ward where between 10% and 25% of males worked in mining. Less than 10% worked in mining in a couple of rural areas and in eight 'inner city' wards of Rotherham. Taken as a whole, coal mining dominated the sub-region and engendered high levels of solidarity in the workplace and high levels of community spirit in the villages and towns which housed its workforce.

The nine communities, three from each of three boroughs, were originally selected in 2000 by the Social Capital Steering Group. They were chosen to reflect the diversity of the Coalfield using a schema developed by Barnsley MBC representatives. Deprived areas could either be 'inner urban' or 'Pit villages'. Mixed areas are generally more prosperous.

The Index of Multiple Deprivation (IMD) (now produced by the Office of the Deputy Prime Minister) places the nine communities within a wide socio-economic context. Denaby

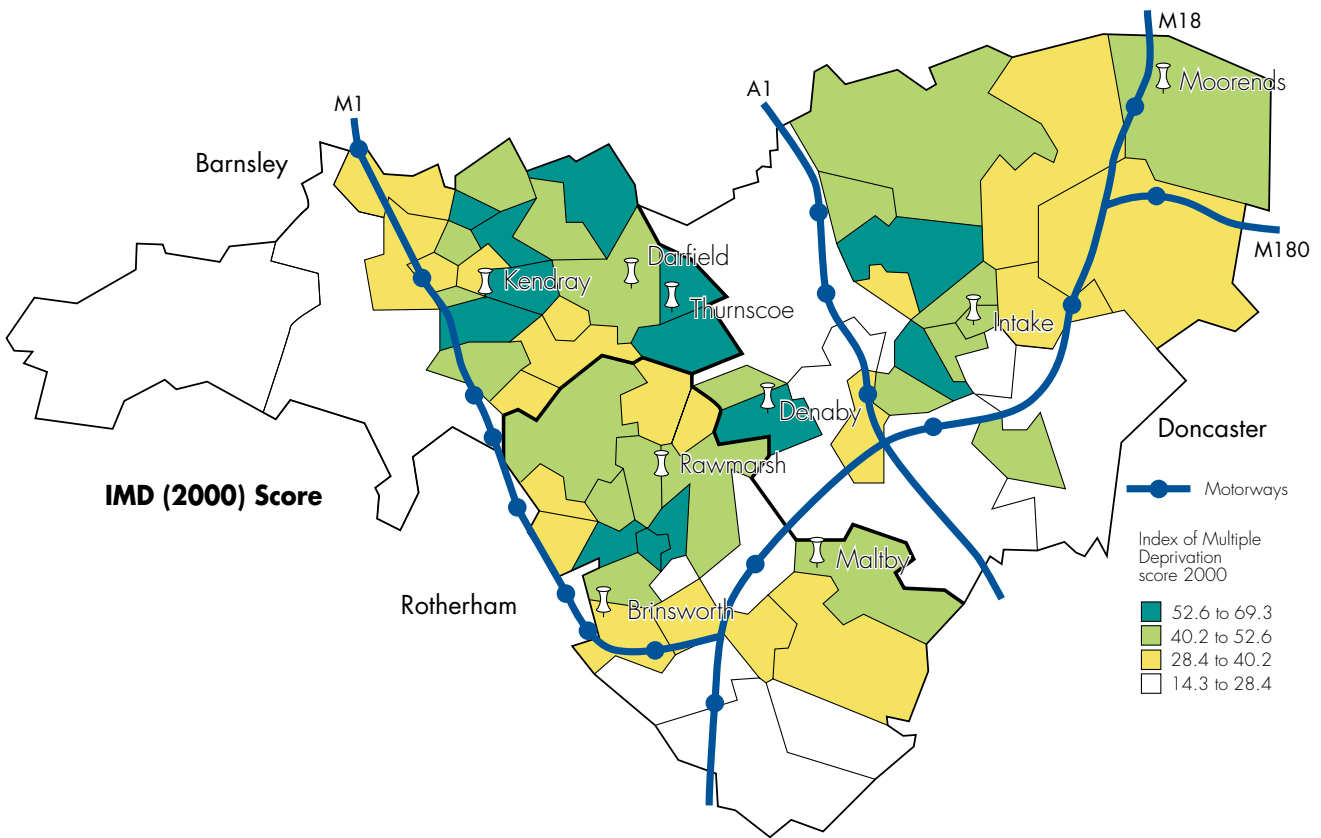
Figure 4.1: **Study areas**

Area	Type	Ward 2004	Borough
Darfield	Mixed	Darfield	Barnsley
Kendray	Inner urban	Stairfoot	Barnsley
Thurnscoe	Pit village	Dearne North	Barnsley
Denaby	Pit village	Conisbrough & Denaby	Doncaster
Intake	Inner urban	Town Moor	Doncaster
Moorends	Pit village	Stainforth & Moorends	Doncaster
Brinsworth	Mixed	Brinsworth & Catcliffe	Rotherham
Maltby	Pit village	Maltby	Rotherham
Rawmarsh	Inner/pit	Rawmarsh	Rotherham

was found to have the highest level of deprivation and only Brinsworth had less deprivation on average than the South Yorkshire Coalfield as a whole. Some areas such as Denaby and Moorends were found to be fairly homogeneous across their Enumeration Districts. In contrast, there was wider variation between the Enumeration Districts in Intake and Thurnscoe.

¹ Beatty C & Fothergill S (1996) Labour Market Adjustments in Areas of Chronic Industrial Decline: The case of the UK coalfields, *Regional Studies*, 30:7.

² Coalfields Task Force (1998) *Making the Difference: A new start for England's Coalfield Communities*. London: DETR.



Despite these differences between the areas, the focus groups held back in 2000 in Kendray, Moorends, Maltby and Rawmarsh held very similar views on 'community spirit':

- Used to be related to working class identity. The discipline of the mining industry helped socialise workers and this regard for other people spilled over into community life.
- Support by trade unions, working clubs, social and sports clubs, dances and events, neighbourhood pubs. There used to be plenty of leisure time activities, both political and non political offering possibilities for gathering and socialising.
- The big change started in the late 1980s when the mines closed. Mass unemployment started migration into and out from the communities. Closing the mines also affected other business in the area.
- Work-related leisure time activities partly collapsed. Also private enterprise diminished due to the economic situation (cinemas and shops closing, fewer facilities to provide meeting places).
- Second generation unemployment has changed family structures and daily routines. Children and young people are lacking social skills and have poor capacity to strive for further education. The economic situation in communities does not give hope for the future.
- Unemployment is not the only reason for the lack of community spirit. People have more individualistic attitudes, regardless of their economic or social status.

- Residents who have lived in the area for 10 years or more are more likely to show interest in community development. This applies also to older generations with personal experiences of the coalfields and community spirit.
- Respect for private property and public property has declined. Graffiti, garbage and vandalism are symptomatic of the decline.
- New initiatives by the communities and by the authorities are helping foster community spirit, but progress is slow and there are never enough resources to rebuild the areas to the same economic and social levels as before.

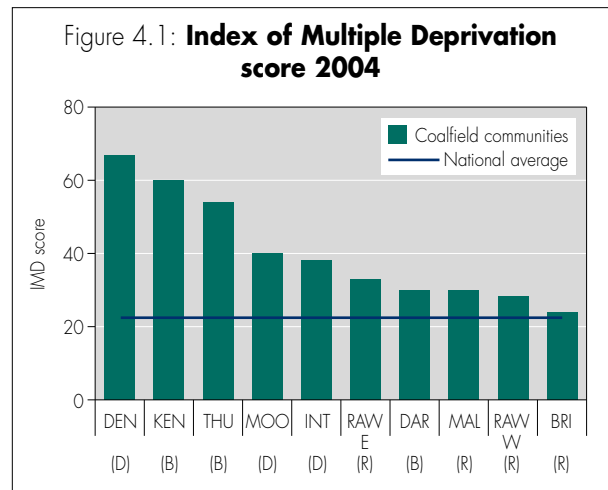


Figure 4.1, indicates current levels of deprivation in the nine communities and compares this to the national average using the Index of Multiple Deprivation 2004 (IMD 2004). The IMD 2004 is a measure of multiple deprivation at the small area level produced by the Social Disadvantaged Research Centre (SDRC) for the Office of the Deputy Prime Minister (ODPM). The Index is a Super Output Area (SOA) level measure of multiple deprivations and is made up of seven SOA level domain indices. The seven domains relate to income deprivation, employment deprivation, health deprivation and disability, education, skills and training deprivation, barriers to housing and services, living environment deprivation and crime. Higher scores indicate more deprived areas.

The IMD scores illustrate that in 2004 all nine of our communities have higher levels of deprivation than the national average. The relative position of the nine study areas to each other is similar to 2000. Denaby and Kendray remain the two most deprived areas. For example, Denaby has an IMD score of 66 compared with a national average of 22 and an average across the nine areas of 40. Brinsworth was the least deprived area in 2000, and is still the least deprived area in 2004. However, it should be noted that the IMD score reveals higher levels of deprivation in Brinsworth compared with the national average.

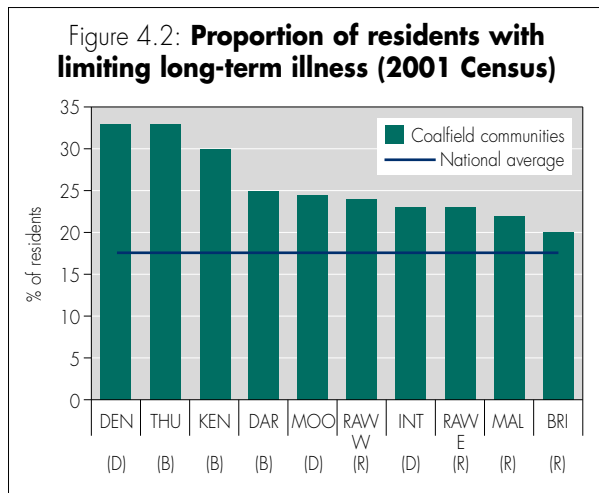


Figure 4.2 illustrates levels of limiting long-term illness across the nine communities and compares this with the national average. All nine communities have higher levels of limiting long-term illness than the national average. This is most notable in Denaby and Thurnscoe, where 33 per cent of residents in both areas have a limiting long-term illness, almost double the national average (18 per cent).

For each of the nine areas we have gathered further information relating to tenure, economic context, health and educational attainment. These statistics, together with contextual information about area characteristic and Area Based Initiative activity are presented as area profiles for each of the nine communities.³

³ **Area Profiles**

It is important to note that not all the data in the area profiles relate to the study areas.

Barnsley areas:

Health indicators and unemployment figures are based on electoral ward boundaries. All other figures are based on the study areas.

Doncaster:

All indicators apart from teenage conceptions (which is based on electoral ward boundaries) are based on Doncaster's locally agreed 'community/neighbourhood boundaries'.

Denaby: the area is identical to the study area.

Intake: the area is virtually identical, but also includes a school and wooded area.

Moorends: the boundary is much larger geographically. However, the additional area is mainly rural incorporating approximately 10 farms and a small residential area near Thorne.

Rotherham:

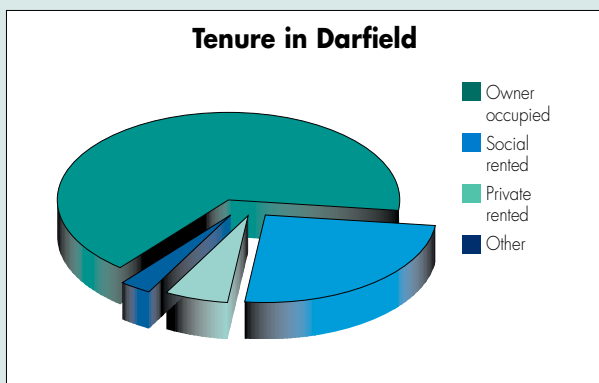
All indicators are based on electoral ward boundaries.



Characteristics and changes

Darfield is a mixed area, traditionally based on coal-mining and now benefiting from large scale environmental and commercial regeneration in the Dearne Valley. New housing development has led to a modest increase in population. Though conditions have generally improved since 2000, Darfield remains divided between traditional coal-mining neighbourhoods and modern estates

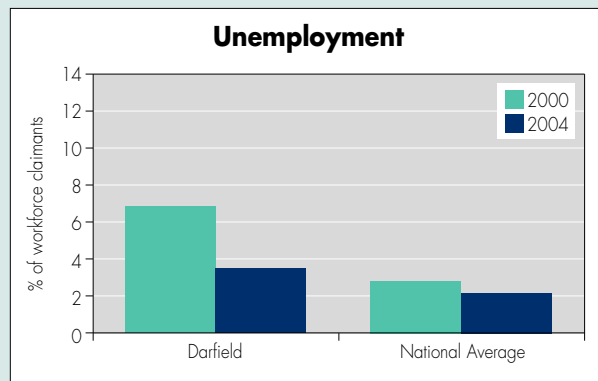
Tenure



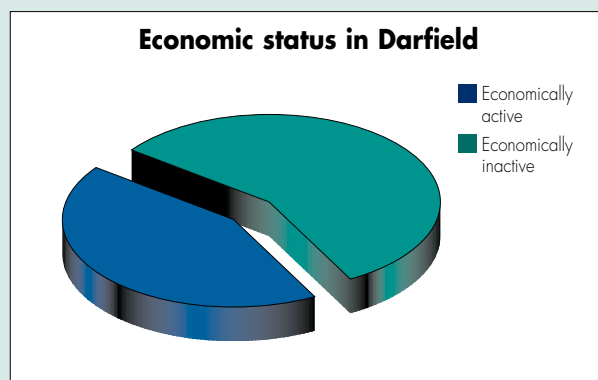
Council housing dominates the central and northern areas of Darfield. These are mainly deprived areas contrasting with affluent modern private housing estates to the west, around Upperwood Hall, and on the southern fringe. The oldest part of the village, around Church Street and School Street, has mixed private housing.

Economic context

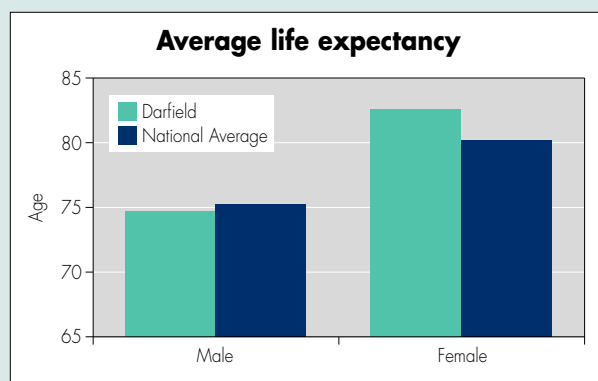
Unemployment in Darfield has tended to be slightly below the Barnsley average. Since 2000 claimant rates have fallen sharply from 6.5 to 3.5 per cent, close to the National average and well below the average for Barnsley.



43 per cent of Darfield residents of working age are economically active. This is the highest proportion of economically active residents of the three Barnsley communities in the study and only five per cent lower than the national average of 48 per cent.



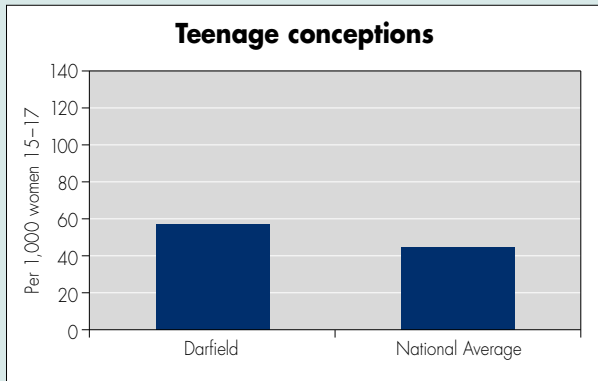
Health



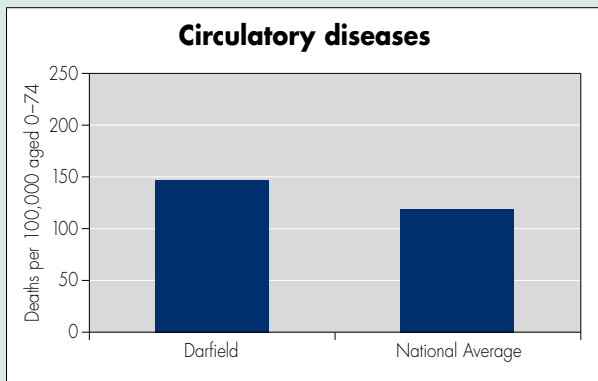
Average life expectancy in Darfield is relatively high compared with the other two Barnsley communities but

similar to the national average. Male residents have a life expectancy of 75, the same as the national average. Female residents have an average life expectancy of 83, three years older than the national average, 80.

Teenage conceptions, at 58 per 1000 women aged 15 to 17, are the lowest of the three Barnsley communities but still substantially higher than the national average (45 per 1000 women aged 15 to 17).

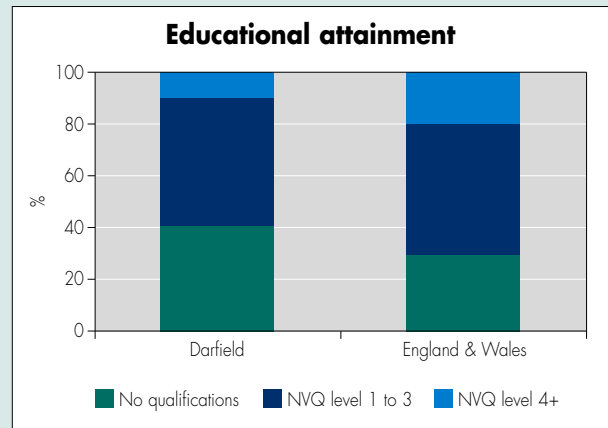


Similarly, the number of premature deaths in Darfield attributed to circulatory diseases is substantially higher than the national average but lower than the other two communities; 148 deaths per 100,000 compared with 120 deaths nationally.



Education

Educational attainment Darfield is highest of the three Barnsley communities. However, it is still substantially below the national average. Ten per cent of Darfield residents have qualifications at degree level or above; half the national average (20 per cent).



Area Based Initiatives

Community initiatives in Darfield have been led by the Villages Four Community Partnership. However, weaknesses in community and voluntary sector led to Objective 1 Pioneer status for the area. A Community Audit was undertaken in 2003 to establish residents' needs and Darfield Community Association has developed Objective 1 regeneration projects.

Darfield has benefited from a number of regeneration initiatives. These include Objective 1 (Priority 4 and a Pioneer Area), Single Regeneration Budget (SRB), Neighbourhood Support Fund, Neighbourhood Renewal Fund, Action Team for Jobs, Enterprise Areas, HAZ and Healthy Living Barnsley.

A Family Support Strategy is being implemented. The HAZ project addresses lifestyle issues through the employment of two health outreach workers. A large new health centre has been built in Darfield Park and more health-related developments are proposed. However, Darfield is not identified as a main priority area for regeneration and funding levels have been notably lower than in the other two Barnsley communities.



Characteristics and changes

On many indicators, Kendray is the most deprived community in Barnsley, with low household incomes and relatively high levels of unemployment and crime.

The biggest change in this 'inner urban' area since 2000 has been the demolition of several large blocks of council housing, in line with the *Kendray Blueprint* plan. Empty homes and associated problems presented a challenge in the mid to late 1990s. Around 5 per cent of the stock was empty in 1999, increasing to 10 per cent a year later. The first phase of demolition removed about 200 houses in the central area (soon after the first Social Capital Study in 2000). Empty homes peaked at 14 per cent in 2003; then a final wave of 150 demolitions in North West Kendray reduced the vacancy rate to 8 per cent in 2004.

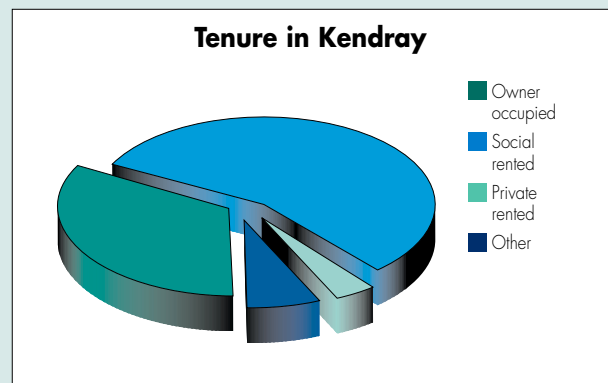
Most of the cleared central area is designated for recreational space although some land may be used for new community buildings. The area cleared in North West Kendray in 2003 is to be redeveloped for new housing. However, very little new replacement housing was actually built between 2000 and 2004.

During the transitional period between the two social capital surveys, demolition and out-migration reduced the population by about 15 per cent, stabilising just below 5,000.

In 2000 only 39 per cent of residents were satisfied with Kendray as a place to live. Then the picture was transformed, according to a NOP survey for the Neighbourhood Management Pathfinder. By 2003, satisfaction increased to 74 per cent and dissatisfaction fell from 55 per cent to 20 per cent.

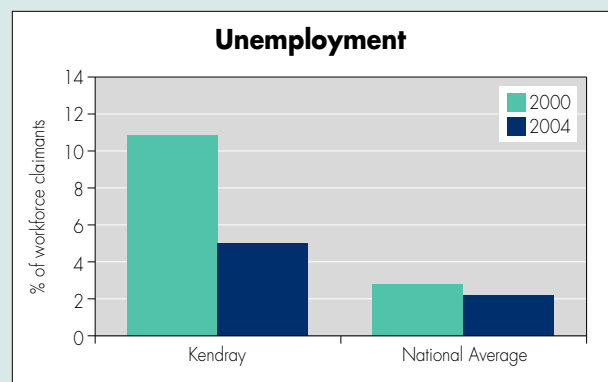
Tenure

Most of Kendray was built as council housing. Deprivation is fairly evenly spread, although it is highest in the central and western parts. The only exception to the general pattern is a small private estate in the south east. The demolition and sale of council houses has reduced the proportion of households renting from the council from 76 per cent to 65 per cent.

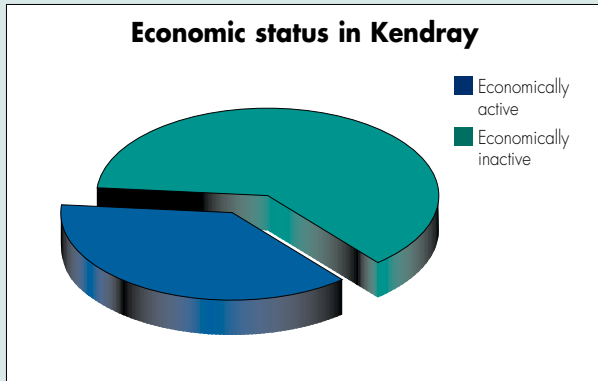


Economic context

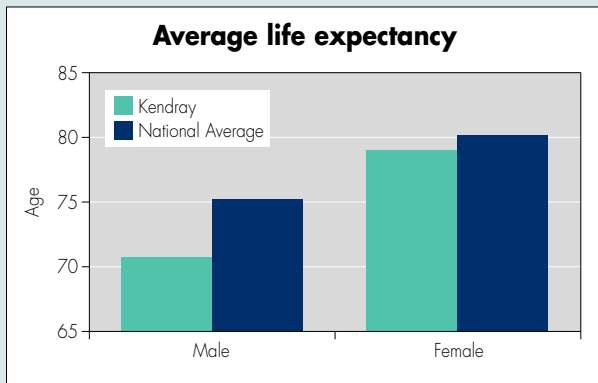
Unemployment in Kendray is high but fell from 11 per cent to 5 per cent between 2000 and 2004, less than in Darfield but typical of Barnsley.



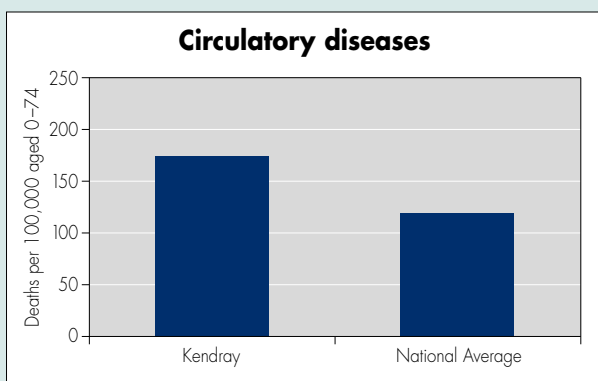
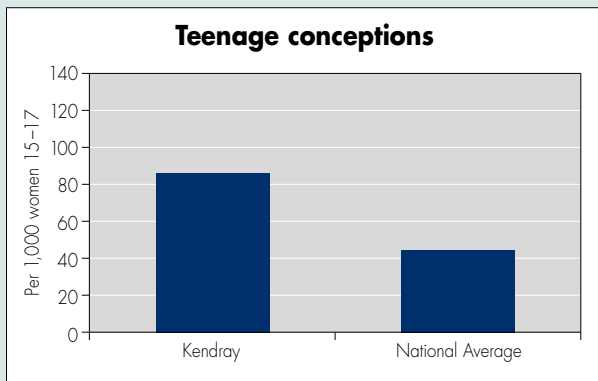
The percentage of the population economically active (32 per cent) is low compared with the national average, and lower than the Barnsley average.



Health



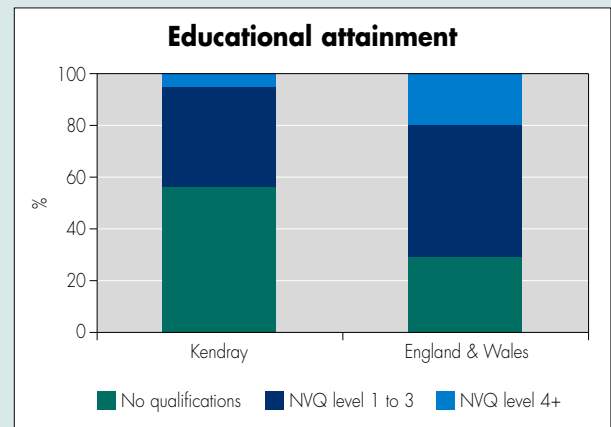
Kendray has similar average life expectancy to the national average for female (79 compared with 80) but lower than the national average for males (70 compared with 75).



The community also has a high teenage conception rate of 87 per 1000 women aged 15 to 17 and a high premature death rate attributable to circulatory diseases of 175 per 100,000 deaths.

Education

Educational attainment is lower in Kendray than for the two other Barnsley communities and substantially below the national average.



Area Based Initiatives

The high level of deprivation and decline of Kendray led to the area being targeted for a host of regeneration initiatives, co-ordinated after 1999 by the *Kendray Initiative*. Residents' involvement is encouraged at all levels of the regeneration process, led by the *Laying the Foundations* group, the *Kendray Initiative Board* and *Kendray and Worsbrough Sure Start*.

Funding for regeneration activity of all kinds has been considerable and many agencies are active in the area. The main funding streams have been SRB5, SRB6 (Target Area for both), Objective 1 Priority 4, Neighbourhood Management Grant, Sure Start and HAZ. Regeneration activity is co-ordinated to help capacity building. Environmental improvements have been made and two new playgrounds opened.

ABIs in Kendray include a Neighbourhood Management Pathfinder with the key themes of Housing and Estate Management, Community Safety, Young People, Worklessness and Promoting Kendray. Kendray has also benefited from being part of a Burglary Reduction Initiative, Education Action Zone (Elmhirst School), Neighbourhood Wardens scheme, Sure Start Programme and a HAZ.



part of Thurnscoe, with about 14 per cent of homes empty in 2003. Since 2000, large blocks of terraced houses here have been demolished and there has been some new building. Most former National Coal Board (NCB) homes are owner occupied but large numbers are rented from a housing co-op or privately.

The larger part of Thurnscoe lies to the west of the railway line and divides crudely into two parts. The areas north of Houghton Road and in the central area are dominated by council estates which are in a better physical condition than the former NCB housing in Thurnscoe East, with few empty homes.

South of Houghton Road, Thurnscoe becomes more mixed. The south western and western fringes, are areas with suburban owner occupied housing. A new housing estate built in south west Thurnscoe since 2000 has reinforced this pattern. South Thurnscoe, similar to Thurnscoe East, is mainly former NCB housing but in very good condition.

Characteristics and changes

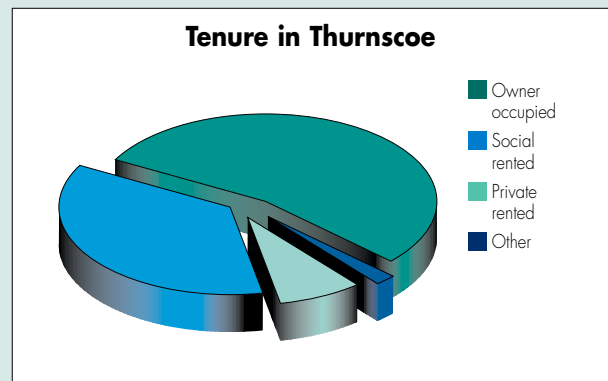
In 2000 Thurnscoe was chosen for the Social Capital Study because it was a deprived "pit village" community. The coal mining industry employed 42 per cent of Dearne Thurnscoe workers as recently as 1981 and the five nearest mines employed 5,743 men. The loss of mining hit Thurnscoe hard and Dearne Thurnscoe/Dearne North is the most deprived ward in the Borough.

Almost all indicators show Thurnscoe to be one of the most disadvantaged communities in Barnsley with high levels of health, employment and education deprivation. Despite the collapse of coal mining and severe social deprivation, Thurnscoe has retained a strong community spirit and has had a relatively low population decline over recent years. A burglary rate below the Barnsley average probably reflects the strength of family and community networks.

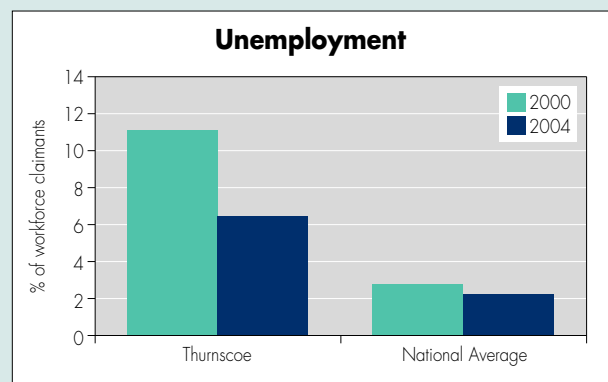
Thurnscoe East is the most deprived neighbourhood in Barnsley, as estimated using the Index of Multiple Deprivation 2004. However, in the west social deprivation is almost as severe as in the east, with very high rates of sickness and disability.

Tenure

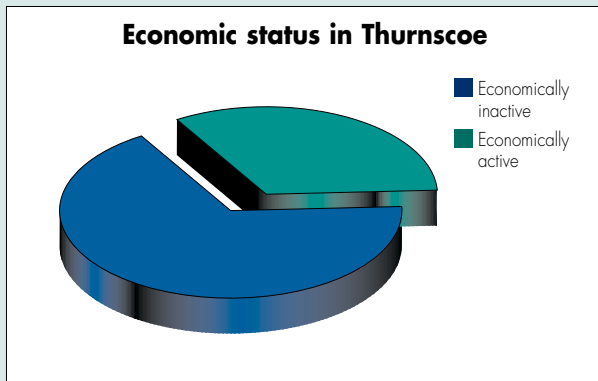
Thurnscoe is divided into two by the Sheffield – York railway line. East of the railway line is Thurnscoe East, dominated by a former NCB housing estate which is the most dilapidated



Economic context



Over 30 per cent of working age people in Thurnscoe are not in employment, many being long term sick. Unemployment has fallen by 40 per cent, slightly less than the Barnsley average and a much lower fall than in Darfield. Only 33 per cent of the population are economically active, a similar proportion to Kendray, but lower than in Darfield.

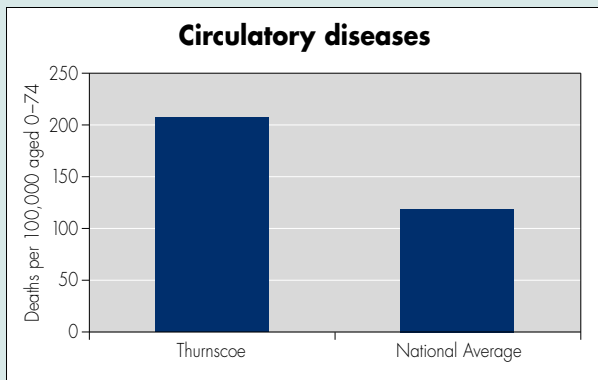
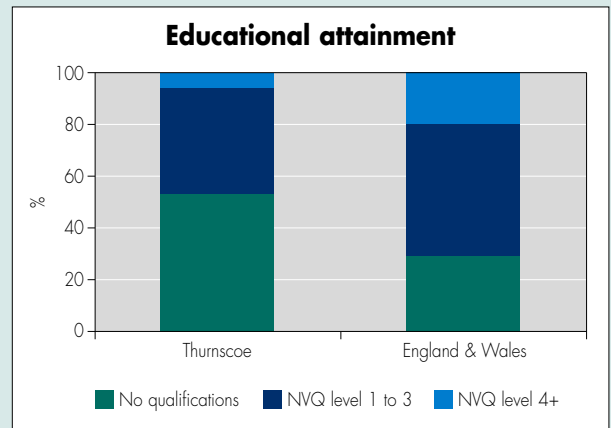
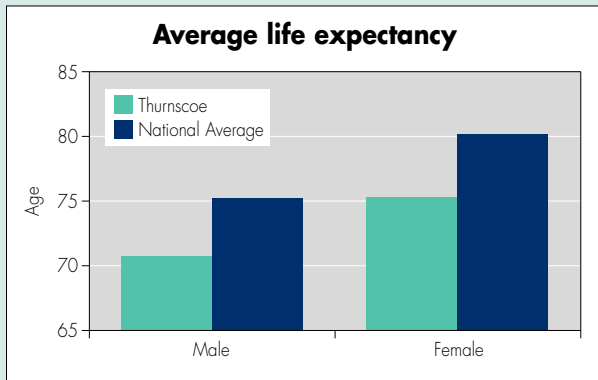


High levels of health deprivation in Thurnscoe are demonstrated by low life expectancy, high rate of teenage conceptions and high number of premature deaths attributable to circulatory diseases. The rate of teenage conceptions, 130 per 1,000 women aged 15 to 17 is particularly striking. This is almost 3 times the national average of 45 per 1,000.

Education

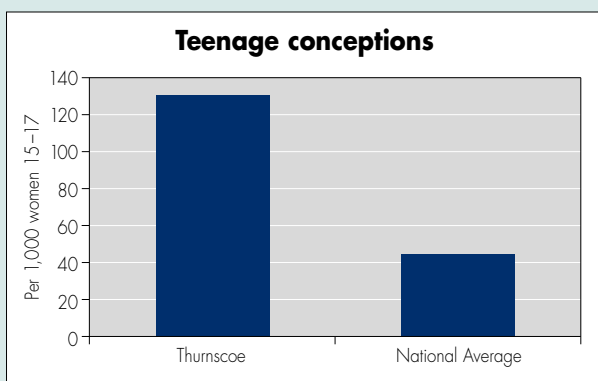
The proportion of residents obtaining any qualification is substantially lower than the national average. Over half of Thurnscoe residents have no qualifications and only six per have a degree.

Health



Area Based Initiatives

The housing problems of Thurnscoe are now being addressed through the "Transform South Yorkshire" Housing Market Renewal Pathfinder. Funding from this source has already been used for demolition work in Thurnscoe East and environmental improvements around the eastern "gateway" to Thurnscoe. However, this initiative did not make a major impact until 2005.



Other initiatives active in Thurnscoe are SRB6 (Target Area), Sure Start, Objective 1 Priority 4, Education Action Zone, Action Team for Jobs and the Healthy schools programme. Environmental improvements have focussed on turning derelict land into recreation and amenity space such as Phoenix Park in the south east. Energy in the Community, funded by TXU has benefited many of the homes in Thurnscoe through energy efficiency measures. The main HAZ project specific to Thurnscoe is the Heart Health Community Development Project which works with the community to improve heart health through physical activity etc. There are also sports development workers.

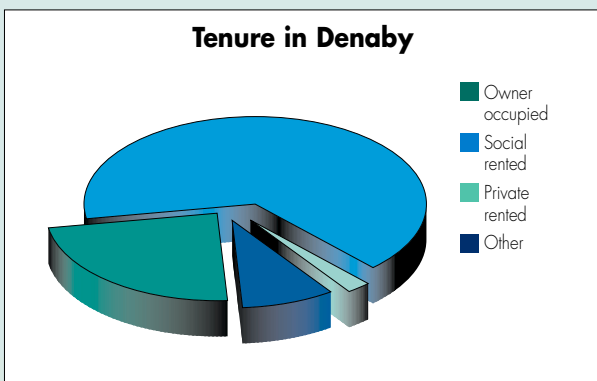
Community action is led by Dearne Community Partnership and the Dearne Area Forum. As identified in 2000, informal social networks are well developed in most of Thurnscoe.



Characteristics and changes

Denaby is a traditional pit village immediately north of Conisbrough, with a population of around 4,000. Notable infrastructure developments are the road bridge over the railway line linking Mexborough and Denaby and the Dearne Valley Leisure Centre. However, The Earth Centre, which is located in Denaby, has recently gone in to administration and is currently closed to the public.

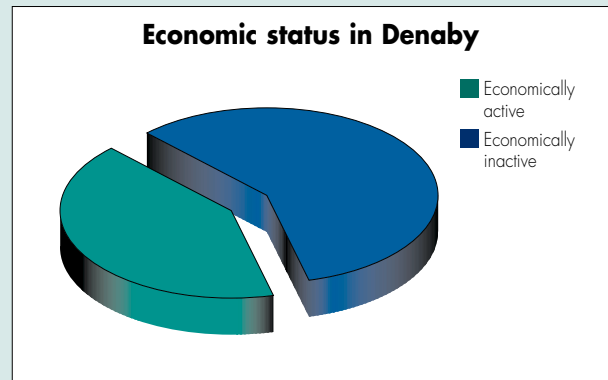
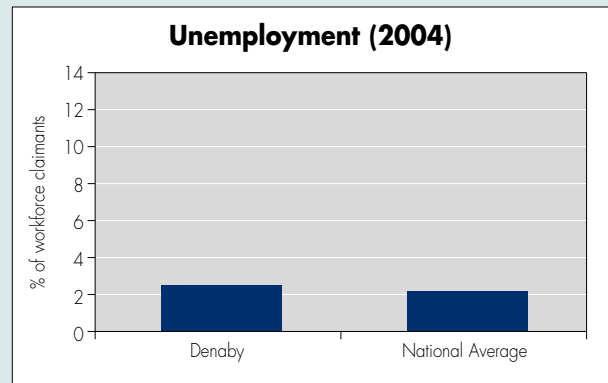
Tenure



Sixty-six per cent of properties in Denaby are social rented. This proportion is over three times the national average (19 per cent) and is substantially higher than the other eight study areas. Owner occupation represents less than 25 per cent of housing tenure.

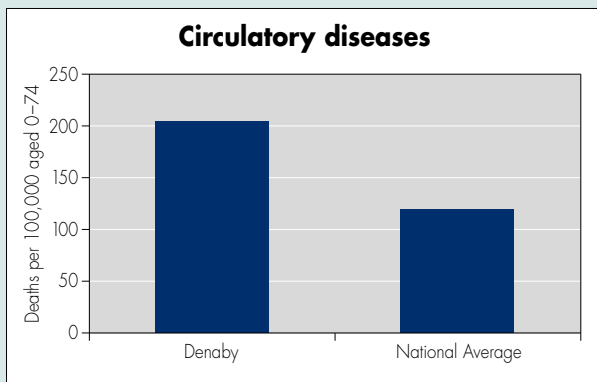
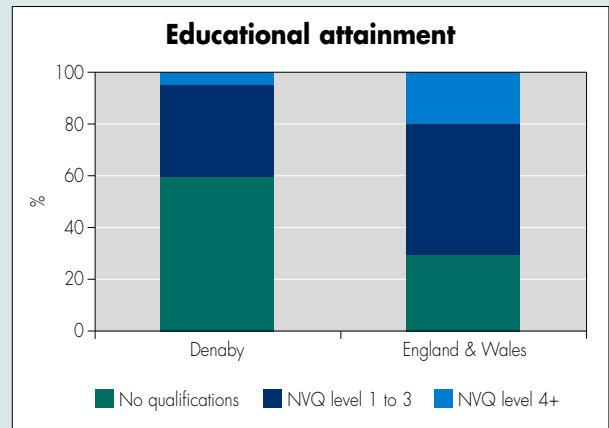
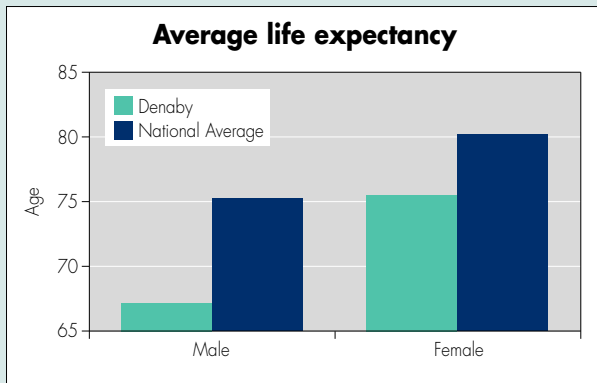
Economic context

The unemployment rate for Denaby (2.5 per cent) is higher than the national average (2.2 per cent), but lower than the Doncaster rate (2.7 per cent). However, Denaby has high levels of limiting long-term illness and only 42 per cent of residents aged 16 to 74 are economically active.



Health

Health indicators reveal that Denaby suffers from high levels of health deprivation compared with both the national picture and the other eight study areas. Life expectancy for men in Denaby is 67 years, 8 years younger than the national average and at least 3 years younger than the other eight study areas. Life expectancy for women (76), is also substantially lower than the nationally average (80) and relatively low compared with the other areas. The premature death rate attributable to circulatory diseases at 203 per 100,000 is also particularly high.

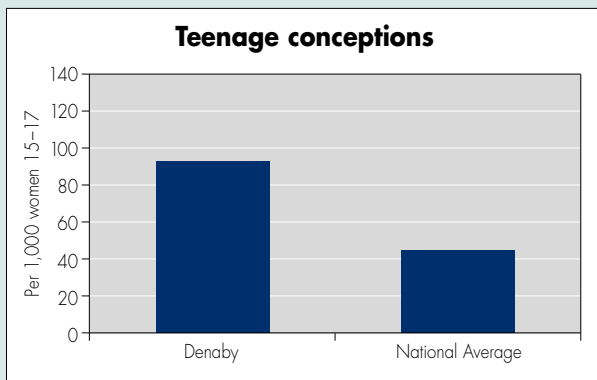


Area Based Initiatives

Denaby Main Forum, with the support of Conisbrough and Denaby Development Trust, hosts a monthly public meeting with increasing numbers of individuals and groups engaged in their community.

Denaby has a local service delivery partnership with a multi-agency membership dedicated to improving local services. It is an Objective 1 (Priority 4a: Supported Communities: Community Action Pan) area and receives SRB6 funding. It is also part of the Housing Market Renewal pathfinder area (although, it should be noted, there have been no major housing projects over the past three years).

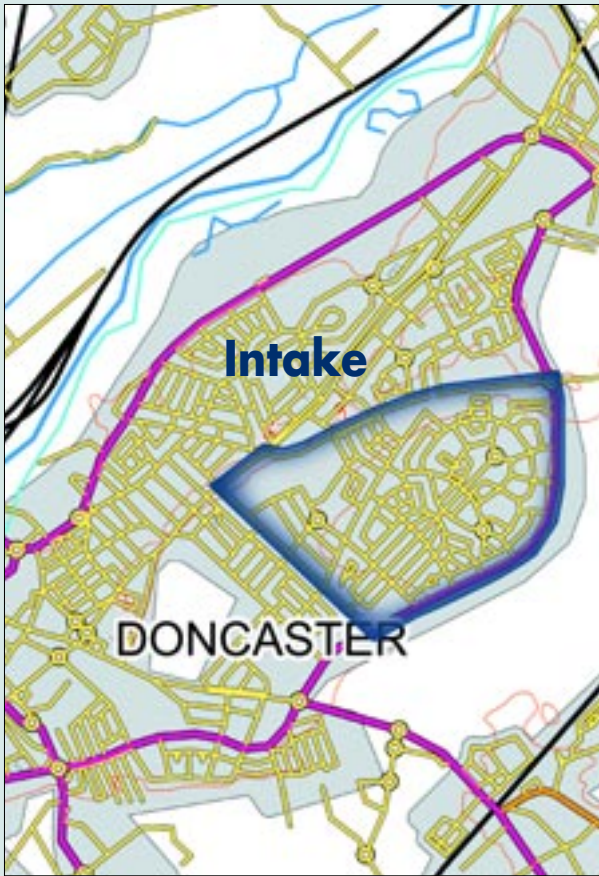
Denaby has a teenage conception rate of 93 per 1,000 women. This is high compared with a national average of 45, but not untypical of the South Yorkshire Coalfield communities.



During the last three years a new leisure centre has been built and a new skate park opened. Northcliffe School and its 'pyramid' of infant and junior schools are part of the only Education Action Zone in Doncaster (EiC Action Zone). To improve employment opportunities in the area a Training and Enterprise Centre was opened in September 2004 by Denaby Main Forum. This centre is a Learning Gateway providing basic skills and IT training which will hopefully lead learners on to accessing construction skills training. The centre complements a community shop run for several years by Denaby Main Forum, with support from Conisbrough and Denaby Development Trust, that attracted over 5,000 users in 2004. Denaby is also located in the area served by Community Wealth Credit Union Ltd., and has the Sure Start initiative.

Education

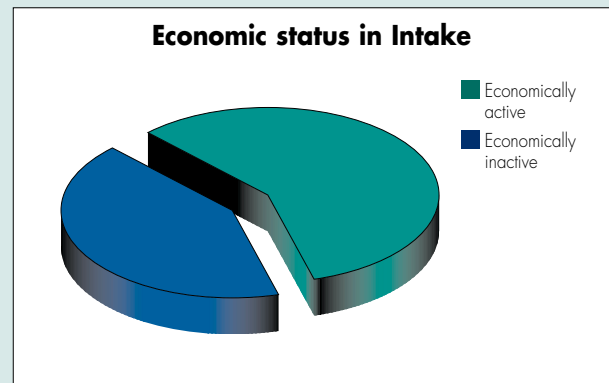
Denaby also experiences high levels of educational deprivation. Compared with the national picture, it has double the proportion of residents without qualifications (60 per cent compared with 29 per cent) and a quarter of the proportion of residents obtaining at least degree level qualification (5 per cent compared with 20 per cent).



Intake is a mixed tenure area. Owner occupation accounts for just over half of all housing in the area and social renting accounts for 38 per cent.

Economic context

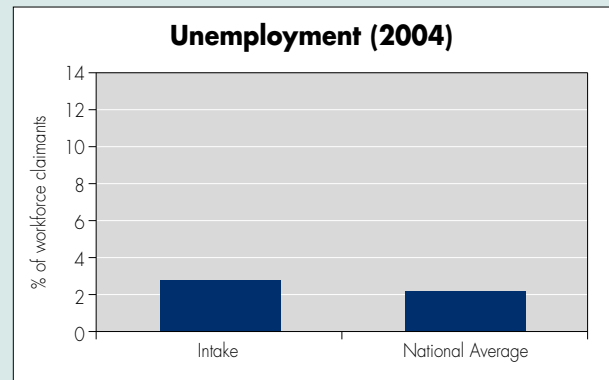
Intake has high levels of economic activity amongst 16 to 74 year olds compared with the other Doncaster study areas. Fifty-eight per cent of residents are economically active compared with 42 per cent in Denaby and 44 per cent in Moorends. However, the unemployment rate in Intake (2.8 per cent) is higher than both the national (2.2 per cent) and Doncaster average (2.7 per cent).



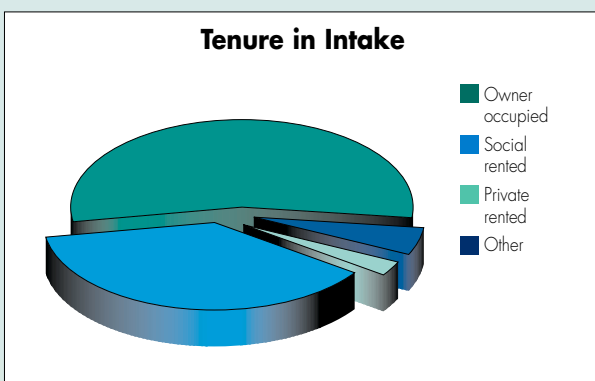
Characteristics and changes

This is a large inner-urban neighbourhood of over 8,500 people to the east of Doncaster town centre. The most notable improvement in infrastructure is a new sports centre which has been built in the last year.

Recently there have been some concerns expressed in Intake over the dilapidated state of the community centre and plans are in place to improve this community facility.

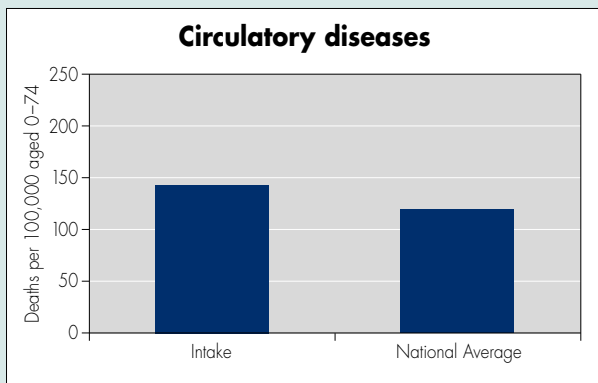
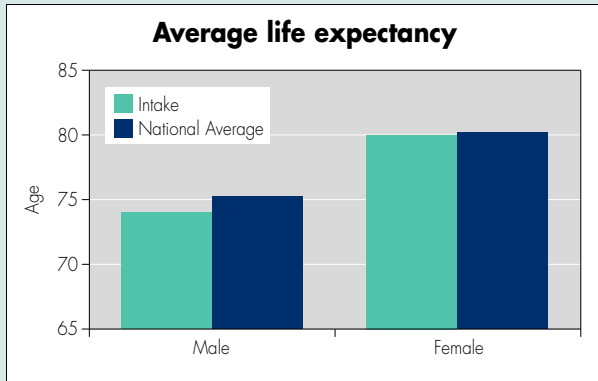


Tenure

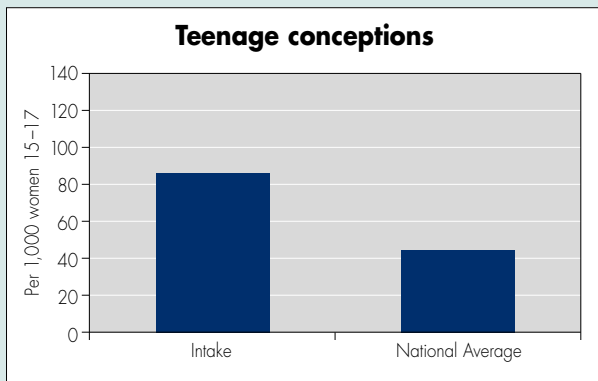


Health

Life expectancy for Intake residents is similar to the national average. Female residents have a life expectancy of 80, the same as the national average and male residents have a life expectancy of 74, one year younger than the national average. Intake has the second lowest rate of premature deaths attributable to circulatory diseases but at 143 deaths per 100,000 residents this is still 23 higher than the national average.

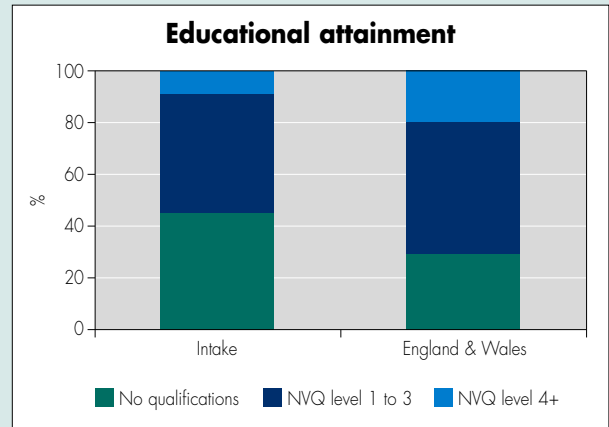


Intake has a lower teenage conception rate than the two other Doncaster areas (86 per 1,000 women aged 15 to 17). However, this figure is almost double the national average (45 per 1,000 women aged 15 to 17).



Education

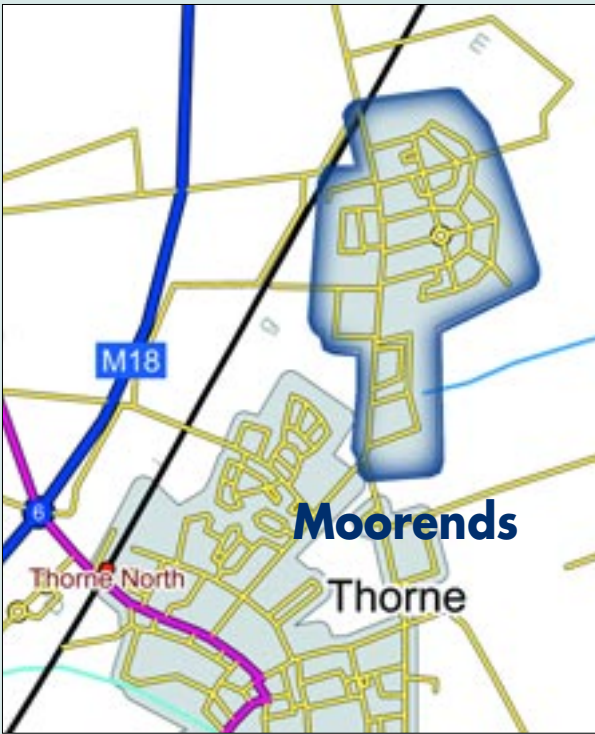
Educational attainment in Intake is typical of the nine study areas. Forty-five per cent of residents have no qualification (compared with 29 per cent nationally) and 9 per cent have degree or equivalent level qualifications (compared with 20 per cent nationally)



Area Based Initiatives

Intake has a well-established Sure Start project run from Sandringham road. Also there is a recently developed community social enterprise centre that has a number of community projects based in it.

Intake has received both Objective 1 (Priority 4a: Supported Communities: Community Action Plans and Target areas) and SRB money to fund various projects and has undertaken a number of community audits. The area also has also produced a neighbourhood management plan.



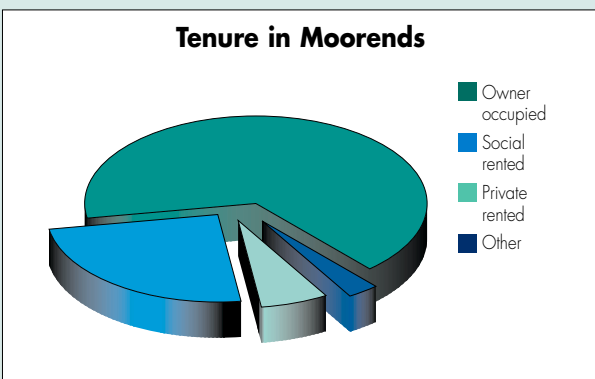
Characteristics and changes

Moorends is a modern pit village of 5,500 people, bordering the old town of Thorne in Doncaster. The super-pit closed in the 1980s and the last visible remains of the colliery have recently been removed. The village is isolated from major industrial development sites.

Most of the housing was purpose-built by the NCB and later bought by sitting tenants or the local authority. There are a few new housing developments and an infant's school has been demolished.

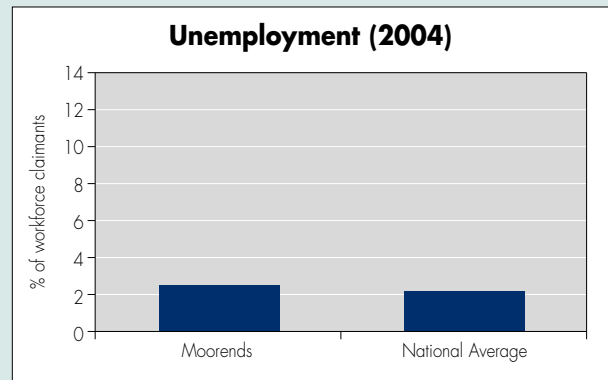
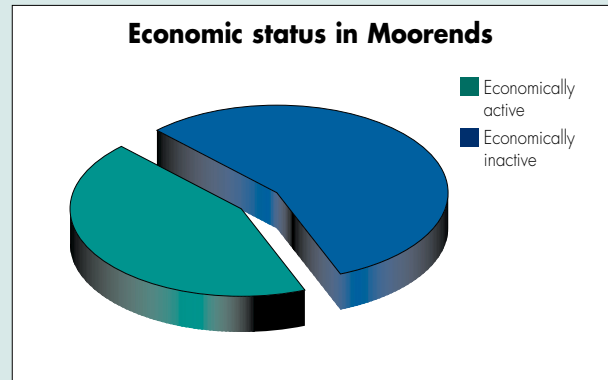
Tenure

Two thirds of the houses in Moorends are now owner occupied. The proportion of social rented housing, 35 per cent, is low relative to the other two Doncaster study areas.



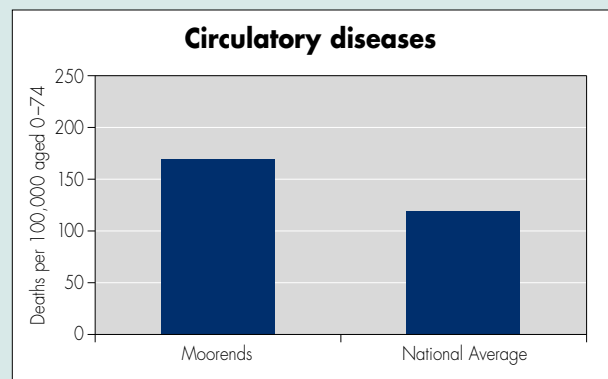
Economic context

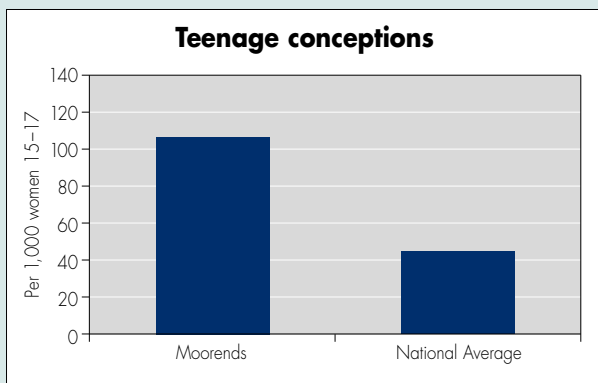
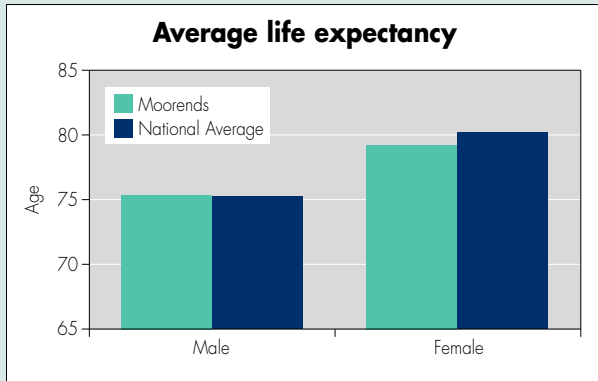
Moorends has an unemployment rate of 2.5 per cent, lower than the Doncaster average (2.7 per cent) but higher than the national average (2.2 per cent). The proportion of 16 to 74 year olds that are economically inactive is relatively high (56 per cent), but not as high as Denaby (58 per cent).



Health

Moorends has a high level of premature deaths attributable to circulatory disease, 169 per 100,000 compared with 120 nationally. However, life expectancy is not dissimilar to the national picture. For men life expectancy is 75, the same as the national average. For females it is 79, one year younger than nationally.

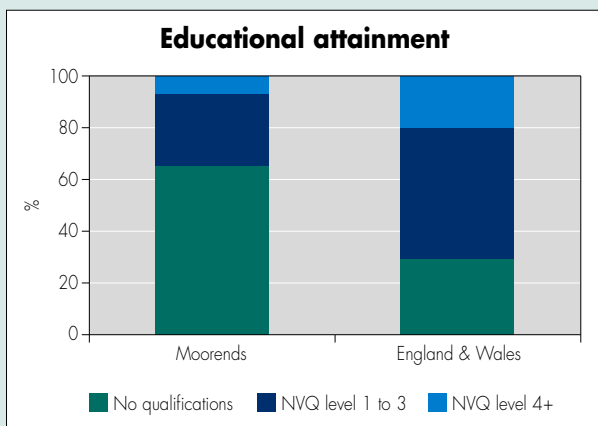




Moorends has a teenage conception rate of 107 per 1,000 women aged 15 to 17. This is the second highest rate across the nine communities (Thurnscoe with 130 has the highest rate).

Education

Educational attainment in Moorends is particularly low. Sixty-five per cent of residents have no qualifications, the highest proportion across the nine communities and over double the national average (29 per cent). However, of the 35 per cent of residents that do have qualifications, almost a quarter have a degree.



Area Based Initiatives

Moorends receives SRB6 funding and is an Objective 1 area (Priority 4a: Supported Communities: Community Action Plan and Target Areas. Priority 4b: Rural Communities).

Other initiatives in the area include Sure Start, and a new £1m centre is being built on the old infant school site. The Bungalow project, a drug's treatment and rehabilitation centre, has started to expand its range and now offers a children's breakfast club.

The community also has a local service delivery partnership and also is part of the *Thorne and Moorends Regeneration Partnership*.



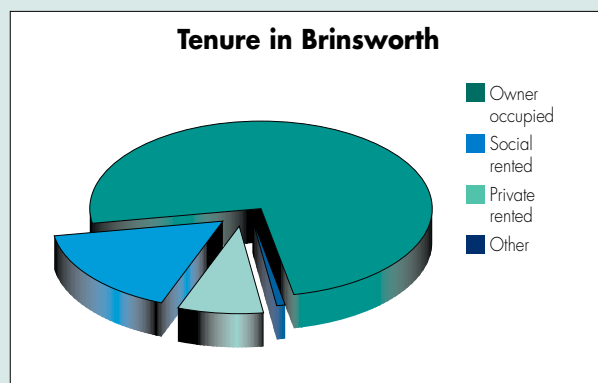
Characteristics and changes

Brinsworth is a mixed industrial suburb located on the Rotherham boundary with Sheffield. Traditionally servicing the steel and engineering industries, its residents now work in commerce, services and on new industrial estates developing alongside the M1 motorway.

New owner-occupied housing estates have increased the population and helped create a relatively prosperous community. Brinsworth, is now one of the less deprived wards in Rotherham. Its relative ranking has changed from 8th least to 6th least deprived as measured by the Index of Multiple Deprivation in 2000 and again in 2004 (although not wholly comparable).

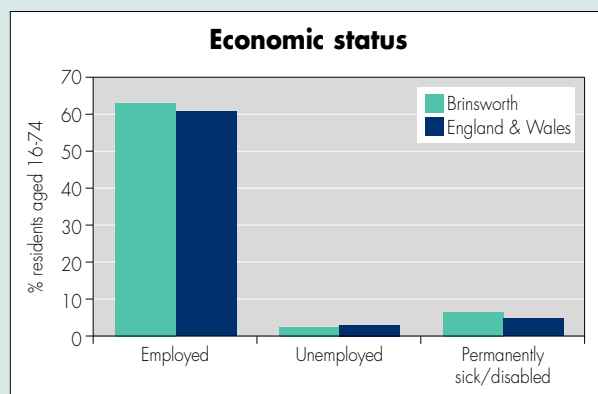
Tenure

Almost three-quarters of the properties in Brinsworth are owner occupied. This is the highest proportion of owner occupation of the three Rotherham study areas and almost 10 per cent higher than the Rotherham average. Less than one per cent of properties are rented from Housing Associations.

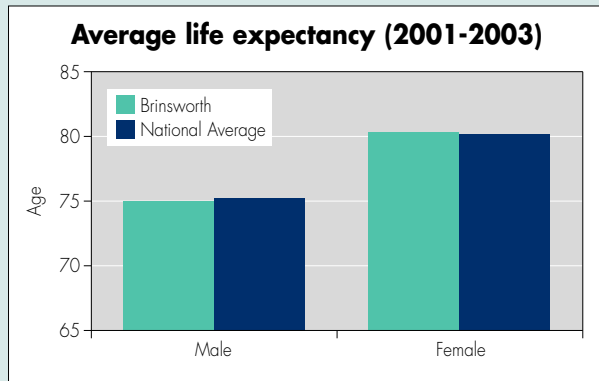


Economic context

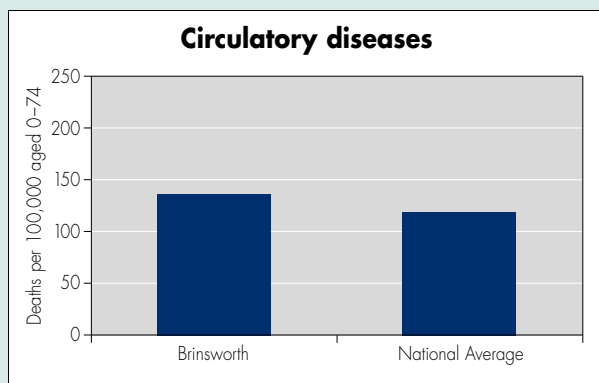
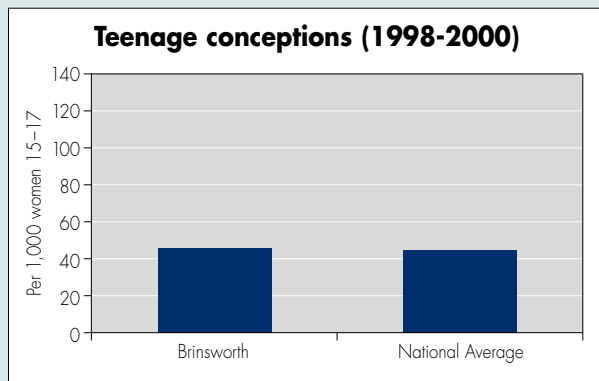
Economic indicators show Brinsworth to be the least deprived of the three Rotherham areas. Employment levels amongst 16 to 74 year olds are higher than the national average (63 per cent compared with 61 per cent).



Health

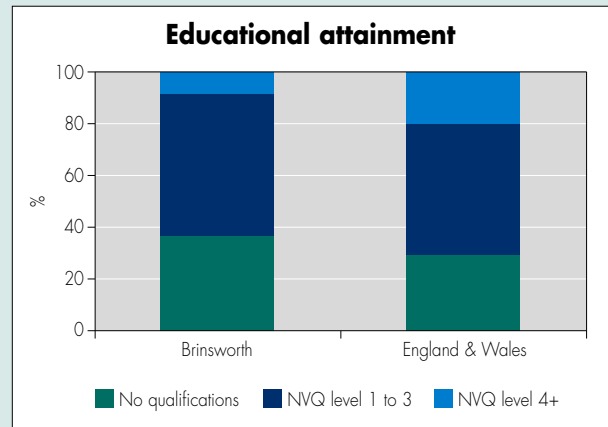


Health indicators for Brinsworth are similar the national average and higher than the Rotherham average. For example, teenage conception rate in Brinsworth is 46 per 1000 women aged 15 to 17 compared with 45 nationally, and 55 for Rotherham as a whole.



Education

Brinsworth is the least educationally deprived of the three study areas in the borough, having the lowest proportion of residents without qualifications (36 per cent). This is slightly better than the Rotherham average of 37 per cent. However, the proportion of residents obtaining degree level qualifications (nine per cent) is substantially lower than both Rotherham and national average (12 per cent and 20 per cent respectively).

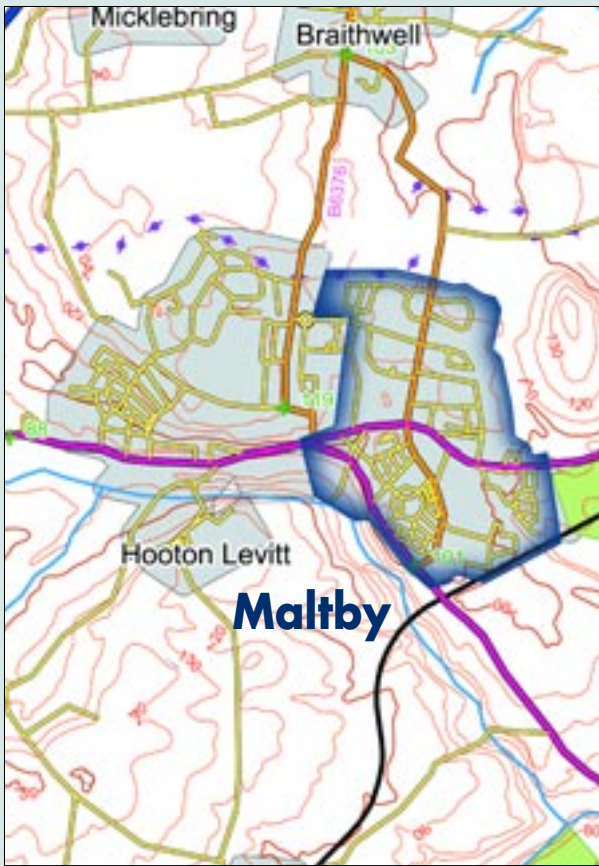


Area Based Initiatives

Brinsworth and Catcliffe Community Partnership is leading community initiatives in this area, including an Objective One Pioneer area. However, compared to the other two Rotherham areas, Brinsworth has received relatively little SRB and Objective 1 funding.

Waverley Community Connects is a community partnership linking Brinsworth, Catcliffe, Treeton, Orgreave and Handsworth areas. The initiative aims to connect the communities to the Advanced Manufacturing Park at Waverley. Housing will be built in an area bordered by the business park.

St Andrews Project in Brinsworth is a development being pioneered by the church and community to create a facility for training and community use. HAZ funded a Heart Health Development Worker in the area for three years up to the end of March 2003, looking at lifestyles and improving heart health.



Characteristics and changes

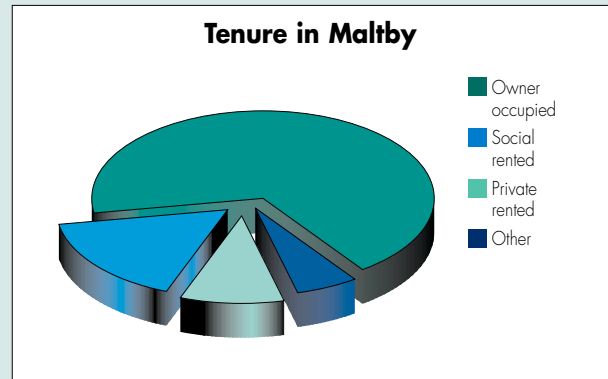
Maltby was a traditional mining town and the pit nearby is one of the few still operating in the South Yorkshire coalfield. Until the 1980's the mining community dominated our study area in the eastern half of the town, though few now work in the industry. Three miles to the west, the expanding Hellaby industrial estate provides over 1000 jobs.

Maltby is now a mixed community of 17,000 residents. Major demolition and refurbishment of social housing on the Birks Holt and White City estates has stabilised the population of social housing tenants. New private estates in the western half of the town has brought an influx of more affluent owner occupiers.

The Maltby ward however, remains one of the more deprived in Rotherham, ranking 8th worst both in 2000 and again in 2004 as measured by the Index of Multiple Deprivation (although not wholly comparable between these two periods).

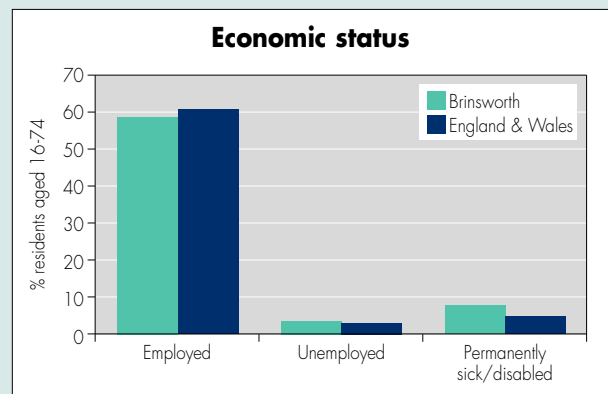
Tenure

Two thirds of properties in Maltby are owner occupied. Of the rented third, most are owned by the local authority. South Yorkshire Housing Association took lead responsibility for regenerating the White City estate of former NCB properties, helping push up the proportion of property owned by housing associations to twice the Rotherham average of three per cent.

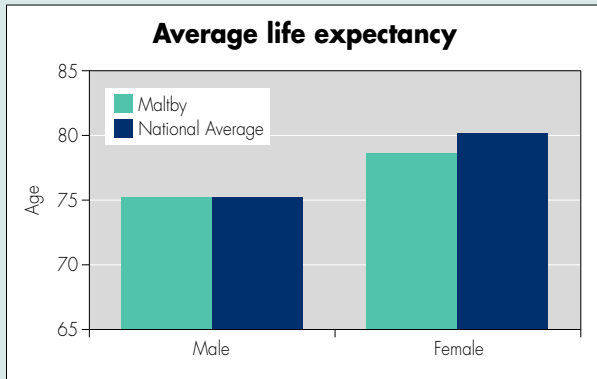


Economic context

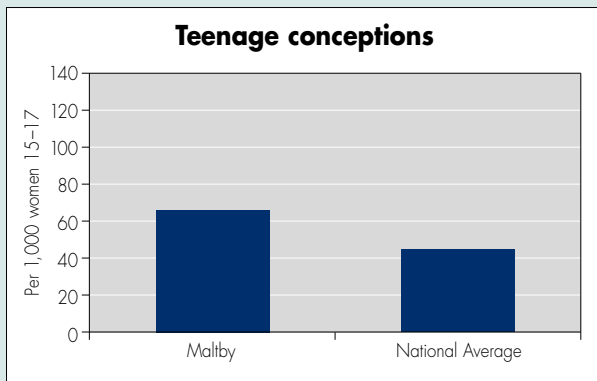
The economic picture in Maltby is typical of the Rotherham area. Amongst the 17 to 74 year olds; 59 per cent are employed, four per cent are unemployed and 8 per cent are permanently sick or disabled.



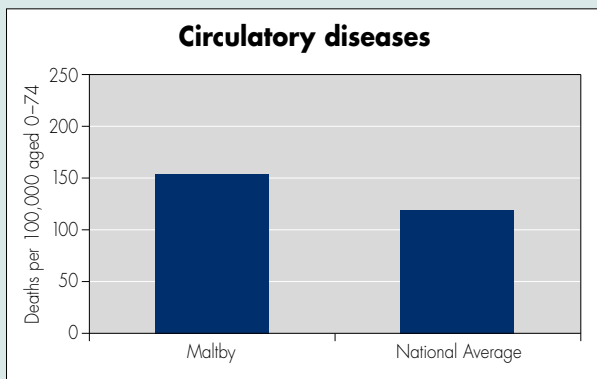
Health



Life expectancy in Maltby for male residents is the same as the national average (both 75) and slightly lower than the national average for female residents (79 compared with 80). Teenage conception at 65 per 1,000 women aged 15 to 17 is higher than both the national and Rotherham average.

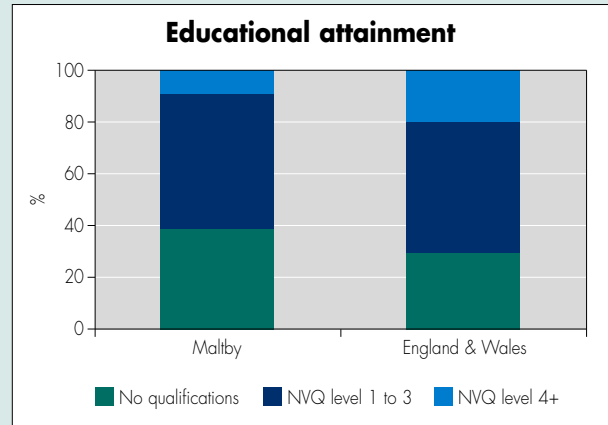


The level of premature deaths attributable to circulatory diseases is also substantially higher in Maltby (154 per 100,000 compared with 120 nationally).



Education

The proportion of residents without qualifications (38 per cent) is similar to the Rotherham average (37 per cent) but substantially higher than the national average (29 per cent).

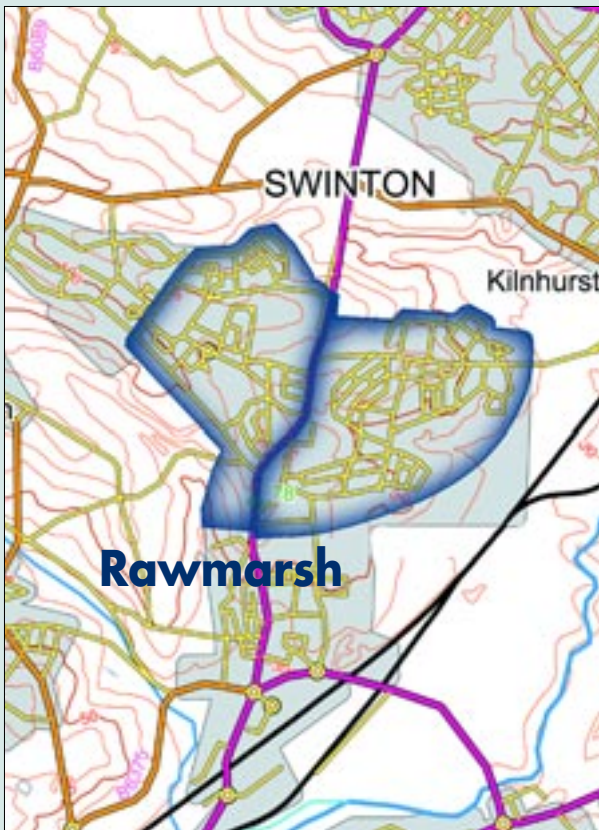


Area Based Initiatives

White City/Birks Holt Estate Partnership and Maltby Forum are both strong community partnerships working in the area. There has been extensive community planning activity and the priorities identified are: transport (especially congestion), leisure and recreation facilities, green spaces, community safety, multiple debt problems and lack of advice services and poor basic skills in young people. Other issues identified in Community Plans include; household burglary, car crime environmental security, road safety, motor cycle nuisance, youth nuisance and vandalism, neighbourhood nuisance, drug and alcohol related incidents and fear of crime.

Maltby is an Objective One area and an Integrated Development Plan area (Priority 4b, measure 23) with pockets of priority 4a, (community infrastructure).

Funding initiatives also include Sure Start, Neighbourhood nurseries, SRB, NRF (Locality substance Use Service) and a Mental Health Awareness Project.



Characteristics and changes

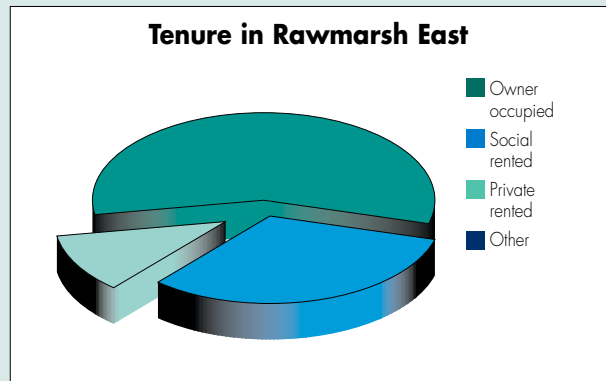
Rawmarsh is an industrial suburb of Rotherham where men were traditionally employed in coal mining or steel manufacture. Although the mines have closed, the giant Aldwarke steel complex remains open. Most local jobs are now provided on the newer industrial and trading estates between Rawmarsh and Rotherham town centre.

The study area was split into the two wards of Rawmarsh East and Rawmarsh West, making a statistical profile hard to compile. Rawmarsh East ward is one of the more deprived wards in Rotherham, with a ranking of 5th of 22 in 2004, up from 9th in 2004 as measured by the Index of Multiple Deprivation.

The southern half of the study area is part of a target neighbourhood in Rotherham's Neighbourhood Renewal strategy. In the top 20 per cent 'Most deprived Residential areas,' it has the highest proportion of households in receipt of state benefits plus domestic burglary rates twice the Rotherham average.

Tenure

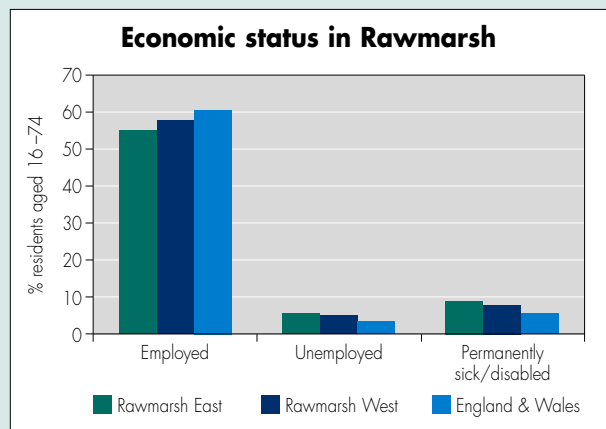
Tenure in Rawmarsh East and West is very similar. Many tenants bought their houses from either the NCB or Local Authority. New house-building has also helped increase the proportion of owner-occupied housing (57 per cent) though



32 per cent remains as social housing (30 per cent in Rawmarsh East and 33 per cent in Rawmarsh West).

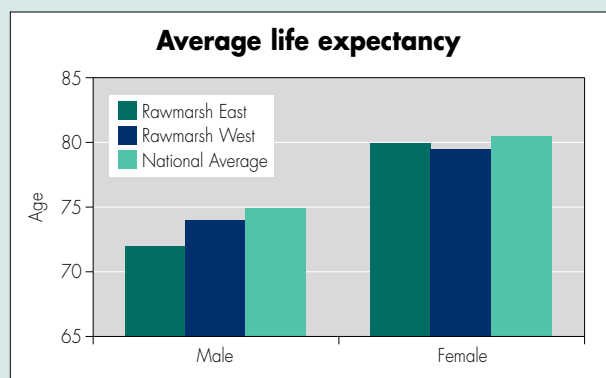
Economic context

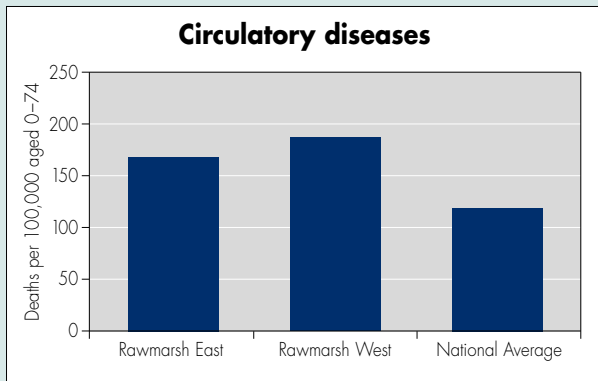
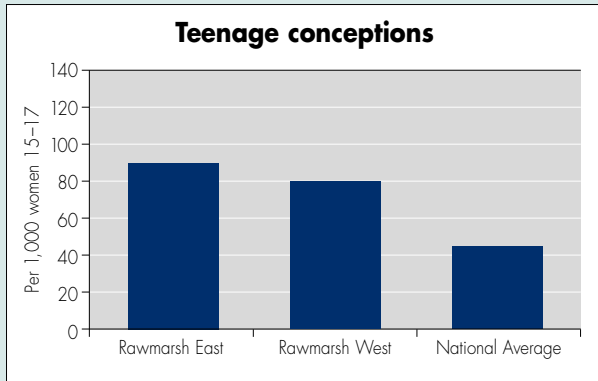
Rawmarsh has the highest unemployment and long term sickness rates and lowest employment rates of the three Rotherham study areas. Only 55 per cent of residents (aged 16 to 74) in Rawmarsh East are employed, compared with 61 per cent in England and Wales.



Health

Rawmarsh has relatively high levels of health deprivation compared with both the national and Rotherham averages.

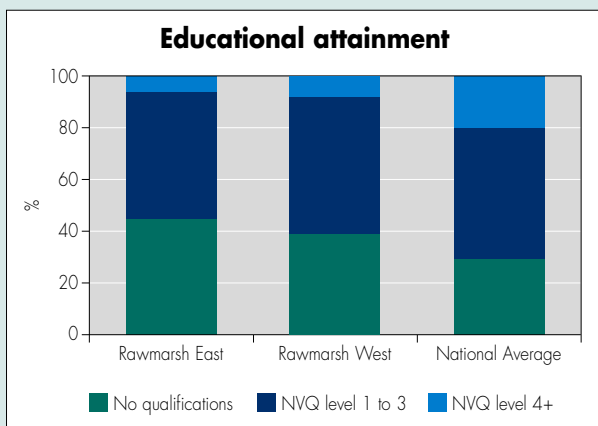




This is particularly true for Rawmarsh East, where the average male life expectancy is 72 (compared with 75 nationally), the teenage conception rate is 90 (compared with 44 nationally) and the rate of circulatory deaths per 100,000 is 178 (compared with 120 nationally).

Education

Rawmarsh, particularly Rawmarsh East, is the most educationally deprived of the three Rotherham study areas. Only eight per cent of Rawmarsh East residents have degree level qualifications, compared with 20 per cent nationally and 12 per cent for the Rotherham area. According to Rotherham's Neighbourhood Renewal Strategy, the GCSE 'Rate' for the Rawmarsh Target Neighbourhood is 30 per cent below the Rotherham average.



Area Based Initiatives

Community planning and consultation has been carried out through the Rawmarsh and Parkgate Community Partnership, for the Objective 1 Integrated Development Plan and for the Rawmarsh Sure Start Programme.

Community priorities are; improving community facilities and leisure opportunities, improving the local environment, reducing crime (particularly drugs misuse) and improving the quality and choice of housing. Other issues identified in local Community Plans include; drug dealing, litter/rubbish, police visibility, graffiti, amount of youth provision and motor-bike nuisance

Funding initiatives include; the Neighbourhood Renewal Fund, SRB, Sure Start, Objective 1 (Integrated Development Plan), Priority 4b (with pockets of 4A, community infrastructure) and Housing Market Renewal Pathfinder.

Other initiatives in the area include: The High Street Centre (a training, employment and conference centre within the local Methodist church), Children's Fund, Neighbourhood and Street Wardens, Extended School and environmental projects. Environmental projects include Groundwork Dearne Valley (which has improved local parks) and Streetpride (with a focus on environmental issues such as lighting, litter and graffiti). Rawmarsh Community School is now a 'Full Service' School with child care, family health guidance and parenting support.

5

- 1. Employment status
- 2. Health status
- 3. Social Capital
- 4. Security

This chapter sets our nine communities within a wider national and sub-regional context. Since our baseline survey in the year 2000, the UK economy has grown, bringing in its train some improvement in the socio-economic composition of the working age population. Beatty, Fothergill and Powell¹ show how ex-coalfield populations reflect these greater employment opportunities.

1. Employment status

Nationally, sustained economic growth over the past four years has resulted in absolutely more people in employment and by 2004 the number of unemployed people had fallen near to a 30 year low.

Figure 5.1 compares the employment status of the 9 coalfield communities over time with the changing UK position. On the basis of our two surveys in 2000 and 2004, it is difficult to be certain of the relative employment performance of our nine coalfield communities.² The profiles in chapter 4 probably give a better picture. The legacy of pit closures endures with the proportion of the working age population who are economically inactive hovering around twice the national average.³ However, consistent with evidence from the profiles, this proportion of inactive residents appears to have fallen between 2000 and 2004 and the proportion in full-time employment increased. Unemployment remains persistently high compared with the national average.

2. Health status

An important social characteristic of our nine communities is poorer health and much higher levels of long-term limiting illness and disability than the national average. Analysis of a cohort of 69,352 men who had a potentially full working history between 1971 and 1981 by Richard Mitchell and others⁴ showed that by the 1991 Census, those living in coalfields were much more likely to suffer from limiting long term illness. There appears to be a 'coalfield effect' over and above social class composition, which co-varies with health status.

The area profiles in chapter four of this report confirm a coalfield effect on long term illness. Figure 4.2 shows that Denaby and Thurnscoe (both defined as 'pit villages' because originally they were heavily dependent on coal mining) have almost twice the national average level of limiting long term illness and the highest level of all the communities in our study. Communities in Rotherham, an area less dependant on coal when compared to Barnsley and Doncaster, tend to have lower sickness rates⁵. Overall, there is probably some over-reporting of limiting long-standing illness consistent with the Beatty/Fothergill hypothesis of 'hidden unemployment.'

Figure 5.1: **Employment status, UK and nine communities**

	Men				Women			
	UK		Nine communities		UK		Nine communities	
	99 %	03 %	00 %	04 %	99 %	03 %	00 %	04 %
Economically active								
F/T employees	61	64*	44	47	36	62*	17	21
P/T employees	5		5	4	27		27	26
Self-employed	12	14	4	2	4	5	1	0
Unemployed	6	5	11	13	4	3	5	6
Economically inactive								
	16	17	36	33	28	27	50	47
Total	100	100	100	100	100	100	100	100

*UK figures for 2003 show full and part time employment combined.

Source UK: Nomis. Notes (1) Percentages are for the population of working age, men 16-64, and women 16-59.

(2) The very small numbers on government training schemes are excluded. (3) Economically inactive people include those with long-term illness, in full time education, retired from paid work, looking after home of family. (4) Percentages are rounded and may not add to 100.

¹ Beatty C., Fothergill S., Powell R (2005) *Twenty years on: has the economy of the coalfields recovered?* CRESR, Sheffield Hallam University.

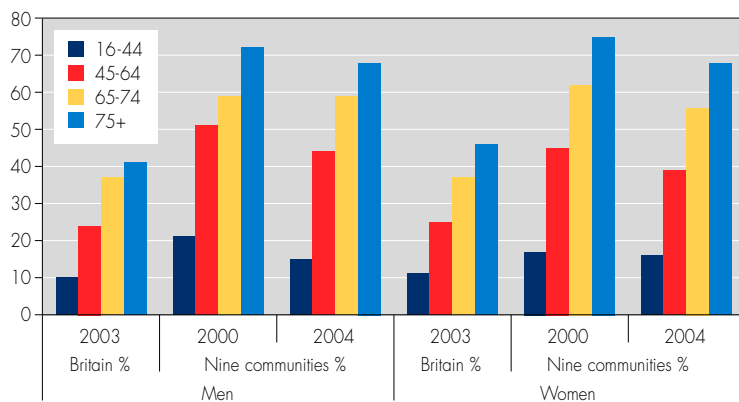
² Compared with the 2001 Census population profile for South Yorkshire, a disproportionate number of older residents and women were interviewed in both our 2000 and 2004 surveys. Table 5.1 distinguishes our sample by sex and population of working age, yet sample bias may remain.

³ Beatty C., & Fothergill S., (2004) *The Diversion from Unemployment to Sickness across British Regions and Districts.* CRESR, Sheffield Hallam University.

⁴ Mitchell R., et al, Health: who you are or where you live? In *Health Variations 2* (July 1998) Economic & Social Research Council

⁵ Note that the figures quoted for Maltby relate to the 'Maltby' ward which includes the more affluent west. Our study area is confined to East Maltby which is less well off.

Figure 5.2: **Limiting long-standing illness in Britain and nine coalfield communities**

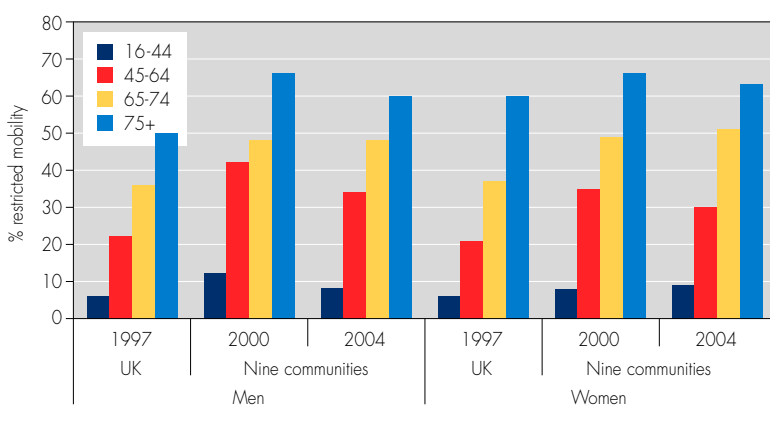


Source: Gen Household Survey 2003. Social Capital Surveys, n=4178 & 3692.

Younger men especially, report lower rates, with the proportion of 16-44 year olds with limiting long-standing illness falling from 21 per cent to 15 per cent. This fall is consistent with the Beatty/Fothergill hypothesis that a trend towards fuller employment is associated with fewer claiming incapacity benefit. Fewer are inclined to report long-standing limiting illness either to the benefit authorities or to our interviewers.

We also compare specific disabilities. The EuroQol-5D (European Quality of Life) schedule asked residents to rate themselves on 5 dimensions of health and then score the general state of their health on a health 'thermometer' with a scale of 1-100. Figure 5.3 takes one dimension, comparing moderate or severe problems with mobility in our nine communities with the national average.

Figure 5.3: **Restricted mobility in Britain and nine coalfield communities**

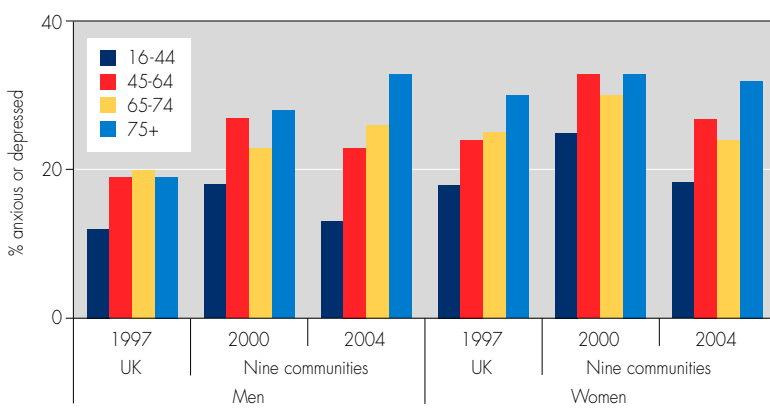


Source UK = Social Trends 30 table 7.9.

Consistent with differentials in relation to limiting long-standing illness, residents in the nine communities report much less mobility than the national average. The legacy of tough working conditions of coalmining and steelmaking help to explain the differentials in older men. Men and women of working age also report above average restrictions on their mobility, though their relative position improved between 2000 and 2004.

The local profile of mental health differs significantly from that of physical health. Differentials are much smaller. On the anxiety/depression dimension of the EuroQol-5D protocol, residents of our nine communities generally have average scores only modestly above national averages; and women in two age bands are similar to the national average.

Figure 5.4: **Anxiety or depression in the UK and nine coalfield communities**



Source UK = Social Trends 30 table 7.9.

There is a general improvement in mental health status between 2000 and 2004. Women in all age bands and younger men report less anxiety and depression. Men in the two older age bands are the exception, recording increases which take them above the national average. Possibly these are the cohort of ex-miners who have found it more difficult to adjust to life since their raison d'être disappeared with the coal mines.

3. Social Capital

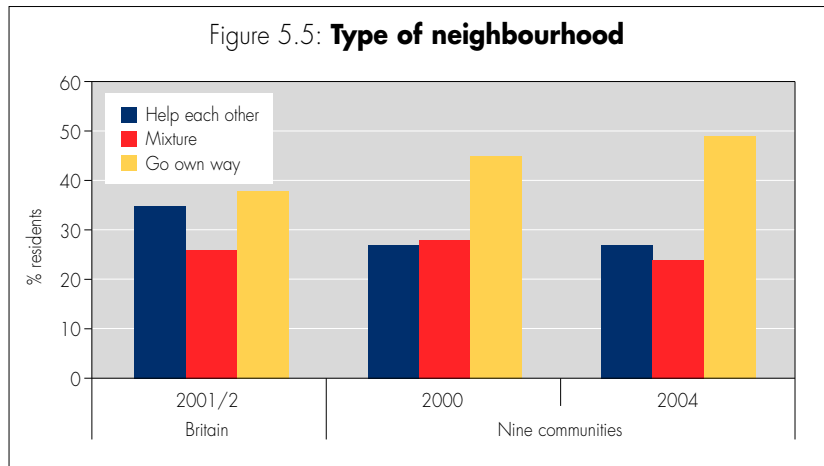
We are able to compare two elements of social capital with national benchmarks. Neighbourhood reciprocity has been measured by the British Crime Survey for many years. Respondents are asked 'In general what kind of neighbourhood would you say you live in? Would you say it is a neighbourhood in which people do things together and try and help each other or one in which people mostly go their own way?' When compared with the national picture (figure 5.5) a slightly smaller proportion of respondents in our nine communities say people help each other. This relatively low percentage (27 per cent compared with 35 per cent) suggests that the social bonds associated with close-knit mining communities have largely dissipated, but there is also evidence that the position stabilised between 2000 and 2004.

Comparing trust is more difficult. National measures were not readily available for our baseline survey in 2000 and those developed subsequently are not strictly comparable with our own. Nevertheless figure 5.6 indicates that the nine communities tend towards the extreme ends of the spectrum of institutional or 'vertical' trust. When asked whether they trusted the local council, marginally more local residents than the national population trusted it 'completely.' However many more (23 per cent compared with 11 per cent in 2004) did not trust the local council at all. The full range of local responses is given figure 6.19 in the next chapter. Changes between 2000 and 2004 are relatively small but they do suggest improvements in institutional trust which run counter to the national trend.

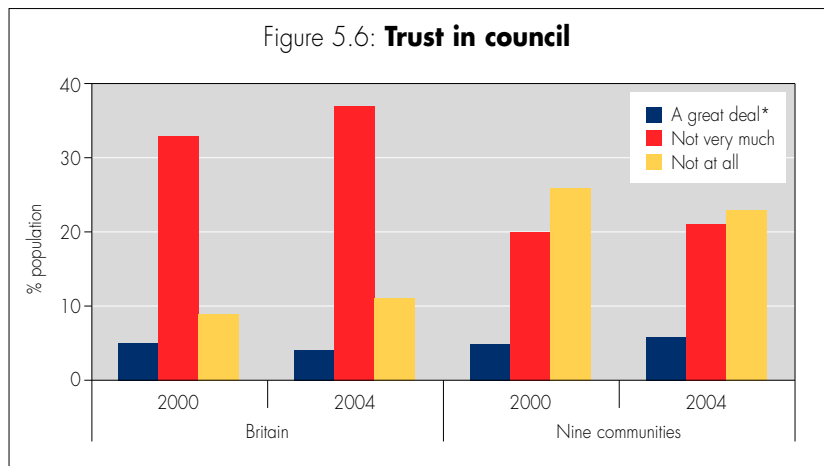
4. Security

Fear of crime has been found to lead to poorer mental health.⁶ In both the baseline and 2004 surveys we included two questions asked in successive British

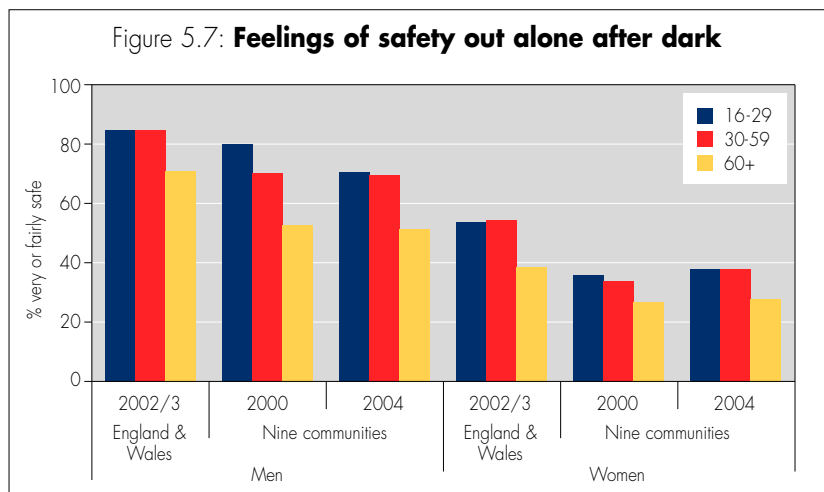
⁶ Green G, Gilbertson JM, Grimsley MFJ (2002) Fear of crime and health in residential tower blocks; A case study in Liverpool, UK. *EJPH* Vol.12, Number 1, March.



Source Britain: British Crime Survey 2001/2



Source Britain: MORI Omnibus Survey. * Note the MORI survey asked if respondents trusted the local council 'a great deal' whereas the nine-community survey asked if they trusted the council 'completely.' Intermediate positions are not comparable on the two scales and so are not shown in the figure.



Source: British Crime Survey 2002/3, N = 9029, Special tables. CRESR Social Capital Surveys; N = 4178 & 3771.

Crime Surveys. The first asked whether residents felt safe in their home alone at night. The second asked whether residents felt safe walking alone in their neighbourhood after dark – a hypothetical question for some who never went out alone at night. Figure 5.7 compares the nine coalfield communities with the average response for England and Wales. To simplify presentation the 'very safe' and 'fairly safe' responses are combined and the 'a bit unsafe' and 'very unsafe' responses are omitted.

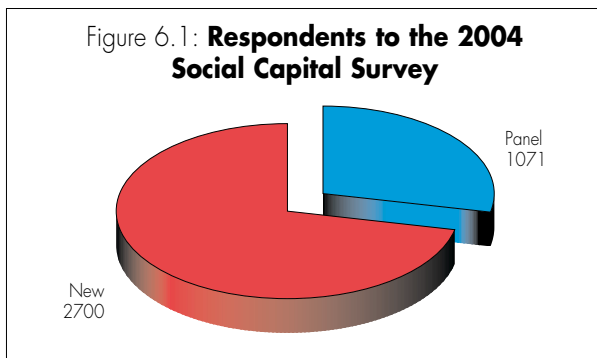
Overall, people over 60, men or women, nationally and locally, feel less safe than the two younger age groups. In our nine communities residents generally feel less safe than the average for England and Wales. And there have been counter trends over time. Compared with 2000, fewer local men and more women felt safe in 2004. Beneath these headline figures are nuanced changes. Just as many men felt very safe in 2004 as in 2000 and fewer felt very unsafe; more reverted towards the centre ground, feeling fairly safe or a bit unsafe.

In summary, the overall socio-economic picture of our nine coalfield communities compares unfavourably with the nation, though taken together, they appear to be on an improving trend. The next chapter compares the nine communities, distinguishing the best performers over the past four years.

6

1. Comparing communities
2. Health
3. Security
- Social capital
4. Reciprocity
5. Civic engagement and efficacy
6. Trust

This chapter compares social capital, health and safety across our nine communities over the period from 2000 to 2004. Both people and place are important in determining variations revealed by our analysis. Opinion may change as a result of changes in *place* brought about by ABIs, such as a safer environment. Or the composition of a neighbourhood *population* – the age profile, socio-economic status and attitudes – may change because of migration. Our sister study shows that migration – into and out of deprived neighbourhoods – is a key influence on levels of social capital.¹ And in an extra twist to the tale, ABIs can *both* influence the reported social capital of long term residents and encourage migration into an area of people with higher levels of social capital.



1. Comparing communities

In this chapter we provide more supporting evidence by distinguishing two groups of respondents in our 2004 survey. First is the 'panel' of 1071 residents previously interviewed in the baseline year of 2000. We track their changing attitudes over time. Second is the group of 2700 randomly selected residents surveyed for the first time in 2004. Added together, these 3771 people are assumed to represent the nine communities in 2004.

In the following sections we compare the fluctuating fortunes of the nine communities over the period 2000-2004. Then we identify the specific contribution of the 'panel' of stable residents.

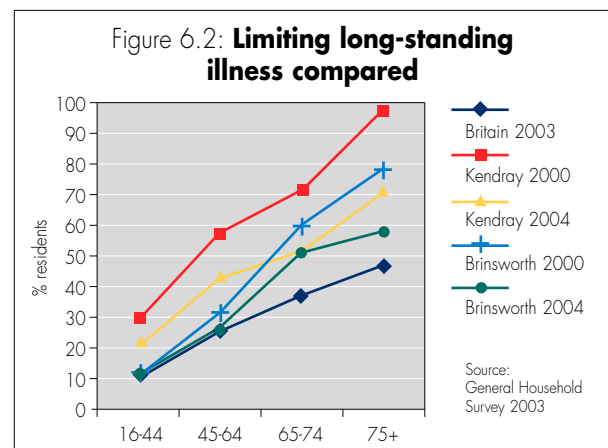
The nine communities are compared over time by highlighting differences between the status and attitudes of the 4217 residents interviewed in 2000 and 3771 interviewed 2004. Acknowledging that both groups are not wholly representative of their communities at either of these points in time, we have adjusted the results to account for age and sex.

Though the 'odds ratios' presented in this chapter appear complex, they do have the great advantage of removing much of the bias caused by our interviewing a disproportionate number of women and older people. The point is illustrated by two contrasting communities. In the baseline survey, Brinsworth (BRI) had the lowest levels of limiting long-standing illness and Kendray (KEN) the highest. By 2004 the raw data shows Kendray's position had improved. Was this because, second time around, we interviewed proportionately fewer women and fewer older people in Kendray. No. Every age group reports less limiting long-standing illness in 2004 than in the baseline year.

2. Health

This section *first* compares changes in the health status of each community relative to the changes in the other eight. This is a zero sum game, so second, we examine absolute changes between 2000 and 2004.

Residents responded to a series of health-related questions. First they were asked 'Do you suffer from any long-standing illness, health problem or disability which limits your daily activities or work in any way?' Then using the EQ-5D protocol, they were asked to rank their 'state of health today on five dimensions of health – mobility, self-care, usual activities, pain and discomfort, anxiety and depression.



¹ Green, G., Grimsley, M. J., Stafford, G.B. (2005) *The Dynamic of Neighbourhood Sustainability*, Joseph Rowntree Foundation. York.

Figure 6.3: **Limiting long-standing illness and health in nine communities** (odds ratios)

	LLSI		Problems Mobility		Problems Self care		Problems usual activities		Pain		Anxiety	
	2000	2004	2000	2004	2000	2004	2000	2004	2000	2004	2000	2004
BRI	0.6	0.6	0.7	0.7	0.5	0.8	0.6	0.7	0.7	0.7	0.9	0.7
DAR	0.7	1.0	0.8	1.0	0.8	1.0	0.9	1.0	1.0	1.1	1.0	1.0
DEN	1.3	1.2	1.1	1.2	1.9	1.7	1.3	1.0	1.0	1.1	1.1	1.7
INT	0.9	0.9	1.0	0.7	1.1	0.9	1.2	0.8	1.1	0.9	1.1	1.0
KEN	1.8	1.3	1.4	1.2	1.2	1.1	1.1	1.3	1.1	1.1	1.4	1.2
MAL	1.0	1.1	1.0	1.2	1.0	0.9	1.2	0.9	1.0	1.2	0.8	0.8
MOO	1.1	1.0	0.9	1.0	0.7	0.9	1.2	1.3	1.2	1.3	0.8	1.1
RAW	0.9	1.0	1.0	1.1	1.0	1.1	0.7	1.2	1.0	1.0	0.8	1.0
THU	1.3	1.1	1.2	1.1	1.5	0.8	1.1	1.0	1.0	0.7	1.2	0.8

Note: Figures are adjusted for age and sex. Those in **bold** are significantly greater than or less than 1 at the 5% level.

Figure 6.3 compares responses to these questions across the nine communities, using adjusted odds ratios (ORs). The OR scores indicate, on average, how likely is a respondent from any community in our study to have limiting long-standing illness or problems with mobility, self care, activities, pain and anxiety compared with the average for the other eight communities. The average OR score across all nine communities is represented as one. Significant differences from the average, above or below, are shown in bold.

In 2000 residents from two of the nine of the nine communities, Brinsworth and Darfield, had significantly lower odds of having limiting long-standing illness than the average, after sex and age have been taken into account. By 2004 Darfield had moved up to average with only Brinsworth retaining significantly lower levels. These changes are shown graphically in figure 6.4

In 2000 residents from three of the nine communities, Denaby, Kendray and Thurnscoe, had significantly higher odds of having limiting long-standing illness. By 2004 all three were still above average, but only Kendray remained significantly so, with an odds ratio of 1.3 or 30 per cent above the average. For residents of Denaby the odds of such illness had reduced to 1.2, but this is not significantly above the average. (This is indicated by the 'tail' for Denaby in figure 6.4 – representing the 95 per cent confidence limits – cutting the average, 1.0, line).

As expected, communities reporting high levels of limiting illness also report more problems with mobility. However, though this pattern endures, differences between the nine communities have diminished over time. Kendray and Thurnscoe, where residents reported significantly more problems with mobility in 2000, still retain this differential in 2004, but it is less marked and not significantly above the average.

Figure 6.4: **Limiting long-standing illness** (odds ratios)

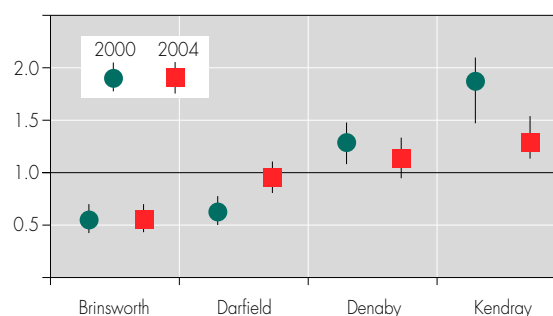


Figure 6.5: **Mobility problems** (odds ratios)

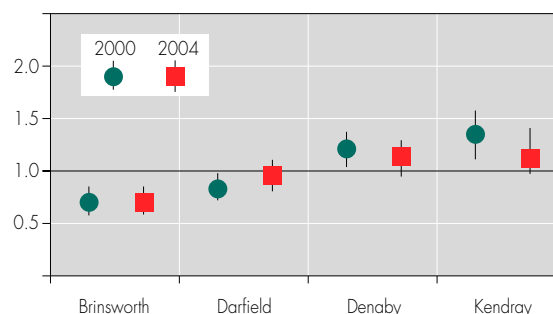
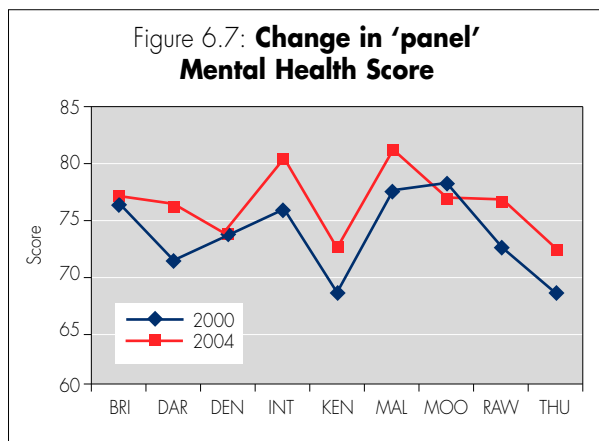
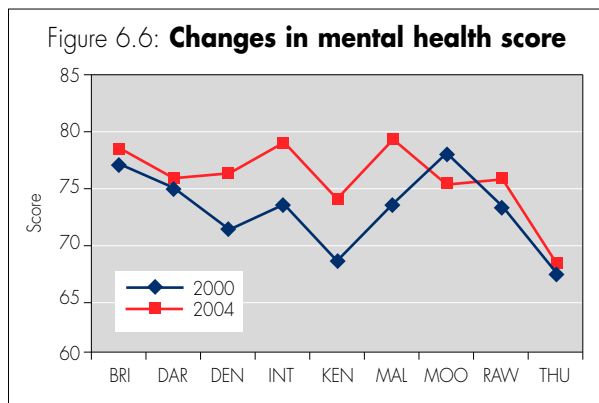


Figure 6.5 also highlights the consistency of Brinsworth, with 30 per cent fewer mobility problems in both 2000 and 2004, and Darfield, significantly better than average in 2000 but not in 2004. From figure 6.3 we can see that overall Intake records the biggest improvement, from average to significantly fewer problems with mobility in 2004.

A wider scan of results in figure 6.3 reveals a degree of consistency over time and across all six dimensions of reported health. The relatively prosperous community of Brinsworth reports better than average health, often significantly better, on all counts. Kendray reports worse than average health on all counts, though its relative position has improved. Intake and Thurnscoe show consistent improvement while Darfield and Rawmarsh show consistent decline.

So far we have accounted for the health status of each community relative to all the others. Now we illustrate absolute changes in each community over time. Priority is given to the key dimension of mental health because we hypothesised that the various ABIs might have more impact on mental health rather than physical disabilities, which are often irreversible.

Only one of the EQ-5D questions touches this issue, asking about anxiety and depression. This is augmented by five questions taken from Short Form 36 Questionnaire (SF-36) used in many other studies.² The answers can be composited into a Mental Health Index (MHI5) with a scale of 0-100 (100 is the highest state of mental health). Figure 6.6 compares the average scores for each of the nine communities in 2000 and 2004, again adjusting for age and gender.



² Brazier JE, Harper R, Jones NMB, O’Cathian A, Thomas KJ, Usherwood T, Westlake. Validating the SF-36 health survey questionnaire: a new outcome measure for primary care. *BMJ* 1992; 305: 160-4.

Only Moorends, with the highest MHI5 mental health score in 2000, records a decline. The other eight communities recorded an increase, with the biggest (5 points or more) in Intake, Kendray and Malby. Much of this change is attributable to the ‘panel’ of residents interviewed in both 2000 and 2004. Figure 6.7 shows their average mental health score increasing by between 3.7 and 4.1 points.

3. Security

As highlighted earlier, mental health may be affected by fear of crime. The previous chapter showed that on the whole, residents of our nine communities tend to feel less safe than people living in other parts of the country. This headline masks great variations between the communities. Using odds ratios, figure 6.8 compares responses to the questions ‘how safe do you feel when you are alone in your home at night?’ and ‘how safe do you feel walking alone in this area after dark?’ Odds have been adjusted for age and sex, as usual, but also for educational attainment and tenure.

Figure 6.8: **Feelings of safety when in the home alone at night or out alone after dark**

	Safe alone in home at night (odds ratios)		Safe walking alone after dark (odds ratios)	
	2000	2004	2000	2004
BRI	2.5	1.2	2.3	1.5
DAR	1.5	1.3	1.2	1.2
DEN	1.0	0.8	0.9	1.0
INT	1.1	1.2	1.2	1.0
KEN	0.6	0.8	0.6	1.0
MAL	0.9	1.4	0.8	1.7
MOO	0.5	0.7	0.9	0.7
RAW	0.7	1.2	1.0	0.9
THU	1.2	0.8	0.8	0.5

Note: Figures are adjusted for age, sex, NVQ and tenure. Those in **bold** are significantly greater than the average (1.0) at the 5% level.

In 2000, residents of Brinsworth and Darfield were significantly more likely to feel safe alone in their homes at night. By 2004 they still felt safer than average, but not significantly so. Indeed the odds for Brinsworth residents fell quite dramatically – from two and half times more likely to feel safe in 2000 to only 20 per cent above the average in 2004. Thurnscoe, above average in 2004, registered significantly below average feelings of safety in their homes in 2004. Residents of Kendray, Moorends and Rawmarsh, all significantly less likely in 2000 to feel safe in their homes, recorded improved their position by 2004, though Moorends remained significantly below average.

Figure 6.9: **Safe at home and out alone**
(odds ratios)

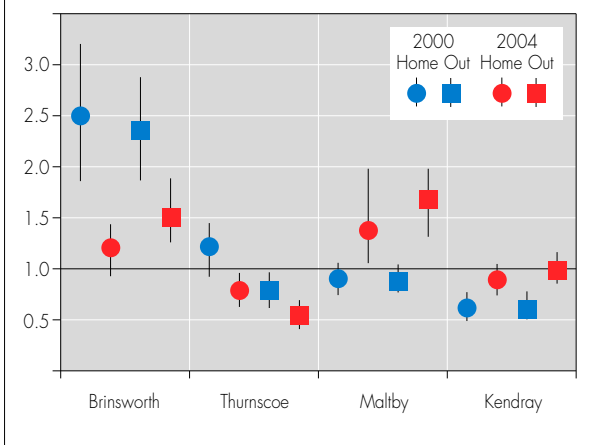
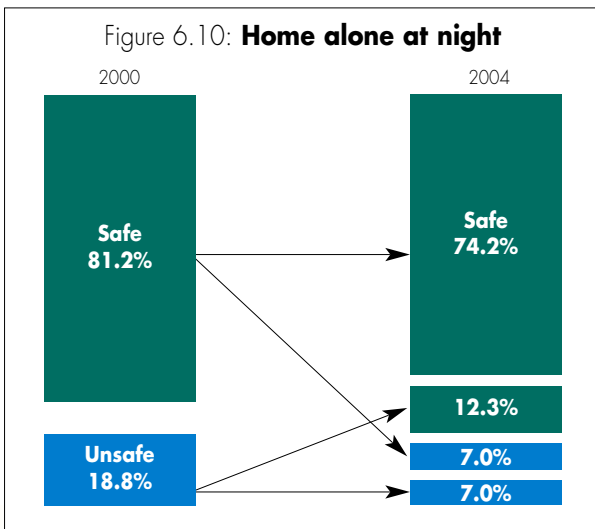


Figure 6.9 highlights a consistent pattern across communities and over time between feeling safe in the home and feeling safe out alone in the neighbourhood at night. In 2000 Brinsworth residents felt safest, 2.5 times the average level feelings of safety in their homes and 2.3 times the average level out alone at night. By 2004 feelings of safety had fallen on both counts, though Brinsworth residents still felt significantly safer when out alone at night.

The position in Thurnscoe has deteriorated; by 2004 residents felt significantly less safe on both counts – in their homes and out alone in the neighbourhood at night. Maltby and Kendray have improved in both counts. Kendray, the worst overall performer in 2000 was average or close to average in 2004. Maltby, a poor performer in 2000, improved the most by 2004, with residents feeling significantly safer both in their homes and out at night.

Figure 6.10 indicates changes in feelings of safety at home expressed by the panel of residents interviewed in both 2000 and 2004.

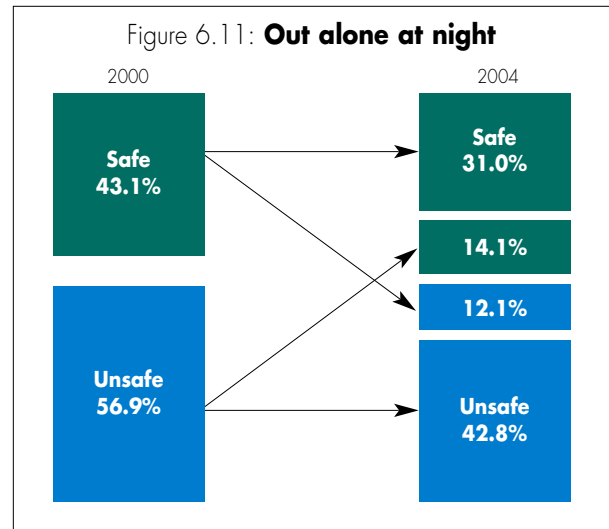
Figure 6.10: **Home alone at night**



Three-quarters remain safe (very or fairly) at both points in time, but 7.0 per cent report a change from safe in 2000 to unsafe in 2004 and 12.3% from unsafe to safe.

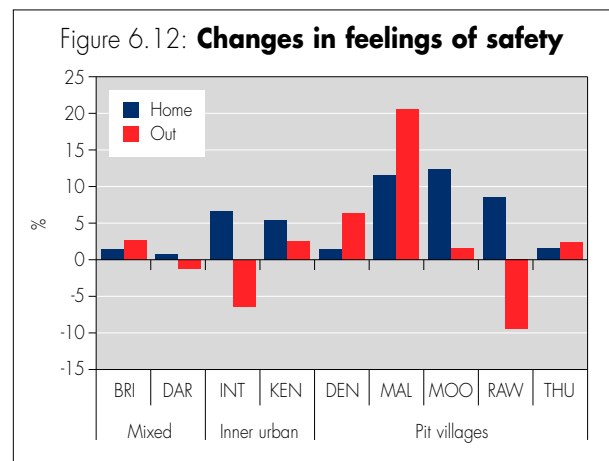
Only a minority of these residents feel safe out alone after dark. Figure 6.11 shows only 31.1 per cent feeling safe at both points in time; 12.1 per cent change to feeling unsafe in 2004 and 14.1 per cent change from unsafe to safe.

Figure 6.11: **Out alone at night**



The net effect is an increase in the overall perceptions of safety by this panel of residents, though as Figure 6.12 shows, there are big variations in responses from different communities.

Figure 6.12: **Changes in feelings of safety**



Panellists from all nine communities report, on average, feeling safer home alone at night in 2004. The most positive changes in perception are in the three pit villages of Rawmarsh, Moorends and Maltby, helping improve the position of these communities relative to the others (Figure 6.8).

On the whole, panellists' feelings of safety out alone after dark also change for the better. Exceptions are Darfield, Intake and especially Rawmarsh, where the proportion of those feeling safe shrinks by 9.6 per cent. In contrast there is

a big rise (over 20 per cent) in feelings of safety by Maltby panellists, helping the community to the top of the rankings in 2004.

Social capital

In the next three sections we review three elements of social capital identified in earlier chapters, *first* reciprocal help and support ('reciprocity') *then* civic engagement and efficacy, *finally* trust, both vertical and horizontal.

4. Reciprocity

Three questions were used to elicit reciprocity. The first, taken from the British Crime Survey asks 'Would you say your neighbourhood is one in which people do things together and try and help each other or one in which people mostly go their own way?' The second asks 'In the past 6 months have you done a favour for a neighbour?' And the third asks 'If you needed a lift to somewhere urgently, could you ask anyone for help?'

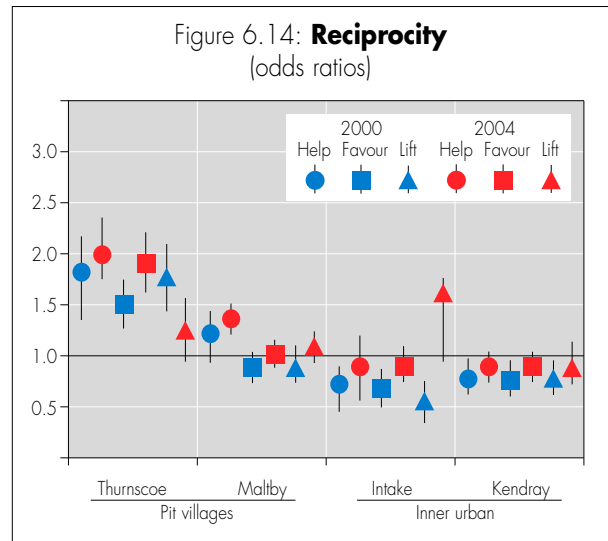
Figure 6.13 analyses responses to the three questions, again using odds ratios to compare the relative position of each community over time.

Figure 6.13: **Neighbourhood reciprocity**

	Help each other		Done favour for		Ask for lift	
	2000	2004	2000	2004	2000	2004
	BRI	1.3	1.0	1.1	0.8	1.1
DAR	1.8	0.9	0.9	1.1	1.2	1.1
DEN	1.0	0.7	0.8	0.9	0.8	0.8
INT	0.6	0.8	0.7	0.9	0.5	1.6
KEN	0.7	0.9	0.7	0.9	0.7	0.8
MAL	1.2	1.3	0.9	1.1	0.8	1.1
MOO	0.5	1.0	1.5	0.9	1.6	0.5
RAW	1.0	0.9	1.1	0.8	1.2	1.3
THU	1.8	2.0	1.5	1.9	1.7	1.2

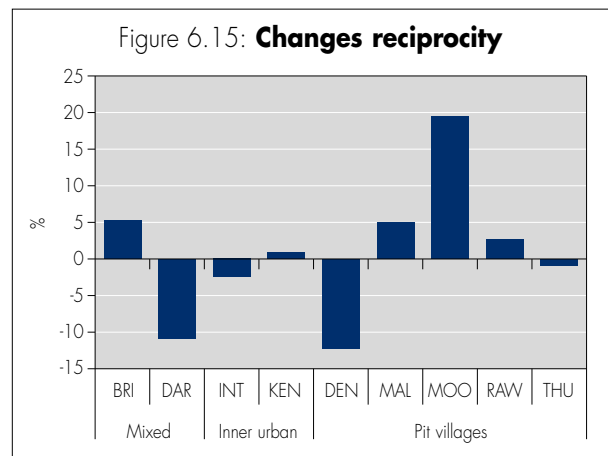
Note: Figures are adjusted for age, sex, NVQ and tenure. Those in **bold** are significantly greater than or less than 1 at the 5% level.

Figure 6.14 selects four communities to illustrate a degree of consistency between responses to the three questions and over time. These responses help measure levels of 'bonding' social capital. In the baseline report we highlighted Thurnscoe as exemplifying the enduring community bonds generated by working in the coal mining industry. Four years on these bonds have been reinforced, with Thurnscoe residents twice as likely to have done a favour for a neighbour or to think their neighbours help each other.



Maltby is also an ex-pit village (or town) where these bonds have been reinforced, though only the response to the first of the three questions was significantly more positive than the average in 2004. In the baseline report the two inner-urban communities of Intake and Kendray were significantly worse than the average on all three aspects of reciprocity. By 2004 they had improved on all counts, bringing them up close to the average, and beyond in the case of Intake residents' willingness to ask for a lift.

Panellists gave a mixed response. Figure 6.15 shows four communities where less of these residents think their neighbourhood is one where people help each other. Erosion is marked in Darfield and Denaby and helps explain their relative decline. In 2000 Darfield residents were (with Thurnscoe) the most likely to assess their neighbourhood positively. By 2004 their assessment was below average. In contrast, panellists in Moorends rated their neighbourhood poorly in 2000, but above average in 2004, improving this community's relative position (figure 6.13) from lowest (OR 0.5) to average (1.0) in 2004.



5. Civic engagement and efficacy

Three questions were used to elicit civic engagement and efficacy.

'Would you say you are well **informed** about local affairs?'

and how much do you agree with the following statements;

'I am satisfied with the amount of **control** I have over decisions that effect my personal life'

'By working together, people in my neighbourhood can **influence** decisions that affect the neighbourhood'

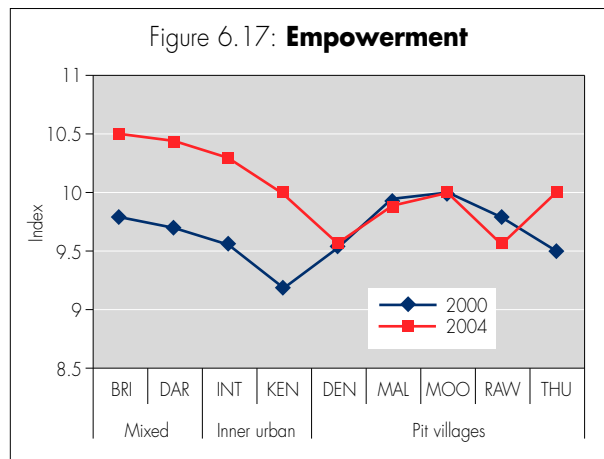
Figure 6.16: **Compares the relative position of each community over time**

	Well informed		Level of control		Influence	
	2000	2004	2000	2004	2000	2004
BRI	1.4	1.4	1.1	1.0	0.7	0.8
DAR	1.2	1.6	1.0	1.1	0.8	0.9
DEN	1.1	0.6	1.1	1.0	0.8	1.3
INT	0.9	1.3	1.0	1.2	0.9	1.1
KEN	0.7	1.5	0.8	1.2	1.0	0.8
MAL	1.2	0.9	0.9	0.7	1.0	1.4
MOO	1.1	0.8	0.9	1.2	2.0	1.0
RAW	0.9	0.8	1.0	0.8	1.1	0.9
THU	0.8	0.8	1.4	1.0	1.2	1.0

Note: Figures are adjusted for age, sex, NVQ and tenure. Those in **bold** are significantly greater than or less than 1 at the 5% level.

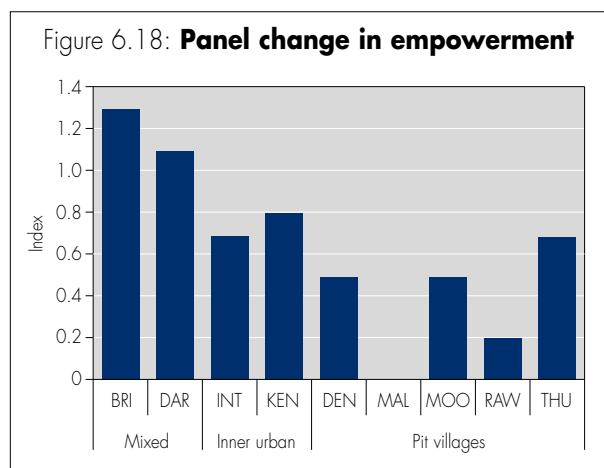
Between 2000 and 2004 residents' assessment of how well informed they were about local affairs became more polarised. In the baseline year only Brinsworth residents reported they were significantly better informed (OR 1.4) than average, and only Kendray (OR 0.7) and Thurnscoe (OR 0.8) were significantly less well informed. By 2004 the two inner-urban areas of Kendray and Intake were also significantly better than average, and now four communities were significantly less well informed.

Otherwise there is no clear pattern to the responses, possibly because responses to the question on 'control over your personal life' has no necessary connection with the other two questions which elicit a response on civic engagement. Nevertheless, an empowerment index constructed by combining answers to all three questions does show a general improvement between 2000 and 2004. Figure 6.17 compares mean scores.



The biggest increases in empowerment are reported from the mixed communities of Brinsworth and Darfield and the inner-urban areas of Intake and Kendray. Pit villages report less change between 2000 and 2004 with Rawmarsh showing the only decline in empowerment.

A significant part of the increase community in empowerment is attributable to changes in the assessment of the panellists between 2000 and 2004. Figure 6.18 shows that they report greater empowerment in all the communities except for Malby. The biggest increases, as expected, are in the two mixed and two inner areas.



6. Trust

In the baseline and 2004 surveys, residents were asked if they trusted two groups of people. 'Vertical' trust was elicited by asking their opinion on local politicians, the local council and employers. 'Horizontal' trust was established by asking opinion on neighbours family and friends. The 2004 survey was augmented by questions on the police, the courts and government, to strengthen the component of vertical trust.

Figure 6.19 summarises trust in various groups of people or institutions in the two survey periods. Vertical trust is consis-

tently low, but in 2004 marginally more residents trusted councillors, their local council and employers, either a little, or completely. In contrast, horizontal trust is consistently high, though complete trust in neighbours and friends has eroded a little.

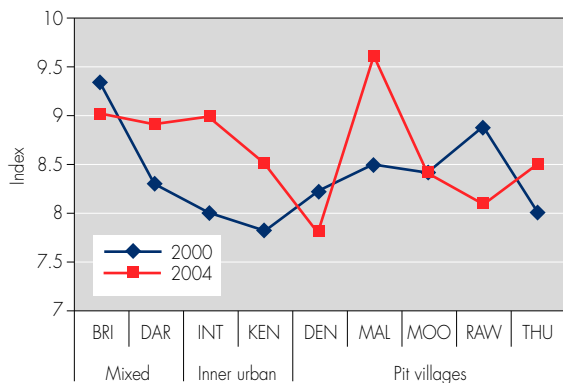
Figure 6.19: **Levels of trust in the nine Coalfield Communities**

		Completely	A little	Neither/DK	Not much	Not at all
Police	2000	*	*	*	*	*
	2004	20	30	22	16	12
Courts	2000	*	*	*	*	*
	2004	10	20	37	19	14
Government	2000	*	*	*	*	*
	2004	6	17	25	23	29
Councillors	2000	5	18	36	17	25
	2004	7	21	28	21	23
Council	2000	5	22	28	20	26
	2004	6	23	27	21	23
Employers	2000	7	21	61	5	5
	2004	8	25	60	4	4
Neighbours	2000	56	31	8	3	2
	2004	44	31	19	4	2
Friends	2000	86	11	3	0	0
	2004	77	20	3	0	0
Family	2000	94	4	1	0	0
	2004	94	4	1	0	0

* figure not available for 2000

In order to compare each community with the others, we have constructed indices of vertical and horizontal trust. To give comparability over time, vertical trust includes opinion

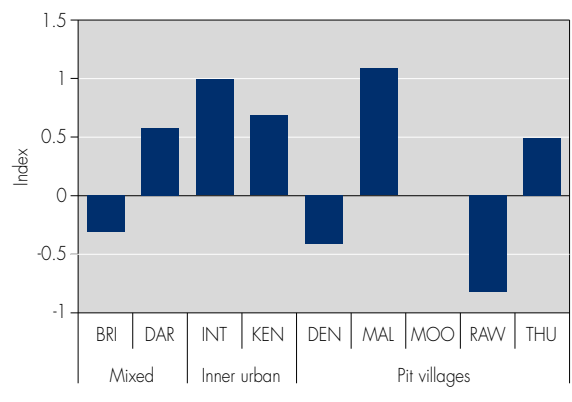
Figure 6.20: **Change in 'vertical' trust**



on councillors, the local council and employers, but excludes the police, courts and government since these were not referred to in the baseline study. Horizontal trust includes opinion on family, friends and neighbours. Figure 6.20 compares vertical trust.

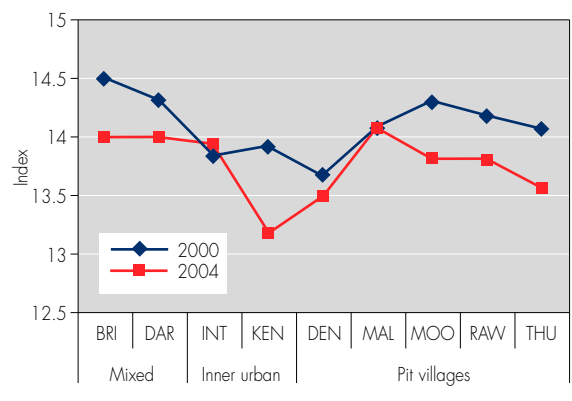
As with empowerment, residents of the two inner-urban communities of Kendray and Intake report higher levels of vertical trust in 2004 compared with the baseline year. A significant part of the increase is attributable to changes in the assessment of the panellists. Figure 6.21 shows that they report improved vertical trust in the two inner-urban communities and explain the significant jump in Maltby.

Figure 6.21: **Panel changes in 'vertical' trust**



The erosion of trust in family and friends reported above (figure 6.19) is reflected in a general decline in the 'horizontal trust' index. Figure 6.22 compares communities and trends between 2000 and 2004.

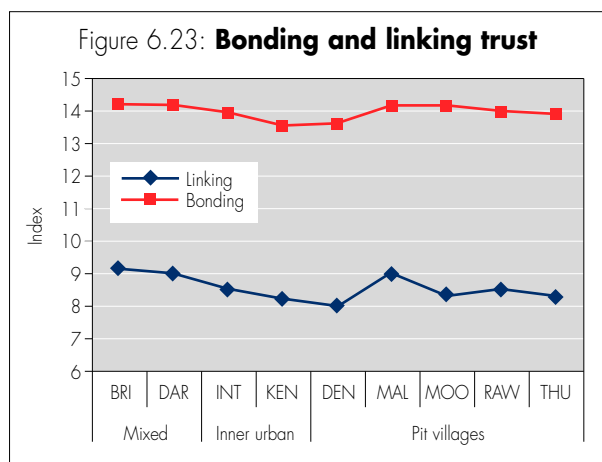
Figure 6.22: **Changes in horizontal trust**



Only the residents of Intake (+0.1 on the index) and Maltby (0.0) reverse this trend. Residents in Kendray record the biggest drop (-0.7) in contrast to their improved vertical trust in Kendray (+0.7). This is probably explained by population movements caused by the redevelopment process in the area. The opinion of panellists from Kendray tends to support this proposition. These residents have lived in Kendray for

four years or more. They are part of an established community. Their trust in neighbours and friends did not decline significantly. Their index of empowerment declined only marginally by -0.1 points.

In earlier chapters we distinguish between 'bonding' and 'linking' social capital. Bonding is with similar sorts of people to yourself and is exemplified by 'horizontal' trust. 'Linking' is with institutions which may enable you to get on in life. Linking is exemplified by vertical trust. Figure 6.23 compares them using a common index and combined scores for 2000 and 2004.



On the face of it, there are no compelling reasons why at an individual level, vertical trust should be related to horizontal trust. Yet when communities are compared there is an evident correlation between the two. Limitations of resources and time preclude an exploration of the links at this stage but there may be a 'trusting personality' type. Alternatively, confidence in political and civil institutions may engender more confidence in neighbours and thus in horizontal trust.

Most striking is the gap between the two types of trust, reflecting differences at a national level. Many of our nine communities have high levels of horizontal trust close to the national average. Most have levels of vertical trust even lower than the national average. Though vertical trust has improved, our nine communities remain largely disaffected from the political institutions which are helping regenerate their social and physical infrastructure.

7. Summary

Though the results of our surveys are complex and at first sight difficult to interpret, this chapter has established clear and consistent patterns across the nine communities and over time. More analysis would allow us to review more thoroughly the pathways and links between different forms of social capital. The next chapter at least establishes links between social capital and health.

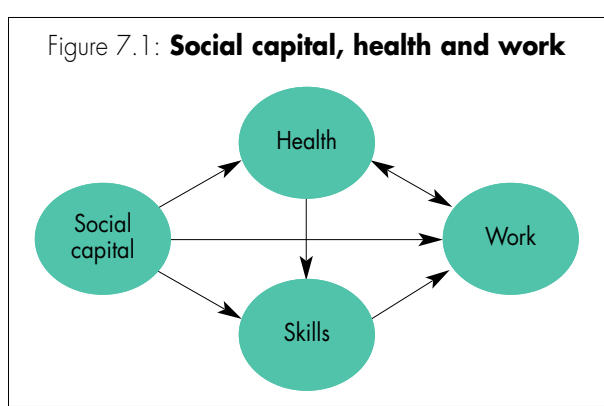
7

- 1. Health, skills and work
- 2. Social capital and health
- 3. Social capital, security and health

This chapter addresses the dynamic of social capital, health and economy, using new survey data to analyse the key links shown in figure 7.1. These routes are complex and traffic moves along in both directions. The *reciprocal* relationship between health and economy is highlighted in the framework document produced by the Government Office for Yorkshire and the Humber Region. *Our Region: Our Health*¹ states:

'An economically strong and innovative region can make a lasting difference to the health and well-being of the people of the region; a fit and healthy workforce can drive a robust and progressive economy.'

The focus of this chapter is social capital as a determinant of health and, in turn, an influence on peoples working lives. Earlier chapters paint a picture of relatively poor health and relatively low levels of employment in our nine communities. The various ABIs described in the next chapter are designed – inter alia – to reverse this spiral of decline and create a virtuous circle of health and work. Investment in social capital is a key intervention.



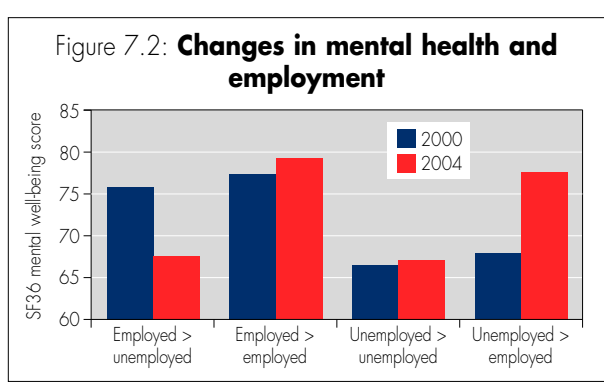
The chapter divides into three parts. *First* we add to the evidence of a triangular relationship between health, skills and work. *Second*, more innovatively, we use the information from our group of panellists to link changes in their perception of social capital between 2000 and 2004 with changes in their health status. *Third*, we examine security as intermediary between social capital and health.

¹ Yorkshire and the Humber Regional Public Health Group (2004) *Our Region; Our Health: A Regional Strategic Framework for Public Health in Yorkshire and the Humber*. Government Office for Yorkshire and the Humber.
² Beatty, C. and Fothergill, S. (2004b) *The Diversion from 'Unemployment' to 'Sickness' across British Regions and Districts*. CRESR, Sheffield Hallam University.

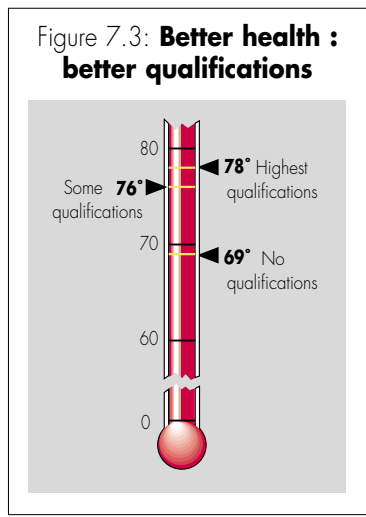
1. Health, skills and work

The link between health and work has political salience nationally, and especially in ex-coalfield areas. The UK government is determined to reverse the upward trend of people claiming state incapacity benefit because they are classed as long-term ill and unable to work. Beatty, Fothergill and others² maintain that a proportion of those on incapacity benefit reflect 'hidden unemployment.' They argue that a reviving economy will lead to fewer people claiming they are ill and incapacitated.

Responses to our two surveys lend support to this argument. In the South Yorkshire coalfield, as elsewhere in the UK, the economy grew between the baseline year of 2000 and 2004, providing more employment opportunities. Chapter 5 shows a complementary improvement in both the physical and mental health of the working age population in our nine communities over the same period. In figure 7.2 we dig beneath these headlines to reveal the dynamic relationship between health and employment. The panellists employed in 2000 but unemployed in 2004 report a sharp decline in mental well-being whereas those previously without a job and employed in 2004 report a sharp increase from 67.9 to 77.7 on the SF36 mental health index.

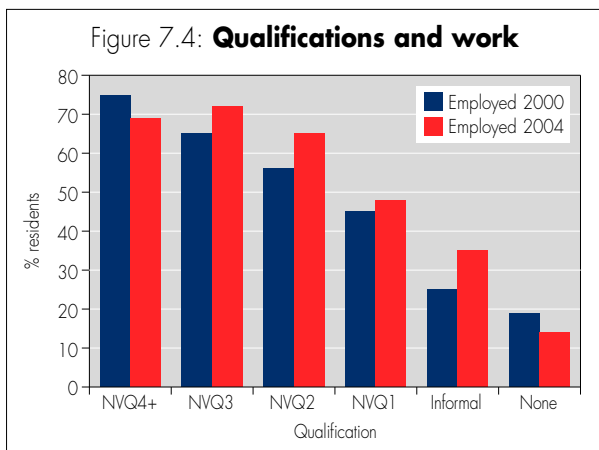


Addressing a second face of the triangle, the baseline survey established a clear relationship between health and qualifications. Residents were asked 'which NVQ (or equivalent) best describes your highest skills or qualifications?' There was an option for those who 'have skills but no formal qualifications.' Figure 7.3 shows how more qualified residents reported higher scores on a health thermometer – part of the EQ-5D instrument which asks



residents to rate 'how good or bad is your health today?' The 2004 survey reinforces these results.

A third face of the triangle is the relationship between qualifications and work. Our surveys show they are clearly linked, though the perfect gradient between NVQ level and employment established in the baseline survey is not exactly mirrored in 2004. For each level of qualification figure 7.4 compares the percentage of residents of working age who are employed.



The 'panel' of residents interviewed in both surveys give further insights into the triangular relationship between health, qualifications and work. Between 2000 and 2004 their NVQ attainment levels improved by 2 per cent and 4 per cent more were employed. However, though NVQ attainment is a good predictor of mental health status, differences narrowed between 2000 and 2004.

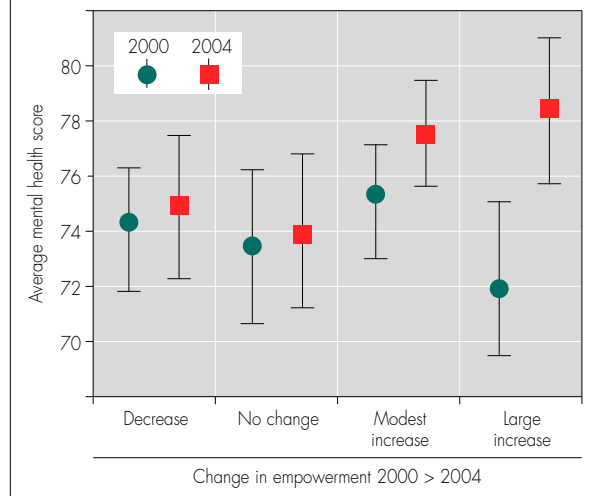
2. Social capital and health

In this section we examine how different elements of social capital reported in the previous chapter – empowerment and trust – are linked to health status. More particularly we link changes in social capital to changes in health. Our analysis is more powerful than the links identified in the baseline report because we use evidence from the panel of people surveyed in 2000 and again in 2004. When we report a change in social capital or health we can be confident that these are real changes in the attitudes of a specific group, rather than a cross-sectional comparison between two different groups (however representative) selected separately in 2000 and 2004.

(a) Empowerment

In the previous chapter, three questions on civic engagement and efficacy were combined into an 'empowerment index' with a range 0-14. The higher a resident's score, the better her knowledge of local affairs, the more control she felt over her personal life and the more influence she perceived over

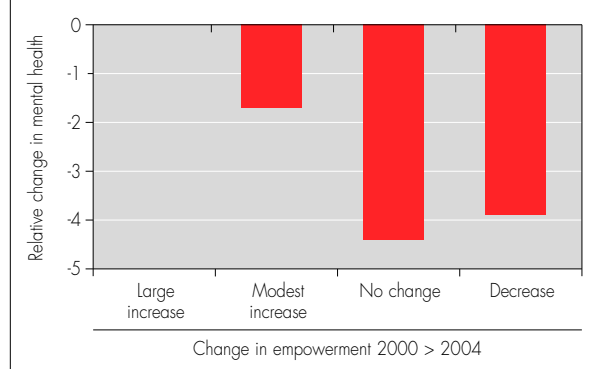
Figure 7.5: Change in empowerment and mental health



decisions that affected her neighbourhood. We find that empowerment is related to mental health status. For every unit increase in empowerment recorded by the panel of residents group between 2000 and 2004, there is an average increase in mental health score of 0.75 on the MHI5 scale of 0-100. Figure 7.5 compares scores for four groups of panellists – those whose sense of empowerment decreases, those who do not change, and those whose sense of empowerment increases, modestly or substantially between 2000 and 2004.

All groups of panellists record an increase in their average mental health score (on a scale of 0-100) but the increase is greater in the groups reporting increases in empowerment. Whereas the average mental health score improves by approximately 0.6 points in the two groups reporting a decrease or no change in empowerment, it improves by 2.4 points in the group reporting a modest increase in empowerment and 6.3 points in the group reporting a large increase. Figure 7.6 highlights significant differences between these groups.

Figure 7.6: Change in empowerment and mental health



Note: Adjusted for age and sex and 2000 scores

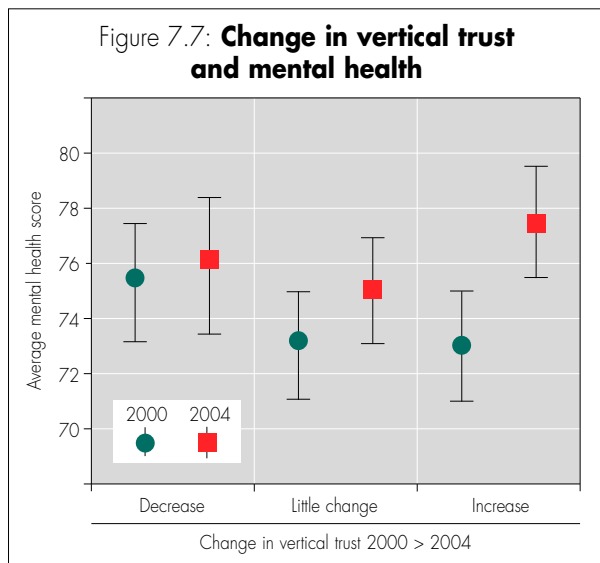
It is difficult to provide a simple representation of the model which compares relative changes in both empowerment and mental health. Here the changes in the adjusted mental health score are shown relative to the group with a large increase in empowerment between 2000 and 2004. When this group is given a zero baseline, the average mental health score in the group with only a modest increase in empowerment is 1.68 points less; for the group showing no change it is 4.39 points less and for the group showing a decrease in empowerment it is 3.88 less.

These differences of magnitude are significant ($p < 0.01$) and suggest that an increase in empowerment improves mental health. Generally the finding supports the proposition, represented in figure 7.1 that enhanced social capital leads to better health. However, a note of caution; further statistical analysis (such as least squares testing) may reveal a reciprocal pathway, where better mental health enhances social capital.

(b) Vertical trust

We compared changes in vertical trust with changes in mental health between 2000 and 2004. An index was constructed from questions on trust in councillors, the local council and employers. Mental health was measured by the MHI5 index. There is a significant relationship ($p < 0.05$). For every unit increase in trust (on a scale 0-15) there is an increase in mental health score of 0.37 (on a scale 0-100).

Figure 7.7 shows panellists were divided into three groups. First were those whose trust had decreased between 2000 and 2004; second those whose trust had changed little and third, those whose trust had increased.



As with empowerment, all these groups report an increase in average mental health over time. However mental health has improved most, from 73.2 to 77.7 (+4.5), in the group which recorded an increase in empowerment. The group reporting little change in empowerment recorded an increase in mental health of +1.9 points (73.3 to 75.2) and those reporting a decrease in empowerment reported an increase in mental health of +0.5 points (75.6 to 76.1). Again the finding supports the proposition, represented in figure 7.1 that enhanced social capital leads to better health.

(c) Horizontal trust

Finally we compared changes in horizontal trust with changes in mental health between 2000 and 2004. An index was constructed from questions on trust in neighbours, family and friends. Mental health was measured by the MHI5 index. There is a strong relationship, of borderline statistical significance. For every unit increase in trust (on a scale 0-14) there is an increase in mental health score of 0.76 (on a scale 0-100).

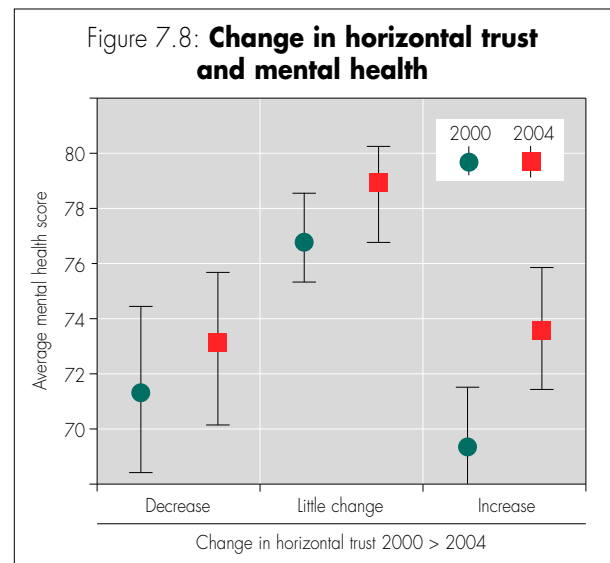
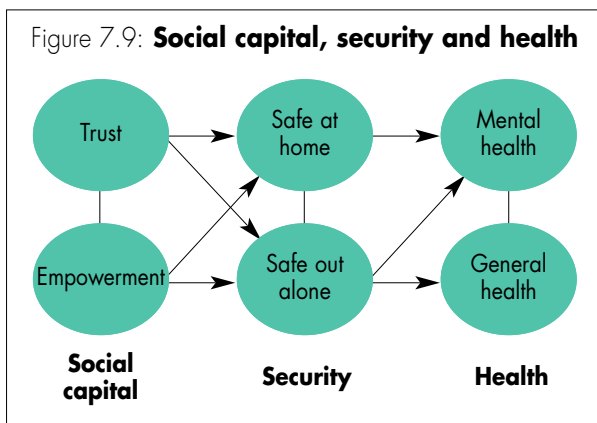


Figure 7.8 mirrors figure 7.7 in showing panellists divided into three groups. And, as with both empowerment and vertical trust, all these groups report an increase in average mental health over time.

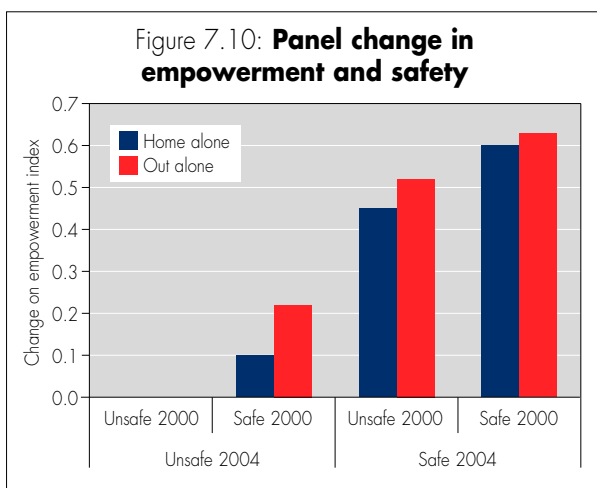
However *mental* health has improved most, from 69.4 to 73.8 (+4.4), in the group which recorded an increase in empowerment. The group reporting little change in empowerment recorded an increase in mental health of 1.7 points (77.1 to 78.8) and those reporting a decrease in empowerment reported an increase in mental health of 1.6 points (71.5 to 73.1). Again the finding supports the proposition, represented in figure 7.1 that enhanced social capital leads to better health.

3. Social capital, security and health —

The route between social capital and health is complex. In this final section we identify security as a mediating factor. Figure 7.9 hypothesises links between the social capital components of trust and empowerment and feelings of safety at home or out in the neighbourhood after dark. Then links are suggested between these security components and health, either mental, as measured on the MHI5 index, or general, as measured on the health 'thermometer.'



Powerfully, our analysis shows statistically significant associations between all the components linked by arrows in the diagram. Figure 7.10 illustrates the link between safety and empowerment. Panellists were divided into four groups according to their reported safety in 2000 and 2004, then divided again according to their feelings of safety in their homes alone or out in the neighbourhood at night.

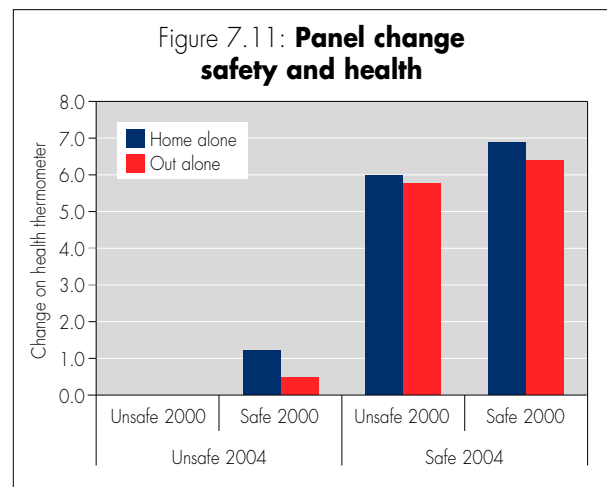


Using as the base the group who felt unsafe at both points in time, then those who felt safe at home on both occasions recorded a significant increase ($p < 0.01$) of 0.60 points on the empowerment index. Those who felt unsafe in 2000 but safe in 2004 also reported a significant increase ($p < 0.05$) of 0.45 points on the empowerment index. There were similar strong links between a positive change in empower-

ment and feelings of safety out alone at night. In summary, those whose feelings of safety remained positive on both occasions reported an increase in empowerment compared with those whose feelings of safety remained negative. Those who reported an increase in safety also reported a relative increase in empowerment.

There is also a consistent and significant association between increases in trust – horizontal and vertical – and feelings of safety both in the home and out alone at night. Further analysis will provide a more in-depth understanding of these relationships.

The link between changes in feelings of safety and health is underlined by figure 7.11. Health is measured by the health 'thermometer' which is part of the EQ-5D instrument. Those who felt safe at home on both occasions recorded a significant increase ($p < 0.01$) of 6.9 points on a thermometer scale 0-100. Those who felt unsafe in 2000 but safe in 2004 also reported a significant increase ($p < 0.01$) of 5.9 points on the thermometer. There were similar significant links between a positive change in feelings of safety out alone and positive changes in health.



Finally there are significant links also between feelings of safety and mental health. The key question however, is whether there is a reciprocal relationship; with positive changes in health leading to positive changes in perceptions of safety, and in turn, higher levels of social capital. Our earlier analysis³ of residents in Liverpool showed that improvements in residents' safety led to improvements in mental health. In the Liverpool study there was a clear sequence of cause and effect; investment leading to greater feelings of safety leading to better health. The next chapter will help throw some light on the impact of investment in our nine South Yorkshire communities.

³ Green G, Gilbertson JM, Grimsley MF [2002] Fear of crime and health in residential tower blocks; A case study of Liverpool, UK. *European Journal of Public Health*, vol12, Number 1.

8

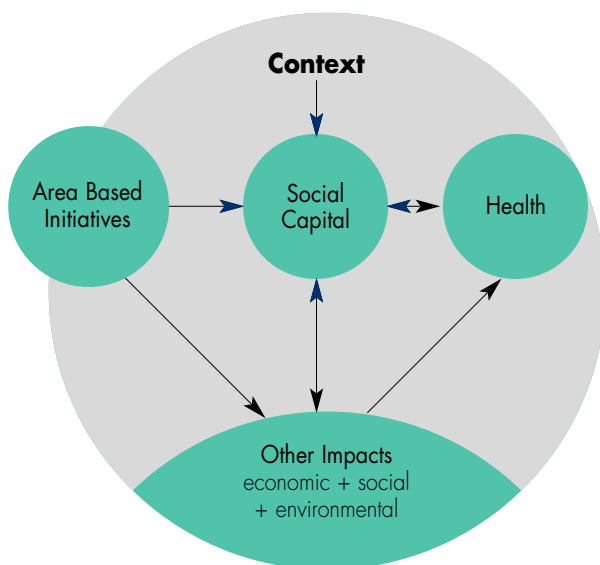
1. Attribution
2. Realistic evaluation method
3. Assessment
4. Assessment and survey results

A key question is 'Have area based regeneration initiatives helped revive social capital in our nine communities?' bringing in its train the positive benefits of health and employment outlined in the previous chapter?' The probable answer is 'yes' but it is difficult to attribute precise social capital outcomes to ABIs. The picture is complicated by three factors.

1. Attribution

First it is difficult to distinguish the wider impact of interventions applied across the whole sub-region from the narrower effect of projects focused on specific communities. Enormous sums have been invested in regenerating the South Yorkshire sub-region, principally via the Objective 1 programme funded by the European Union.¹ There is evidence of modest but widespread economic recovery since the mining closures of the 1980's.² A rising tide of economic prosperity may help re-float all our stranded communities, circumscribing (figure 8.1) potential gains from ABIs.

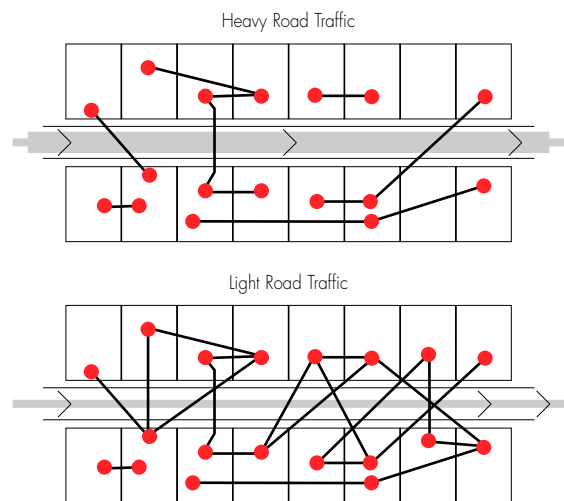
Figure 8.1



Second, also providing context, is (a) the weight of mainstream services, administered by health authorities or local authorities, and (b) historical factors – social, cultural and environmental – which have shaped a community's development and influence now its trajectory. 'Vertical trust' in political institutions illustrates the point. We define it as a key component of 'linking' social capital. By 2004 it had improved from residents' very low assessment in the baseline year of 2000. Possibly this is because (a) the three local authorities and the PCTs had improved their performance. Or (b) possibly residents had regained some confidence in civil society following a period of political alienation after the pits closed.

Third, though most ABIs do not focus explicitly on social capital, many will have an indirect impact on social capital formation. Synergies are shown with two way arrows in figure 8.1. An example is shown in figure 8.2. It could apply to the comprehensive physical renewal of Kendray. Here there are two rows of houses either side of a road with much road traffic travelling through. The road is dangerous. Children do not play in the street. Contact between neighbours is low: the neighbourhood network is not developed. The urban planners intervene to reduce through traffic. Contact between neighbours increases: the neighbourhood network develops.

Figure 8.2: **Contact between neighbours in two housing blocks**

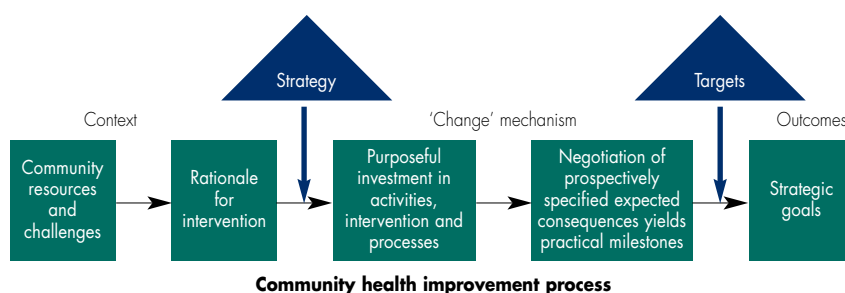


¹ Government Office for Yorkshire and the Humber (2000), *South Yorkshire Objective 1 Programme (2000-2006)*, (Wath-upon-Deane: GOYH).

Wells, P., Gore, T., and Hanson, S., (2003), *South Yorkshire Objective 1 Programme Mid Term Evaluation*, (Wath-upon-Deane: Government Office for Yorkshire and Humber).

² Beatty, C., Fothergill, S., Powell, R., (2005) *Twenty years on: has the economy of the coalfields recovered?* CRESR, Sheffield Hallam University.

Figure 8.3: **Realistic evaluation and theories of change**



2. Realistic evaluation method

In order to attribute the role of ABIs in raising levels of social capital we should ideally combine our 'before and after study' with 'realistic evaluation' of these contextual factors. Developed by Pawson and Tilley³ and proposed for the national evaluation of HAZs, such an approach discards a basic input-output model of change in favour of one which takes account of processes and context. The model is summarised by Ken Judge⁴ who directed the national HAZ evaluation and used in our local evaluation of Sheffield HAZ. Figure 1 from our report⁵ is reproduced above as figure 8.3.

The 'context' of 'community resources and challenges' applies equally to our nine communities. Then in our case the 'Change mechanism' is not only the combination of programmes and projects funded by South Yorkshire HAZ, but also the projects and programmes funded by the SRB 5/6. Our Steering Group supplied original bid documents showing how, from the outset, PCT and Local Authority staff negotiating these programmes with central government officials looked ahead ('prospectively') and agreed 'targets' in order to secure positive 'outcomes'.

With limited time and resources we have used some of the concepts of realistic evaluation in conjunction with other research methods. In January 2005, regeneration or development managers in the 9 communities under review were asked formally to assess the impact of ABIs on the development of social capital in their area between 2000 and 2004. We were interested in their assessment of change in social capital over this period, and in relation to other South Yorkshire communities, not absolute levels of social capital.

The ABI assessment form is reproduced in Appendix 2. We kept the scoring system simple. Regeneration managers were first asked to use five criteria to rank the impact of ABIs on social capital in their area, either as high (H), medium (M) or low (L). The five criteria were:

- Size of capital and revenue expenditure
- Number and diversity of projects on the ground
- Average level and duration of interventions
- Level of community participation
- Community capacity, confidence, awareness of opportunity; learning skills base

Second, managers were asked to assess the overall impact of ABIs on social capital in their area, including the interactive and indirect impacts highlighted at the end of the previous section. They gauged the overall impact of ABIs after making a judgement about the relative weight to give each criterion. Third, they accounted for contextual factors before ranking their net impact on social capital formation. These factors, which might erode or enhance social capital formation in their areas, could include for example, major building programmes, factory closures and improvements in mainstream local authority or health services.

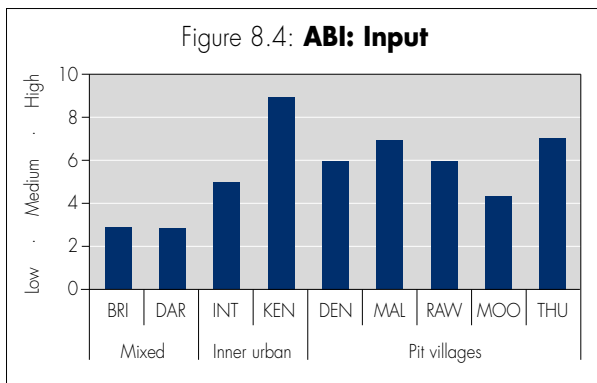
3. Assessment

Assessments were provided by managers identified by their regeneration team. In Doncaster these were quasi autonomous bodies covering an area larger than our study neighbourhoods – *Conisbrough and Denaby Community Development Trust, Thorne and Moorends Regeneration Partnership and Intake Community Enterprise*. In Barnsley there were similar arrangements, with managers accountable to quasi autonomous 'forums' supported by the Council, in *Darfield & Wombwell* and *Dearne North-Thurnscoe*. In the Kendray area, the manager reported to the *Neighbourhood Management Pathfinder*. In Rotherham managers were accountable to 'Area Assemblies' in *Rother Valley West, Wentworth Valley* and *Wentworth South*, all part of an extended democratic structure funded by Rotherham Metropolitan Council.

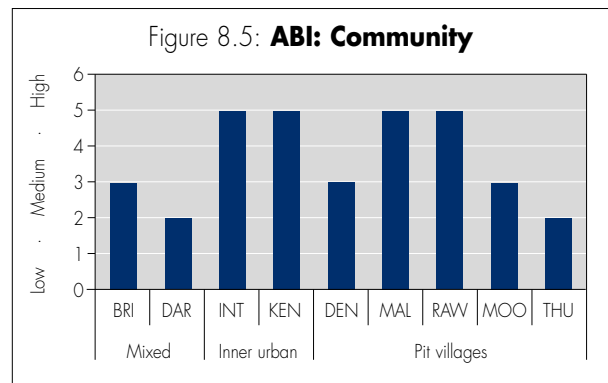
³ Pawson R, Tilley N (1997) *Realistic Evaluation*. Sage. London.

⁴ Judge, K. (2000) Testing evaluation to the limits: the case of English Health Action Zones. *Journal of Health Service Research Policy* 5; 1 January.

⁵ Peters J, Suokas A, Green G (2002) *Tackling Health Inequalities in Sheffield*. CRESR, Sheffield Hallam University.



Note: Managers were asked to rank ABIs in their area as high (3), medium (2) or low (1) according to (a) number, (b) level of expenditure and (c) duration. Figures are summed to a maximum of 3x3 = 9.



Note: Managers were asked to rank ABIs in their area as high (3), medium (2) or low (1) according to (a) community involvement and (b) community participation. Figures are summed to a maximum of 2x3 = 6.

Managers assessed the mix of ABIs reported in the area profiles summarised in chapter 4, with the *South Yorkshire Objective 1 Programme* often the major source of funding. Though applied across the whole sub-region to promote economic regeneration, significant elements of the programme are implemented at a community level. Priority 4a is 'aimed at rebuilding social and community strength and organisation' through a combination of initiatives to promote employment, health awareness and community safety. Measure 20 highlights preventive actions which tackle barriers to community participation arising from crime and fear of crime.' Often Objective 1 funds are matched with the Single Regeneration Challenge Funds (SRB5/6, 1999-2007).

The match is variable. At one end of the spectrum is the inner-urban area of Kendray (KEN), host to a concerted and growing regeneration effort between 2000 and 2004. The manager reports 'a dedicated staff team of six people driving forward the renewal agenda and ensuring co-ordination of all (extensive) funding sources.' This is reflected in figure 8.4 where it is ranked highest according to the number of projects on the ground, their duration and level of resources.

At the other end of the spectrum are the two mixed, relatively prosperous areas of Brinsworth (BRI) and Darfield (DAR) where the respective managers report 'no ABIs specifically targeted at Brinsworth' and 'Darfield has received little in terms of funding programmes.' These two ends of the funding spectrum reflect sub-regional policies of assigning most resources to the most deprived communities.

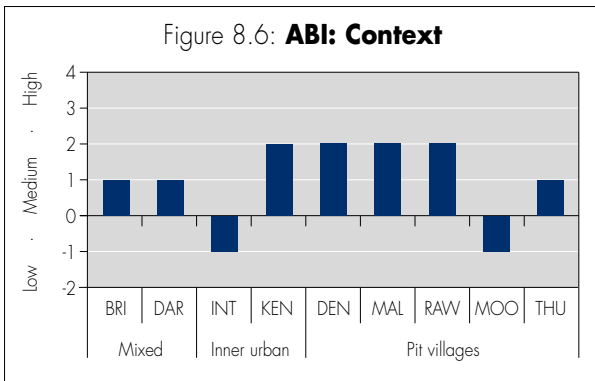
Ranked in the middle of the spectrum are the five ex-mining communities, all eligible for ABIs derived from Objective 1 and other funding sources. Managers' varying assessments reflect differing political and administrative challenges in bringing projects on-stream. The regeneration manager for Moorends (MOO) reported 'a lot of talk and little action from mid-2002 to 2003' with real progress only in 2004 when political differences were resolved. For managers in Rawmarsh (RAW) and Maltby (MAL), 'slippage' is caused

by the bureaucratic demands of the Objective 1 programme – 'changing the goalposts in not allowing something one year and then changing their minds or even going to the extent of not allowing something that they have previously agreed to' and 'frustration within the community regarding accessing the Objective 1 money targeted at the area. Red tape and changing priorities appear to be the main complaints, resulting in little money spent so far.' The manager assessing ABIs in Intake (INT) concurred. Though much has been achieved 'the process of accessing and actually receiving funding from the EU has been beset by problems, delays and a series of goal-post changing decisions that have the potential to bring the (regeneration) organisation to its financial knees.'

Three of the five managers reporting high project inputs also report the highest levels of community involvement and capacity (figure 8.5). 'A key principle of the Kendray Neighbourhood Management Pathfinder is to ensure community engagement at all levels.' Then 'the establishment of the Town Council, Maltby Forum, Maltby Community Development Trust and East Maltby Neighbourhood Renewal Partnership is an indication of Maltby people starting to take control over their lives once more.' The Denaby assessment team of four people reported 'more individuals and groups engaged in their communities.'

Thurnscoe is the exception, with relatively high levels of reported investment but low levels of community involvement and capacity. The manager reported that, as elsewhere, the threat of large scale demolition associated with Housing Market Renewal 'demonstrated that residents distrust the agencies that are trying to help' and 'it is difficult to get the community to accept they are part of the solution.' In Darfield, limited ABI activity is matched by low levels of community participation. Such limited local funding 'could significantly impact on the community's belief in itself that it can actually make a difference to its own locality.'

Other managers reflect on the fluctuating fortunes of their areas. Intake appeared to be riding high when our resident survey was conducted in the autumn of 2004 but 'a serious



Note: Managers were asked to rank the contextual influences on social capital as high (3), medium (2) or low (1) with provision for a negative impact (-1).

setback occurred in November/December 2004 when a significant element of the located funding was withdrawn... Locally, people did not understand how this could be allowed to happen and a degree of disengagement occurred.' In Moorends the slow pace of implementing ABIs induced some scepticism in the community, though the manager anticipates an upturn in community involvement. 'From 2004 'the staff team has worked to engage the community at all levels; holding capacity building events, community spirit events, promoting training and development, encouraging volunteering, strengthening community and voluntary groups by sharing information and promoting sustainability... I would anticipate the impact on social capital to be very positive.'

Context is important. The performance of ABIs and their impact on social capital, can be enhanced or eroded by wider influences. Managers were asked to rank and elaborate these factors, with provision for making a negative assessment.

Again the most positive report was from Kendray, where a major housing renewal programme was assessed as having a positive impact. In Maltby also, 'the 'painful' process of housing demolition and renewal has given way to positive

perceptions` of the end result. In Denaby the 'trials and tribulations' of the failed Earth Centre is counterbalanced by the 'positive impact of investment in the transport and leisure infrastructure.' The two negative assessments for Moorends and Intake relate to the fluctuating fortunes of ABI investment referred to earlier. Both refer to the 'stubbornness' and resilience of their communities in the face of setbacks.

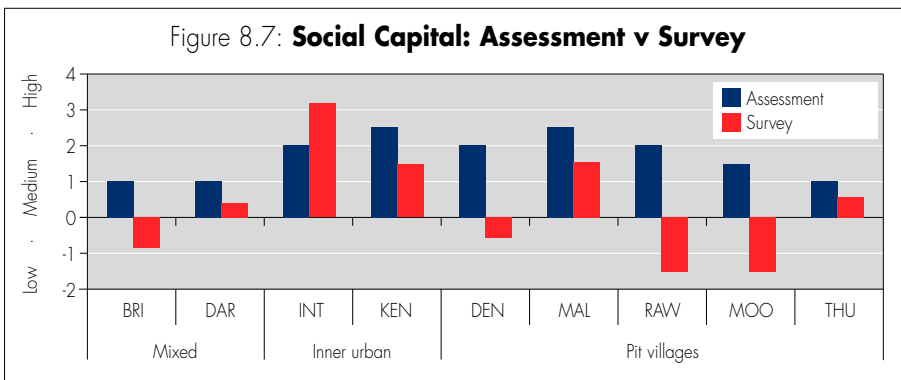
4. Assessment and Survey results

How do the expert assessments of regeneration managers compare with the results of the residents' survey? The headlines in final figure 8.7 shows only limited correspondence. Here managers' overall assessment (a) of the combined impact of ABIs and context on social capital formation is compared with (b) an estimate of change in social capital between 2000 and 2004 derived from the survey of residents. Resident opinion is derived by summing four elements of social capital identified in chapter 6 – neighbourhood reciprocity, empowerment, vertical trust and horizontal trust.

Not too much should be read into these headlines at this stage. Clearly the two inner-urban areas of Kendray and Intake rank high according to managers overall assessment and resident opinion; the two mixed areas rank low on both. But results from the 'pit villages' are mixed.

Limitations on time and resources have limited the analysis. A more sophisticated analysis would take account of the different time periods for assessment (in early 2005) and survey (in the autumn of 2004). For example, in Intake, the manager's assessment reflected a deterioration in November 2004, whereas in Moorends the manager reported an upwards trajectory from mid 2004, continuing after the survey period. A more sophisticated analysis would also explore linkages and pathways by decomposing both the assessments and resident opinion into constituent elements of social capital. Kendray is a good case in point. The area has been disrupted, much more than all the other

eight, by demolition and housing renewal. A consequently high turnover of residents can be plausibly linked to the reduction in bonding or 'horizontal' trust. As a counterpoint, sustained community involvement in a concerted regeneration programme led to the biggest increase in empowerment of all nine communities and the second biggest increase in vertical trust in political institutions since the year 2000.



Note: Managers were asked to rank the overall context of ABIs in their area as high (3), medium (2) or low (1). Changes in resident perceptions of social capital were derived from changes in neighbourhood reciprocity (fig 6.8) in empowerment (fig 6.10) in vertical and horizontal trust (fig 6.13).

9

1. Social capital, health and prosperity
2. Reversing decline
3. Balanced investment
4. Synergies
5. Asset or welfare: drain or sustain
6. Healthy neighbourhoods, not just healthy lifestyles
7. Incapacity benefit
8. Community safety
9. What works?

Our social capital surveys set out to assess the combined impact of two major public programmes on nine communities in South Yorkshire. These are a HAZ and round 5 of a programme financed from the UK Government's SRB. Both nest within the £1.7 billion *Objective One Programme* for the sub-region supported by the European Union. And both were designed – inter alia – to boost levels of social capital in deprived communities of the sub-region. The results of our evaluation are presented in technical chapters 5-8 of the report. In this concluding chapter we have drawn on the expertise of the Steering Group for this study to highlight **nine key messages** for Government Departments, Local Strategic Partnerships (LSPs), Regional Development Agencies (RDAs), PCTs, Local Authorities (LAs) and the community and voluntary sector.

1. Social capital, health and prosperity

Our main message is that 'social capital contributes to health and prosperity both at a regional and neighbourhood level.'

reinforcing the message of our baseline study in 2000. The 2004 follow-through study has added more compelling evidence than could be derived from the baseline study alone. Measuring change over four years, the follow-through survey reveals the *dynamic* of social capital, health and economy. There is evidence of recovery, both from national reports and our own study. And though much of the expenditure under European and national regeneration

programmes is on physical infrastructure and business development, it is clear that investment in the social fabric of our communities has made a significant contribution to health and prosperity.

2. Reversing decline

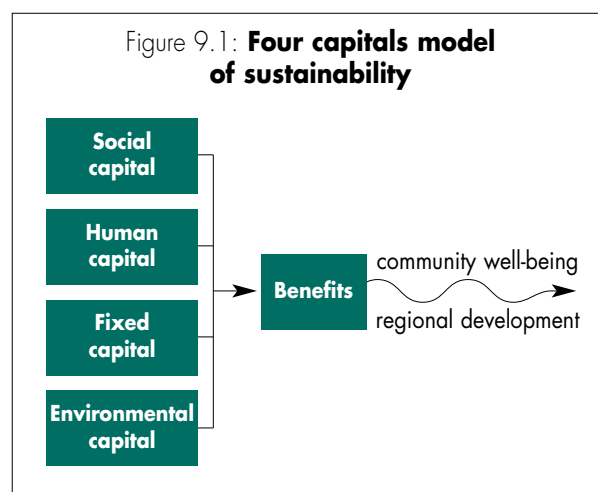
Message two is 'successful regeneration is influenced by the scale of resources and the degree of community engagement.'

Comparing all our neighbourhoods, the most significant improvements are in Kendray in Barnsley. Here, a critical volume of investment has helped the community recover from a low point in the year 2000. And equally important, the process of renewal has engaged the community, engendering significant improvements in 'linking social capital' – connections with wider society necessary, in the words of Robert Putnam, for residents to 'get on' in life rather than just 'get by.'

3. Balanced investment

Message three is 'investment in social capital is a vital element of any balanced regeneration programme.'

Our baseline report proposed a four capitals model of neighbourhood sustainability and regional development derived from the World Bank. These are shown in figure 9.1 as producing a flow of benefits.



Ref: World Bank

The first three capitals – physical, environmental and human – are long established. The recent addition of social capital reflects recognition by the World Bank that investment in society is a key element of development programme no matter where in the world it takes place. According to a vice president Ismail Serageldin,

*'Social capital refers to the internal social and cultural coherence of society, the norms and values that govern interactions between people and the institutions in which they are embedded. Social capital is the glue that holds society together and without which there can be no economic growth or human well-being.'*¹

There is a strong message here for regional development agencies in the UK. It is not enough to invest in fixed capital such as roads and plant, nor even just in the skills element of human capital. Significant investment in the maintenance and renewal of social capital is a vital part of a balanced approach to regeneration. Moving now beyond an early focus on fixed capital investment, a balanced approach is more evident in strategic documents such as the updated *Regional Economic Strategy (RES)* for Yorkshire and the Humber² and in the *South Yorkshire Investment Plan (2004-2009)*.³ There is greater recognition that socially cohesive communities and workplace networks enhance economic performance.

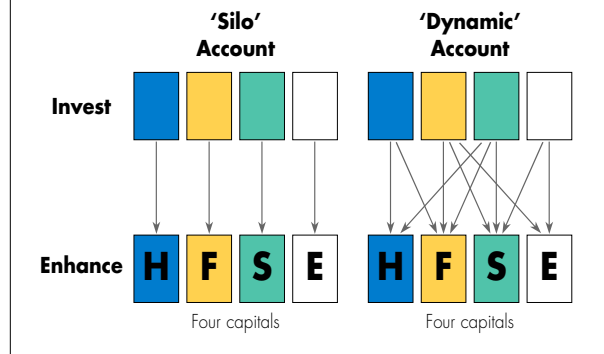
4. Synergies

Message four is 'investment in social capital has enhanced levels of human capital and helped people into work.'

Synergies like this, 'spillovers' as economists call them, are not sufficiently articulated in strategic development frameworks. The RES and the *Our Region: Our Health*⁴ both now at least acknowledge health as an asset for economic development. Put more formally, health is one of the two key components of human capital, ranking alongside skills and qualifications to make a person 'fit for work.' However, our study suggests much greater precision is required in modelling and measuring synergies between capitals. This *dynamic* form of accounting shown in figure 9.2, considers not only the impact of investment within the 'silo' – for example the impact of investment in transport on transport infrastructure and the benefits which flow in the form of enhanced communication – but also the wider impact of any investment on the formation of other types of asset.

Our evidence is that investment in social capital has reaped dividends by enhancing levels of human capital and, as chapter 5 shows, by greater participation in the labour market. There is a powerful message here for regional

Figure 9.2: 'Dynamic' versus 'silo' accounting



agencies and LSPs, 'don't be imprisoned by 'silo' targets which measure investment outcomes only within a single domain.' Instead consider 'dynamic' targets across the piece – for example, assess the value of fixed capital investment in housing by health targets, or use economic performance targets as a way of evaluating investment in social capital. Then, after accounting for all these synergies, consider the combined assets of a community or region as drivers of social development and economic growth.

5. Asset or welfare: drain or sustain

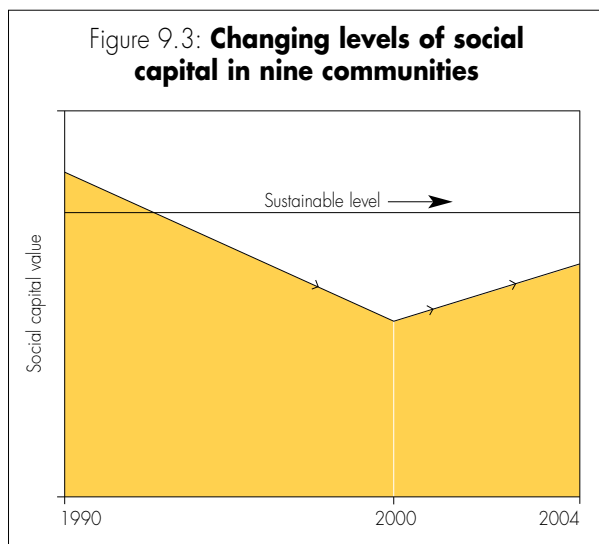
Message five is 'social capital is an asset which must be replenished in order to promote economic regeneration and neighbourhood sustainability.'

Social capital is just that – 'capital.' It is an asset for community and regional development rather than a drain on resources. LSPs and RDAs could sharpen up this distinction in their strategies and framework documents. Health and social cohesion often figure in strategic documents. But too often they are regarded as downstream welfare issues, the human face of economic development. The RES and *'Our Region: Our Health'* have now at least rehabilitated health as an asset. The challenge is to do the same with social capital, embedding it centrally within strategic documents, mainstream service plans and regeneration programmes. The South Yorkshire Investment Plan acknowledges there are *'connections between the economic, environmental and social fortunes of an area'* and *'future reviews.. will highlight these connections more fully.'*

¹ Referred to in Grootaert G., *Social Capital: The Missing Link?* (PDF file) World Bank. SCI Working Paper No. 2, April 1998. See also OECD 2001a, *The Well-Being of Nations; the Role of Human and Social Capital*. Centre for Educational Research and Innovation. Paris OECD.
² *Regional Economic Strategy: Ten year strategy for Yorkshire and the Humber 2003-12*. Yorkshire Forward 2003.
³ *South Yorkshire Investment Plan 2004-2009*. The South Yorkshire Partnership 2004.
⁴ Yorkshire and Humber regional Public Health Group (2004) *Our Region; Our Health: A Regional Strategic Framework for Public Health in Yorkshire and the Humber*. Government Office for Yorkshire and the Humber.

LSPs and regional development agencies also need to sharpen up their understanding of sustainable development. The Rio Earth Summit popularised the concept of environmental sustainability; not compromising the world's long term environmental capital for short term economic gain. But the concept applies also to human and social capital. The coalmining industry in South Yorkshire Coalfield played a major role in depleting human capital in the sub-region by bringing illness and disability in its train, thereby compromising future economic development. Any amount of investment in fixed capital assets will not deliver economic performance unless the workforce is fit for work. And as chapter 5 shows, long term limiting illness in our nine communities runs at twice the national average, though the position now appears to be improving.

As the South Yorkshire Investment Plan argues (page 25), the erosion of social capital also compromises future development. Figure 3 is a schematic representation of the decline and modest improvement in the value of social capital in our nine communities. There is anecdotal evidence of its decline in the period following pit closures, when the bonds which tied together close knit mining communities, gradually unravelled. Having lost their economic rationale, these communities were also very obviously becoming socially dysfunctional, with reciprocity, trust and feelings of safety on an unsustainable downward trajectory. *In extremis* streets will be abandoned when neighbourhood assets are so depleted as to be wholly unattractive to existing residents and potential incomers.



Changes in social capital values between 2000 and 2004 suggest these nine neighbourhoods may now be on an upwards trajectory. They may not yet have achieved sustainable levels of social capital, but are on the way to doing so.

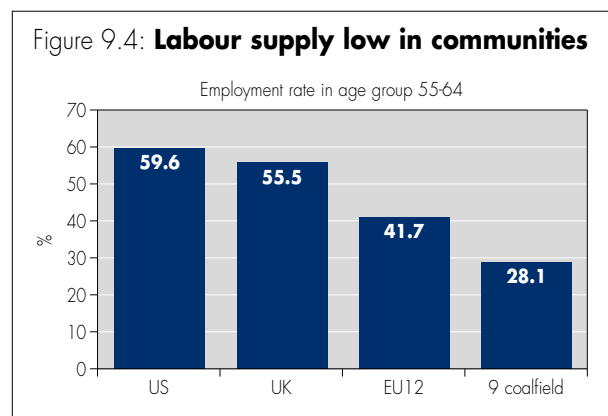
6. Healthy neighbourhoods, not just healthy lifestyles

Message six is 'empowerment and trust contribute to healthier neighbourhoods through improved mental health. These aspects of social capital may be as amenable to public interventions as promoting healthy lifestyles.'

Social context is an important influence on health status, with implications for the policy and practice of reversing health inequalities. Encouraging individuals to choose a healthier lifestyle, the current public health approach of the UK government,⁵ should be balanced by investment designed to enhance the social capital of deprived neighbourhoods. The increasing proportion of obese people and only modest reductions in smoking over the past 20 years point to limitations in lifestyle programmes which focus on the individual. WHO has criticised this '*deficit model*' which accepts an unhealthy social system and responds by 'buying-back health through public health programmes.'⁶ Chapter 7 implies an alternative route to physical well-being. Empowerment and trust, key elements of social capital, are inextricably linked to mental health. In turn, there is evidence indicating 'mental well-being is crucial to good physical health.' (*Choosing Health*, executive summary). Empowerment, trust and reciprocity are all amenable to programme interventions at a neighbourhood local level.

7. Incapacity benefit

Chapter 5 shows how despite some improvement between 2000 and 2004, employment rates are much lower in our nine communities than the national average, and figure 9.4 shows just how much they are below the averages for the United States and European Union.



Source: EU = Eurostat 2004

Differences within UK regions are much greater than between regions. For example the male employment rate in Barnsley for 50-64 year olds is 23 points below the rate in prosperous Harrogate; permanent sickness/disability accounts for 64 per cent of inactive males aged 50-64 in Barnsley but only 32 per cent in Harrogate.

⁵ Department of Health. *Choosing Health: making healthier choices easier*. HMSO 2004

⁶ Suhrcke M, McKee M, Sauto R, Tsolova S, Mortensen J [forthcoming 2005] *The Contribution of Health to the Economy in the European Union*, European Commission.

Message seven is 'social capital encourages participation in the labour market through better mental health, a key factor behind high rates of long-term sickness. Social capital can also help create a neighbourhood milieu which encourages people back to work.'

There are clear implications for government policy. *Pathways to Work*,⁷ highlights mental and behavioural disorders as the single biggest cause of incapacity and a brake on economic performance. Yet the focus of the UK government is (as with public health) on individualised programmes. The pilot projects which emanate from the key government Green Paper, focus on 'giving people choices.' Our evidence suggests it would be useful if there is flexibility to utilise broader community programmes into the range of measures to overcome barriers preventing incapacity claimants entering or re-entering the labour market. Locally as nationally, about a third of incapacity claimants cite 'mental or behaviour disorder' as the cause of their incapacity. Chapter 7 of our report highlights the link between raised levels of social capital and better mental health and of the relationship between health and employment.

8. Community safety

Message eight is 'community safety is enhanced by increased levels of social capital, reducing fear of crime and leading in turn to better mental health.'

Our results (chapter 5) confirm that fear of crime in the nine communities is a big issue, more prevalent than elsewhere in Britain. However there has been a slight improvement in feelings of safety since 2000, probably associated with generally raised levels of social capital and the target hardening programmes favoured by local regeneration agencies. Chapter 7 provides powerful new evidence that increased levels of social capital increase feelings of safety. People feeling more empowered in 2004 than previously were less fearful of going out alone in their neighbourhood at night and this in turn was linked to better health.

9. What works?

Final message nine is 'further analysis is needed to properly assess how ABIs have contributed to increasing social capital. "What works best, and how" should be the subject of further research.'

We concluded in chapter 8 that the various ABIs to regenerate the nine communities, have contributed in some way to the overall increase in social capital and to the improvements in employment and health and security revealed in chapter 5. However, the picture is complex. Without further analysis

it is difficult to distinguish the impact of special regeneration initiatives from the influence of the mainstream programmes of local authorities and PCTs. The overall prospects for each neighbourhood may have improved, but what has worked best? Can we attribute big gains to certain programmes and can these be reinforced to maximise future benefits? Our partners wish to know. We have decided to investigate further.

⁷ Department of Work and Pensions. *Pathways to work: Helping people into employment*. HMSO 2002.

South Yorkshire Coalfield Social Capital Survey			
Interviewer Initials	Date Interviewed	Label Reference	
[] [] [] []	Day: [] [] / Month: [] [] / Year: [] [] [] []	[] [] [] [] [] [] [] []	
Good morning/afternoon my name is _____ from Sheffield Hallam University and we are carrying out a survey in South Yorkshire. You should have received a letter from us recently saying we would call. All your answers will be treated with the strictest confidence.			
Q1 a) How many people live in this household?			
Adults (18+)	[] []	Children	[] []
Total		[] []	
b) If living with children, how many are there in each of the following age groups? (fill in all that apply)			
0 - 4 year	[] []	5 - 14 years	[] []
15 - 17 years		[] []	
Q2 Is the house/flat you which you live? (mark one box only)			
Rented from Housing Association	<input type="checkbox"/>	Owned outright (no loan)	<input type="checkbox"/>
Rented from Co-op	<input type="checkbox"/>	Owned with mortgage	<input type="checkbox"/>
Rented from Council	<input type="checkbox"/>	Other	<input type="checkbox"/>
Rented from private landlord	<input type="checkbox"/>	Don't know	<input type="checkbox"/>
Q3 a) How long have you lived in (insert relevant area)? (mark one box only)			
Less than a year	<input type="checkbox"/>	1 year but less than 2 years	<input type="checkbox"/>
2 years but less than 4 years	<input type="checkbox"/>	4 years but less than 5 years	<input type="checkbox"/>
5 years but less than 10 years	<input type="checkbox"/>	10 years but less than 20 years	<input type="checkbox"/>
b) How long have you lived in this property? (mark one box only)			
Less than a year	<input type="checkbox"/>	1 year but less than 2 years	<input type="checkbox"/>
2 years but less than 4 years	<input type="checkbox"/>	4 years but less than 5 years	<input type="checkbox"/>
5 years but less than 10 years	<input type="checkbox"/>	10 years but less than 20 years	<input type="checkbox"/>
Q4 Taking everything into account, to what extent are you satisfied or dissatisfied with (insert relevant area)? (SHOWCARD 1)			
Very satisfied	<input type="checkbox"/>	Fairly satisfied	<input type="checkbox"/>
Neither satisfied nor dissatisfied	<input type="checkbox"/>	Fairly dissatisfied	<input type="checkbox"/>
Q5 Over the last 5 years, how, if at all, has (insert relevant area) changed as a place to live? (mark one box only)			
Got a lot better	<input type="checkbox"/>	Got a little better	<input type="checkbox"/>
Stayed about the same	<input type="checkbox"/>	Got a little worse	<input type="checkbox"/>
Got a lot worse		(spontaneous) Don't know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q6 a) Do you want to stay in (insert relevant area)? (mark one box only)													
Yes <input type="checkbox"/>			No <input type="checkbox"/>										
b) How likely are you to stay in (insert relevant area)? (mark one box only)													
Very likely to stay	<input type="checkbox"/>	Fairly likely to stay	<input type="checkbox"/>	Not very likely to stay	<input type="checkbox"/>	Not at all likely to stay	<input type="checkbox"/>						
						(spontaneous) Don't know							
						<input type="checkbox"/>							
Q7 Please say whether you are satisfied with these local amenities? (SHOWCARD 1) (Please mark one box on each line)													
		Very satisfied	<input type="checkbox"/>	Fairly satisfied	<input type="checkbox"/>	Neither	<input type="checkbox"/>	Fairly dissatisfied	<input type="checkbox"/>	Very dissatisfied	<input type="checkbox"/>	(spontaneous) Don't know	<input type="checkbox"/>
a General appearance of the area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b Quality of local health services (surgeries, health centres etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c Quality of the local police service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d Availability of jobs for local people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e Public Transport to where you want to get to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f Quality of the local shops	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g Quality of leisure & community facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
h Quality of housing in the area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q8 Can you tell me how much of a problem alcohol or drug use is in your area? (mark one box only)													
Very big problem	<input type="checkbox"/>	Fairly big problem	<input type="checkbox"/>	Minor problem	<input type="checkbox"/>	Not at all a problem	<input type="checkbox"/>	It happens but not a problem	<input type="checkbox"/>	(spontaneous) Don't know			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q9 Can you tell me how much of a problem hooliganism and vandalism is in your area? (mark one box only)													
Very big problem	<input type="checkbox"/>	Fairly big problem	<input type="checkbox"/>	Minor problem	<input type="checkbox"/>	Not at all a problem	<input type="checkbox"/>	It happens but not a problem	<input type="checkbox"/>	(spontaneous) Don't know			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q10 Thinking about your immediate area would you say that you know (mark one box only)													
most of the people in your neighbourhood		many of the people in your neighbourhood			a few of the people in your neighbourhood		do not know many people in your neighbourhood						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q11 To what extent do you agree or disagree that this neighbourhood is a place where people from different backgrounds get on well together? (mark one box only)													
Definitely agree	<input type="checkbox"/>	Tend to agree	<input type="checkbox"/>	Tend to disagree	<input type="checkbox"/>	Definitely disagree	<input type="checkbox"/>	(spontaneous) Don't know		(spontaneous) Too few people in neighbourhood			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
(spontaneous) All same backgrounds													
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Q12 How often do you talk to the following groups of people; friends, family not living with you, and neighbours. How often do you talk socially with work or college colleagues out of hours? (Please mark one box in each column)				
	Friends	Family	Neighbours	Work/study colleagues
a Everyday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b 2-3 times a week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c About once a week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d About once a month	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e Every few months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f Special occasions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g Hardly ever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h Never	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i Don't know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j Do not have any	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k Not applicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q13 In general what kind of neighbourhood would you say you live in? Would you say it is a neighbourhood in which people do things together and try and help each other or one in which people mostly go their own way? (mark one box only)				
Help each other		Go own way		Mixture
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q14 In the past 6 months, have you done a favour for a neighbour? (mark one box only) (probe)				
Yes		No		Just moved into area
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q15 a) If you needed a lift to be somewhere urgently, could you ask anyone for help? (mark one box only)				
Yes		No		Don't know/depends
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) If yes, please can you look at this card and tell me who you could ask for help (mark all that apply) (SHOWCARD 2)				
Husband/wife/partner <input type="checkbox"/>				
Other household member <input type="checkbox"/>				
Relative (outside household) <input type="checkbox"/>				
Friend <input type="checkbox"/>				
Neighbour <input type="checkbox"/>				
Work colleague <input type="checkbox"/>				
Voluntary or other organisation <input type="checkbox"/>				
Other <input type="checkbox"/>				
Would prefer not to ask <input type="checkbox"/>				
(spontaneous) Don't know <input type="checkbox"/>				

Q16 How much do you trust these groups of people? (Please mark one box on each row)						
	Trust them completely	Trust them a little	Neither trust nor distrust them	Do not trust them very much	Do not trust them at all	(spontaneous) Don't know
a Police	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b Courts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c Government	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d Local council	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e Local councillors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f Local employers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g Neighbours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q17 How safe do you feel when you are alone in your home at night? (If you are never alone, how safe would you feel if you were alone?) (mark one box only)						
Very safe		Fairly safe		A bit unsafe		Very unsafe
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q18 How safe do you feel walking alone in this area/estate after dark? (If you never go out alone at night, how safe would you feel if you were out alone?) (mark one box only)						
Very safe		Fairly safe		A bit unsafe		Very unsafe
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q19 In the past 12 months have you been a victim of crime? (mark one box only)						
Yes		No		(spontaneous) Don't know		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q20 Would you say that you are well informed about local affairs? (mark one box only)						
Very well informed	<input type="checkbox"/>	Fairly well informed	<input type="checkbox"/>	Not well informed	<input type="checkbox"/>	Poorly informed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Other
						<input type="checkbox"/>
						(spontaneous) Don't know
						<input type="checkbox"/>
Q21 Have you been involved in any local organisation(s) or activities over the last 3 years? (such as sports, PTA, youth clubs) (mark one box only)						
Yes			No			Other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						(spontaneous) Don't know
						<input type="checkbox"/>

Q22 Which of these categories on this card best describe any groups you have taken part in over the last 3 years? (mark all that apply) (SHOWCARD 3)

Hobbies/social clubs

Sports/exercise groups, including taking part, coaching or going to watch

Local community or neighbourhood groups

Groups for children or young people

Adult education groups

Groups for older people

Environmental groups

Health, disability and welfare groups

Political groups

Trade Union groups

Religious groups, including going to a place of worship or belonging to a religious based group

Other group (please write in box)

(spontaneous) Don't know

Q23 How much do you agree or disagree with the following statement 'I am satisfied with the amount of control I have over decisions that affect my personal life' (mark one box only)

Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree

Q24 How much do you agree or disagree with the following statement? 'By working together, people in my neighbourhood can influence decisions that affect the neighbourhood' (mark one box only)

Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree

Q25 Do you suffer from any long standing illness, health problem or disability which limits your daily activities or work in any way? (mark one box only)

Yes, health problem limits activities No, have no such health problem

Q26 Please mark one box to indicate which of these statements best describes your own state of health today?

a) Mobility

I have no problems walking about

I have some problems walking about

I am confined to bed

b) Self care

I have no problems with self care

I have some problems with washing or dressing myself

I am unable to wash or dress myself

c) Usual activities (e.g. work, study, housework, family or leisure activities)

I have no problems performing my usual activities

I have some problems with performing my usual activities

I am unable to perform my usual activities

d) Pain/discomfort

I have no pain or discomfort

I have moderate pain or discomfort

I have extreme pain or discomfort

e) Anxiety/depression

I am not anxious or depressed

I am moderately anxious or depressed

I am extremely anxious or depressed

Q27 To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is 100 and the worst state you can imagine is marked 0. Please indicate on this scale how good or bad your health is today in your opinion. (SHOWCARD 4)

Indicated number

Q28 These questions are about how you feel and how things have been with you during the past four weeks. For each question, please indicate the one answer that comes closest to the way you have been feeling. (mark one box per row) (SHOWCARD 5)

	All of the time	Most of the time	A good bit of time	Some of the time	A little of the time	None of the time
a Have you been a very nervous person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d Have you felt downhearted and low?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e Have you been a happy person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q29 Which of these sentences best describes the amount of stress or pressure you experienced in the past 12 months? (mark one box only) (SHOWCARD 6)

I have been completely free of stress or pressure

I have experienced a small amount of stress or pressure

I have experienced a moderate amount of stress or pressure

I have experienced a large amount of stress or pressure

(spontaneous) Don't know

Q30 a) Is there any way in which your life is healthier now than it was four years ago? (mark one box only)

Yes No

b) If yes, in what ways has it become more healthy? (mark all that apply)

Eat more fruit and/or vegetables

Stopped or reduced drinking alcohol

Stopped or reduced smoking

Increased physical activities (e.g. gardening/walking/sports)

Other (please write in box)

Q31 Are you:

Working full time (30 hours or more a week)

Working part time (up to 30 hours a week)

Self employed

On a government training scheme

Unemployed and looking for a job

Unable to work because of long term sickness or disability

At school or in other full time education

Retired from paid work

Looking after the home or family

Other (please write in box)

Q32 Are you undertaking any part time study?

Yes No

Q33 Which best describes your highest skills and qualifications? (mark one box only)

Have skills but no formal qualifications	- Such skills as childcare, gardening, cooking, knitting, DIY, typing, car maintenance, using computers	<input type="checkbox"/>
NVQ 4+	or HNC, HND, higher BTEC Teaching qualification First Degree NVQ 5 Higher Degree Nursing qualification Other professional qualification	<input type="checkbox"/>
NVQ 3 qualifications	or Apprenticeship qualifications (Advanced) A level BTEC National/ONC/OND, etc GNVC - Advanced level	<input type="checkbox"/>
NVQ 2 qualifications	or City & Guilds GCSE at A-C, O level BTEC General Diploma RSA Diploma Apprenticeship qualifications (Basic) GNVC - Intermediate	<input type="checkbox"/>
NVQ 1 qualifications	or CSE Ungraded GCSE D - G	<input type="checkbox"/>
Other (Please specify)	<input type="text"/>	
None	<input type="checkbox"/>	

Q34 Finally, what would make this area a better place to live?

Please give your full date of birth

Day / Month / Year

Are you: Male Female

Thank you for your time. All the information that you have given is strictly confidential.

THE IMPACT OF AREA BASED INITIATIVES ON SOCIAL CAPITAL FORMATION

The Social Capital Steering Group decided to simplify the assessment proforma in response to input from regeneration managers at our meeting on 20th January 2005.

We would like regeneration/development managers in the 9 communities under review to assess the impact of ABIs on the development of social capital in their area between 2000 and 2004. We are interested in change in social capital over this period, and in relation to other South Yorkshire communities, not absolute levels.

We have kept the scoring system simple. **First** use five criteria to rank impact on social capital high (H), medium (M) or low (L). **Second**, gauge the **overall** impact of ABIs by adding up the scores. In doing so, please judge the relative weight to give each criterion; they will differ. **Third**, please consider other contextual factors and rank their combined impact on the area.

Please tick one box per row – negative or High, Medium, Low

Community Name.....		Impact on Social Capital			
		Negative	Positive		
Area Based Initiatives : Criteria			H	M	L
1. Expenditure	size of capital and revenue				
2. Projects off the ground	number and diversity				
3. Duration	average level of interventions between 2000 and 2004				
4. Community involvement	level of participation				
5. Community capacity	confidence, awareness of opportunity, learning/skills base				
<i>Overall ABI impact</i>	<i>social, economic and environmental interventions. Have the combined interventions really made an impact on social capital? Elaborate overleaf</i>				
<i>Context</i>	<i>gauge the impact of other factors e.g. major building programme, factory closure, improvement in mainstream local authority services. Elaborate overleaf</i>				
ABI + Context	The combined impact of ABIs and context 2000-2004				

<i>Overall ABI impact</i>	<i>Elaborate here the reasons</i>
<i>Context</i>	<i>Elaborate here key contextual issues and their impact</i>

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